

*Inspection Report***Services at Bedford Hills Correctional Facility**

by the Correctional Association of New York's Women in Prison Project Visiting Committee

Editor's Note: In the United States, the Correctional Association of New York has rare statutory authorization for a private organization to conduct regular inspections of state prisons. The particular inspection described in this article was conducted on January 9, 2007, in conjunction with the organization's Women in Prison Project. The article itself details some of the group's observations regarding the Bedford Hills, NY, facility's mental health programs and services based on information gathered from both inmates and staff. The full report, which covers additional topics and includes footnotes and recommendations for various state agencies, is available at www.CorrectionalAssociation.org/WIPP/prison_monitoring/Bedford_Mental_Health_2007.pdf.

Mental Health Overview

Bedford Hills is designated as a mental health level one facility, which means that it has the capability to provide women with the most intensive mental health services available in the state prison system. The facility has a 16-bed Intermediate Care Program (ICP), a 15-bed Residential Crisis Treatment Program (RCTP) with nine dormitory beds and six observation cells (operated by the Department of Correctional Services with the Office of Mental Health providing clinical services), a 16-bed Therapeutic Behavioral Unit (TBU), a 50-person Mentally Ill Chemically Addicted (MICA) program, and a 60-person Network program. Bedford's MICA and Network programs, ICP, and TBU, are the only programs of their kind for women inmates in Department of Correctional Services (DOCS) custody.

Caseload Increase. As of January 2007, more than 50% of Bedford's total population (421 women) was on the Office of Mental Health (OMH) caseload. This figure represents an increase in the percentage of inmates on the caseload in July 2005 (42%). Of the women on the mental health caseload, 30% had been diagnosed with a major mood disorder

(which includes depression, psychotic depression, and bipolar disorder) and 15% had been diagnosed with a psychotic disorder (which includes schizophrenia). A total of 44% of women on the caseload had an Axis I diagnosis. Just over 72% were taking psychotropic medication; nearly half were taking neuroleptic medication.

From January to June 2007, Bedford had 10 admissions to Central New York Psychiatric Center, an OMH-run secure psychiatric hospital located in Marcy, NY, with 17 beds reserved for state-sentenced women inmates. Nine of these admissions were from Bedford's general population and one was from the Special Housing Unit (SHU).

During that same time period, Bedford had 197 admissions to its RCTP, which provides short-term housing for inmates in psychiatric crisis and intensive monitoring for inmates on suicide watch. Thirty-five of these admissions were from SHU, 42 were from TBU, and 120 were from general population.

Extraordinary Challenges. The challenges facing OMH and DOCS in providing adequate care to the hundreds of women suffering from mental illness at Bedford Hills are extraordinary. In recent years, both agencies have taken constructive steps, which we strongly support, to expand the facility's mental health program. Nevertheless, it is clear that serious deficiencies in the facility's mental health services persist and that substantial improvements are needed to ensure that the women in Bedford's custody receive appropriate mental health treatment and support.

The positive aspects of the facility's mental health program include the following:

- The opening of the TBU, the diversion of a number of otherwise SHU-bound inmates to the unit;
- The opening of the MICA program;
- The continued operation of the ICP and Network program;
- Positive feedback from inmates about the quality of many mental health staff members;
- Improved mental health assessments of women in the SHU;

- Reports from inmates that psychotropic medication is distributed in a timely fashion and that medication side effects are explained by mental health staff;
- The maintenance of a solid medication contraindication/reconciliation system; and
- Aggressive recruitment of new staff to fill vacancies.

Our main concerns include the following:

- Insufficient mental health services for women in Bedford's general population;
- The confinement of women with serious mental illness in SHU and inadequate mental health services for SHU-confined inmates;
- Flaws in the TBU model, including requiring inmates to remain in SHU, ticket-free for at least a month before being transferred to the TBU unit and having return to SHU as a potential consequence for misbehavior;
- The underutilization of the TBU and ICP;
- The absence of a mental health component in MICA and the lack of adequate mental health staff for the program;
- Mistreatment of inmates by certain correction staff assigned to the TBU and to the MICA and Network programs;
- Inadequate staffing for the Network program; and
- The lack of a gender-specific, culturally sensitive, and trauma-informed approach to Bedford's mental health-related programming and services.

