

**Testimony on Special Housing Units
before the Corrections Committee of the New York State Assembly**

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I am the director of the Prison Visiting Project of the Correctional Association of New York, a nonprofit organization founded in 1844. The Correctional Association is one of just two nongovernmental organizations in the United States that has statutory authority to enter prisons and report on conditions of confinement to policymakers and the public. Our access offers a unique opportunity to observe and document conditions and to learn from inmates and staff about the strengths and weaknesses of prison operations and practices.

The subject I will address today is the dire need for more humane housing and treatment for the nearly 1,000 inmates with mental illness who are currently confined in 23-hour disciplinary lockdown in New York State prisons. My testimony is based on findings from a recently completed two-year research study, of which I served as principal investigator. The study examined the quality of mental health care in New York prisons and involved site visits to 23 correctional facilities by project staff and outside psychiatrists.

The vast New York State prison system, comprised of nearly 66,000 inmates in 70 prisons, is home to an increasing number of inmates with mental illness. Currently, approximately 7,400 inmates are on the mental health caseload, a 71% increase since 1991. DOCS and OMH staff we interviewed reported that resources and treatment beds have not kept pace with the growing number of seriously mentally ill inmates in the prison system. For example, despite the near tripling of the inmate population since the state's inpatient hospital for inmates with mental illness (Central New York Psychiatric Center) opened in 1980, it has never been expanded.

While inmates with mental illness constitute approximately 11% of the general prison population in New York, their representation in 23-hour disciplinary lockdown is more than double that percentage: fully 23% of the inmates in disciplinary lockdown are mental health patients. Inside these prisons within prison, officially known as Special Housing Units, or SHUs, inmates can spend months or even years isolated in a concrete cell measuring 56 square feet with little natural light, no programs and minimal human interaction. Essentially, inmates in SHUs are warehoused, with little to do but read, pace or stare at the walls. They are "cell-fed" through "feed-up" slots in thick metal doors. If they choose to leave their cell for their hour of court-mandated recreation, they are mechanically restrained with handcuffs attached to waist chains, and leg irons if deemed seriously violent or escape-prone.

In the course of our research, we interviewed a total of 162 inmates on the mental health caseload in SHUs in 10 maximum-security prisons. We collected data using a structured survey questionnaire designed with input from forensic psychologists. Findings from the research, presented below, underscore the need for passage of Assembly Bill 08849.

Attesting to the seriousness of their mental illness, nearly one-third of the inmates in our sample reported prior stays in psychiatric hospitals. Sixteen percent reported diagnoses of schizophrenia,

12% bi-polar disorder and 29% Post Traumatic Stress Disorder. Of interest was that 40% were housed in disciplinary lockdown for nonviolent offenses (operationalized as refusing to obey a direct order or use or possession of drugs). A more striking finding was that inmates with mental illness have SHU sentences that are six times longer than the average SHU sentence: 38 months (slightly over three years) compared to DOCS' figure of 6.5 months for inmates generally.

With regard to treatment, OMH staff are required to make daily rounds in the SHU, spending a minimum of one hour per week for every ten inmates. This policy translates to about 1 minute and 20 seconds of mental health contact every weekday. Logbooks that we reviewed confirmed that OMH meets this meager standard, but many inmates complained that staff typically "whiz by," stopping only for inmates who submitted referrals or who were identified by correction officers on the unit. Noteworthy is that more than half of inmates (55%) reported that access to mental health staff in the SHU was insufficient. A similar percentage felt that they could not see a therapist if they had an urgent need, saying that banging on one's door and yelling or threatening suicide were more effective ways to get staff attention.

While 86% of inmates were prescribed psychotropic medication, more than half reported that the psychiatrist did not explain to them why they were on medication or what side effects they might experience. These findings suggest that the administering of mental health services in SHUs represents a flawed clinical practice.

Compounding the problem is the paradigm of punishment in SHUs that mitigates against mental health treatment. Too often, correction officers who are poorly trained in mental illness symptomatology respond to conditions such as mania or delusional disorder as disciplinary problems rather than clinical concerns. When inmates act out in lockdown, whether or not their behavior is related to mental illness, they are often disciplined through a regimen of increasingly harsh punishments known as deprivation orders. Common deprivation orders include the loss of such basic necessities as showers, recreation and cell-cleaning supplies. Equally if not more serious, additional SHU time can be added to an inmate's sentence for repeated rule violations, turning lockdown into a kind of quicksand from which inmates can only emerge when their prison sentence expires. A mental health counselor at Sing Sing told us: "Six months of SHU time can turn in to 16 years for guys with mental illness." A striking example is an inmate on the mental health caseload we encountered at Wende Correctional Facility, who was sentenced to 35 years in solitary confinement.