Gender-Specific, Culturally Sensitive, and Trauma-Informed Mental Health Services

Bedford Hills has a long history of offering inmates abuse counseling services through its Family Violence Program, a 12-week program for survivors

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of domestic violence. Unfortunately, there has been a dramatic drop-off in participation in this important program. According to a 1994 DOCS report, there were 137 women in the Family Violence Program in December 1993; at the time of our visit, there

facilities offer effective abuse counseling programs and gender-specific, culturally sensitive, and trauma-informed services. Such services would not only allow women inmates to more effectively access assistance and support, they could also help to reduce recidivism rates and improve facility safety and efficient overall operations.

This task force represents an opportunity for the Department to initiate an effort to ensure that all women's facilities offer effective abuse counseling programs and gender-specific, culturally sensitive, and trauma-informed services.

were only 13 women participating. The program had a capacity of 32 and was staffed by three social workers. These numbers call for an examination of the reasons for the decrease and the creation of a plan to revitalize the program.

A critical need exists not only for courses like the Family Violence Program, but also for mental health services that are developed and implemented with an understanding of the consequences of trauma, the particular mental health issues facing women inmates, the varied experiences of women from different racial and ethnic backgrounds, and the linguistic and cultural barriers individuals may face in accessing treatment and support. An estimated 82% of women at Bedford Hills suffered severe physical or sexual assault during childhood and an estimated 90% have experienced violence in their lifetimes. Being incarcerated, surviving in the prison environment, and being separated from children and other loved ones are often highly stressful, regardless of an individual's personal history. In addition, we also urge that any staffing needs assessment include an evaluation of whether the facility has sufficient Spanish-speaking mental health staff.

The DOCS has recently taken the positive step of creating an executive level task force on issues facing women inmates. This task force represents an opportunity for the Department to initiate an effort to ensure that all women's

Mental Health Services in Special Housing Unit

At the time of our visit, 22 of Bedford's 24 SHU cells were filled. OMH staff estimated that 14 of the 22 women (63%) in SHU were on the OMH caseload. Six of the 14 had applications pending for the TBU. OMH staff informed us that all inmates admitted to the SHU are assessed by mental health staff within 24 hours and that OMH conducts rounds in SHU seven days per week.

The women in SHU we spoke with confirmed the frequency of rounds and that they had been seen by OMH within a day after being transferred. OMH also reported that SHU inmates on the mental health caseload meet with counselors about twice per month and with a psychiatrist once per month, though the frequency varies on a case-by-case basis. These meetings are held in one of two private rooms in the SHU building. There are no group sessions for inmates with mental illness in SHU.

Mental Health Conditions Worsen. Most women in SHU had positive remarks about the quality of mental health staff members they met with. Even with these counseling services, however, many women told us that their mental health condition had worsened since being placed in SHU. Two situations warrant particular attention: One woman who had been diagnosed with depression and post-traumatic stress disorder reported having tried repeatedly to harm herself while in SHU; she had an application

pending for the TBU, but had not yet been approved for transfer. Another woman, diagnosed with manic depression, reported that she had recently been transferred back from the facility's observation cells after trying to kill herself. This woman reported having met with mental health staff only a few times per month before the incident. In general, she seemed disoriented and was unsure if anyone had spoken to her about the TBU.

Restrictive Setting Aggravates Conditions. There is widespread recognition by mental health experts that inmates suffering from serious mental illness should not be placed in SHU. The unit's restrictive setting aggravates most mental health conditions and can cause inmates to decompensate, even if they are able to meet with counseling staff on a regular basis. In the beginning of 2007, one woman at Bedford who had been diagnosed with mental illness committed suicide while she was in disciplinary confinement. In 2006, Bedford reported two Unusual Incidents (UIs) concerning self-injury in SHU. That year, four women from SHU were admitted to CNYPC. From January to June 2007, one woman from SHU was admitted. During that same time period, there were 35 admissions to Bedford's RCTP from SHU.

Some inmates in SHU communicated that the lights inside their cells were too bright and disrupted their ability to sleep. Members of our visiting team observed that many SHU cell lights were half-covered by sanitary napkins—an attempt on the part of some inmates to make the room darker at night. The superintendent explained that the lights allowed officers to check on inmates to make sure they were “still breathing.” Although these concerns are understandable, sleep deprivation can have an acutely adverse effect on any individual, especially one already suffering from mental illness.

Women in SHU and in general population also reported that although some correction officers maintained a professional attitude, others verbally harassed inmates in SHU with mental illness. Reports of harassment included officers using degrading and derogatory terms

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and taunting or provoking inmates with mental illness to misbehave.

Therapeutic Behavioral Unit

Created in June 2005, Bedford's TBU is a 16-bed unit jointly run by DOCS and OMH for mentally ill inmates who have chronic disciplinary problems and who would otherwise remain in disciplinary confinement. The unit's target population are inmates who have:

- An Axis I and/or Axis II diagnosis;
- A demonstrated pattern of Axis II behavioral traits;
- A "disciplinary pattern of disturbed, disruptive behavior with self-control deficits and violent or disruptive impulses" and/or a pattern of "instrumental assaults on staff/inmates" and "custodial management challenges"; and
- A profile that matches the "therapeutic mix of currently admitted inmate-patients for a balance of patients modeling appropriate behaviors with those needing more intensive treatment."

Case-by-Case Evaluations. When we inquired about which SHU inmates would be considered ideal candidates for TBU placement, staff explained that they look for inmates who need intensive mental health services and who have the potential to succeed in the program.

After conducting an initial assessment, the psychologist assigned to SHU can recommend that an inmate be evaluated for TBU placement. The OMH unit chief and other clinical staff evaluate the recommended inmate and, with the superintendent and other DOCS staff, make a final decision about whether to transfer the inmate to the unit. Evaluations are done on a case-by-case basis and it seems that no inmates, even those without formal Axis I or Axis II diagnoses, are automatically excluded from consideration for TBU placement.

Model Phases. The TBU model is comprised of three phases. The first begins while inmates are still in SHU. Once an inmate is accepted into the program, Phase I consists of informing that inmate about the TBU and the expectations of inmates in the program. In order to move to Phase II—and be transferred

to the TBU—an inmate must have at least 30 days of "outstanding behavior," including remaining ticket-free during that time period. After the 30-day period, staff estimated that it takes about two weeks to be transferred to the unit.

During Phase II, inmates are transferred from SHU to the TBU, where they remain "on probation" for the first two weeks, meaning that they are allowed to attend certain groups but are required to remain in their cells for most of the day, including meals. Phase II inmates must maintain good behavior and remain ticket-free during the probationary period to earn "privileges," including the ability to participate in additional therapeutic groups, recreation on a different floor in the building, and meals with other inmates on the unit.

Meetings, Groups. TBU inmates meet at least once per month with a psychiatrist and more often with psychologists and social workers; determinations about frequency are made on an individual basis. For inmates who have successfully completed the Phase II probationary period, these one-on-one meetings are held either on the unit in a private office, on the unit's main area outside of the cells, or off the unit in an OMH office. In addition, each TBU inmate is evaluated every 30 days by a Case Management Committee consisting of DOCS correction staff, DOCS medical staff, and OMH staff. For inmates transferred to the TBU from other facilities, weekly telepsychiatry meetings are held with mental health staff from Bedford Hills and the transferring facility. Staff explained that inmates who decompensate in TBU are transferred first to Bedford's RCTP and then to CNYPC if necessary.

In addition to the individual meetings, Phase II inmates participate in therapeutic programming for four hours per day, five days per week. Two hours per day are spent in "core groups"—therapeutic community, relapse prevention, communication skills, medication education, anger management, positive changes, poetry, spirituality, change, and art. The other two hours are spent in "leisure groups," which consist of yoga, current events, bingo, and art therapy.