Moreover, 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 we interviewed reported receiving deprivation orders while in lockdown. Of those, 62% reported receiving four or more deprivation orders. This finding points to a core group of inmates who cannot or will not control their behavior, and to whom the Department responds mainly by piling punishment on top of punishment.

A particularly severe punishment imposed on inmates who have lost all other privileges, or who throw-or simply threaten to throw-bodily fluids, is the restricted diet, known by inmates as "the loaf." Consisting primarily of flour, yeast and potatoes, the "loaf" is a dense, binding one-pound loaf of bread served to inmates three times a day, along with a side portion of raw cabbage. Over

a third of the inmates in our sample reported being put on the loaf while in lockdown, the majority for charges related to disobeying orders or shouting or banging on their cell doors.

While American Correctional Association standards prohibit using food as punishment, and the Federal Bureau of Prisons and numerous states have abolished use of restricted diets, New York has increased its use by 100% in the past five years, from 626 diets imposed in 1997 to 1,356 diets in 2002.

Given the harsh conditions, it is not surprising that a disproportionate number of suicides take place in disciplinary lockdown. A recent study by the Poughkeepsie Journal found that more than half (52%) of prison suicides in New York between 1998 and 2001 took place in disciplinary lockdown, though disciplinary lockdown contains less than 10% of the inmate population. Of the inmates in our sample, 53% had histories of suicide attempts in prison. This figure, on its face, is extraordinary—more akin to what one would expect to find in a mental hospital than a prison.

Another indication of the pathology bred in disciplinary lockdown is the high rate of self-mutilation, a form of self-directed violence that typically involves cutting or slashing one's wrists, arms or abdomen as a way to alleviate stress or to counteract feelings of psychological numbness. It was not unusual for inmates to extend their forearms through the bars and show us arms laced with scars. One man we interviewed at Great Meadow reported that he ground his head in glass and showed us the scar. "I do this in order to feel," he said. A persistent self-cutter at Wende explained: "I cut myself and the bad comes out." In our sample, 40% of inmates reported that they engaged in self-mutilation during their current incarceration. As incredible and misguided as it seems, the act of "inflicting self-harm" is an official violation of DOCS policy. Correction officials issue misbehavior reports to inmates who attempt to kill or cut themselves, purportedly to discourage malingering. Over half (54%) of the inmates in our sample reported receiving a ticket for an act of self-harm. Roderick Hall, Ph.D., Director of Mental Health Services for the Florida Department of Corrections, was astonished when we asked him whether inmates in Florida can receive tickets for self-harm. "Many years ago we gave tickets for self-harm," he said, "but certainly not now."

In our research, on nearly every site visit, we encountered at least one or two individuals in disciplinary lockdown who were actively psychotic, delusional or immobilized by depression. We interviewed men who were weeping in their cells, who mutilated their own flesh, who hadn't left their cell in months, who smeared feces on themselves or repeatedly attempted suicide. "The COs rape me," a delusional inmate at Five Points told one of our interviewers. Of the 15 years he has been incarcerated, he has spent 13 years in solitary confinement. The inmate's arms were covered with scars. On his neck was a five-inch gash from when he attempted suicide by slashing his own throat. "I hear voices telling me to kill myself," he said. "No one does nothing. I have no faith in anybody."

Some of the strongest advocates for alternative housing for inmates with mental illness are correction officers who work in the SHUs. During our site visits, it was often correction officers who pointed out inmates who were suffering or asked us to put in a word with the administration to have them transferred to the hospital. Correction officers and union officials told us that they receive minimal if any specialized training to manage SHU inmates, have few resources at their disposal to handle inmates with mental illness, and receive little support from the administration

for the traumatic events they experience, such as having to forcefully extract a paranoid inmate from his cell or cut down an inmate who hung himself.

Personally, I can say that conducting this research-interviewing so many inmates in such desperate and deplorable conditions-left me with harrowing memories and on occasion, nightmares. There were times that my staff and I had to terminate interviews because the noise on the cellblocks-inmates yelling or banging on their doors, calling out for help-made it impossible to continue.

The findings from our research speak to the same problems raised by the NYS Commission of Corrections (a government watchdog group) in its inmate death reports. They speak to the same problems raised by journalists across the state and in legal rulings that have shown the poor treatment of inmates with mental illness in New York State prisons. The state's response has been insufficient. It is becoming clear that change will occur only through litigation or legislation, and thus it is critical for our state legislators to take action.