Phase III, Discharge. TBU inmates must remain ticket-free to earn their way into Phase III. Inmates in this phase are allowed additional out-of-

cell time and can continue earning "privileges," including the ability to participate in certain programs with general population inmates. The Case Management Committee decides on an individual basis when Phase III inmates are ready to move off the unit. Inmates can be discharged from the TBU to the ICP, to the MICA program, to the general population at Bedford Hills, or to the general population of the facility from which they were initially transferred. Inmates can also be transferred back to SHU for more serious disciplinary infractions. If an inmate "maxes out" (finishes her sentence while in the TBU), she can be sent from the unit directly back to the community.

Time spent in the TBU is considered part of an inmate's SHU sentence and inmates can earn time off of their SHU sentence for good behavior. Tickets can also be given to inmates in the TBU. If an inmate receives a ticket, the circumstances of the ticket are evaluated by a team consisting of both mental health and DOCS staff. OMH staff reported that decisions about ticket penalties are made on a case-by-case basis and that no one entity or individual "overrides a decision" about what to do with a TBU inmate who receives a ticket. If the offense is serious, the inmate might accrue additional SHU time, lose TBU "privileges," or be sent back to SHU. Minor offenses carry penalties that are less severe. OMH declined to give us specific data about whether any women in the TBU had accrued additional SHU time or earned time cuts, and, if so, how it was accrued or earned. OMH stated that this information would be available in the agency quarterly reports required by the recent settlement of a lawsuit on behalf of Disability Advocates, Inc., concerning people with mental illness in DOCS custody.

Program Evaluation

Some women we spoke with had been in the TBU for a few months; others reported being in the unit for over a year. Women had positive feedback about the quality of mental health services in the TBU, described the OMH staff as caring and accessible, and reported that, unlike their experiences

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in SHU and general population, they met with counselors in the TBU as often as they needed. Inmates' main concern regarding mental health staffing focused on their anxiety about interacting with and trusting new OMH staff members. Women also had positive remarks about the TBU's group sessions, especially because the groups allowed them to leave their cells without restraints and to interact with other inmates.

Overall, we hold the view that incarcerated women, DOCS, OMH, and society at large would be better served if women with serious mental illness were removed from the prison context altogether and placed in secure community-based facilities designed specifically to manage and treat their conditions. Nevertheless, the more intensive mental health services, ability to participate in individual and group therapy, increased access to OMH staff, and additional out-of-cell time for therapy and recreational activities clearly make the TBU a substantially better place than SHU for women with serious mental illness.

Our concerns about the program fall into five main areas:

1. Requirement to remain in SHU;
2. Heavy reliance on the threat and/or use of disciplinary sanctions to motivate compliance with prison rules;
3. Underutilization;
4. Staff screening and training; and
5. Lack of comprehensive discharge planning services.

Requirement to Remain in SHU. The program's goals are undermined by requirements that inmates remain in SHU for more than a month even after they have been deemed an appropriate TBU candidate and that they maintain "outstanding behavior," including remaining ticket-free, during the time in which they are waiting to be transferred to the TBU unit. These requirements are highly problematic: Spending an extended period of time in SHU's restrictive environment can be severely detrimental for inmates with serious mental illness. Particular behavioral traits associated with certain mental illnesses are symptomatic, not willful. Without more intensive treatment and services, certain mentally ill

inmates may not be able to refrain from engaging in the same type of behavior that led them to violate prison rules in the first place or may decompensate before they meet the requirement for transfer.

Ultimately, these regulations decrease the chance that some inmates in dire need of more intensive treatment will receive that treatment. That six of the 14 women in SHU on the mental health caseload had applications pending at the time of our visit and that the TBU's estimated average census (14) is lower than its operating capacity (16) may be, in part, a result of the difficulty inmates have in overcoming this barrier to transfer. Additionally, characterizing the month an inmate spends in SHU preparing for transfer to the TBU unit as "Phase I" is a misnomer. As SHU inmates do not receive the more intensive services offered to inmates in the TBU, time spent in SHU should not be considered part of the TBU program.

Heavy Reliance on Threat, Disciplinary Sanctions to Motivate Compliance. The TBU model relies too heavily on the threat and/or use of disciplinary sanctions to motivate compliance with prison rules. Even with individual assessments, the TBU's disciplinary system is likely to be ineffective and demoralizing for many of the inmates the unit was developed to aid. While the possibility of punishment might deter a healthy inmate from engaging in inappropriate behavior, certain mentally ill inmates may not be able to perform the same action/consequence calculus or stop themselves from engaging in inappropriate behavior even if the consequences are well understood. It is telling that every woman with whom we spoke had received multiple additional tickets since being placed in the TBU. Additionally, the TBU's disciplinary system, which retains transfer to SHU as a potential punishment, is misguided. From a mental health perspective, sending an inmate from TBU to SHU is counterintuitive: A person who is unable to conform to appropriate modes of behavior even in an environment like the TBU is a person in need of more help, not less. Sending that person to SHU, where there will be fewer mental health and other support services and more time in isolation,

will likely cause her mental health condition to deteriorate and increase the chance that she will violate even more prison regulations.

Underutilization. The TBU is underutilized. The TBU's intensive services and supportive environment are highly beneficial to the otherwise SHU-bound inmates who live there. We question why more women are not applying for, being accepted into, or being put on the waiting list for the unit. The often-disproportionate representation of mentally ill inmates in disciplinary confinement indicates that more women should be appropriate candidates for TBU placement.

Staff Screening and Training. Staff assigned to the TBU are not appropriately screened or trained. On the positive side, inmates commented that many officers treat TBU inmates in a respectful and reasonable manner. On the other hand, every TBU inmate we spoke with communicated serious distress about the treatment from certain officers assigned to the 7:00 a.m. to 3:00 p.m. shift. They described these officers as verbally abusive, taunting and provoking inmates to misbehave. Mental health staff explained to us that all TBU officer positions are "bid positions," meaning that more senior officers have the ability to pick whether they want to be assigned to the unit. Even though officers assigned to the TBU participate in additional mental health training, using a bid system ultimately makes it difficult to ensure that officers assigned to TBU posts are those best suited to work in the unit's difficult and sensitive environment.

Lack of Comprehensive Discharge Planning Services. The TBU lacks comprehensive discharge planning services. At least five inmates have been released directly from the unit to the community. OMH reported that inmates who "max out" receive basically the same discharge planning as other inmates, with additional emphasis on connecting them with community-based mental health services. OMH staff also noted that they do not collaborate very closely with Bedford's transitional services staff. Without comprehensive discharge planning services, TBU inmates are more likely to experience disruptions in the continuity of their care and to recidivate.

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Mentally Ill Chemically Addicted Program

Bedford's MICA program is the only one of its kind for women in the state prison system. The MICA program was staffed by one supervisor, three DOCS correction counselors, and one senior corrections counselor. At the time of our visit, no OMH staff were assigned to the program and DOCS MICA staff did not have a regular meeting schedule with OMH personnel. Although an OMH counselor had been assigned to MICA for a few hours each week to conduct 30-minute individual sessions with inmates, this counselor had left the facility a number of months prior to our visit and her position had not yet been filled. MICA counselors informed us that if a situation requiring additional mental health assistance arises, they ask OMH to intervene. A three-day OMH training course for DOCS MICA staff does exist, but had not yet been implemented because of staff turnover.

No Participation Restriction. To be accepted into MICA, an inmate must be on the OMH caseload and have ASAT completion as a requirement of her DOCS work and treatment plan. Inmates who complete the program are considered to have fulfilled their ASAT requirement. If an inmate has already successfully completed ASAT, she is generally not allowed to participate in MICA as well. Women can fill out a MICA application themselves or be referred by DOCS or OMH staff. There is no participation restriction for inmates with more serious mental health diagnoses and inmates are not required to have a particular diagnosis to gain entry into the program.

Programming. MICA has a 39-week curriculum set by DOCS central office. The counselors we spoke with explained that the goal for MICA is to have the program operate like a therapeutic community (TC), although the TC model had not yet been fully incorporated into the program structure. The program has two groups, each of which was comprised of about 20 inmates at the time of our visit. One group participates in MICA programming for three hours during the AM module; the

other participates during the PM module. As of January 2007, programming consisted of one group session five days per week and brief individual sessions on an ad hoc basis. MICA inmates are allowed to participate in programs with the general population during their non-MICA modules.

The group of inmates in MICA at the time of our visit was the second group to participate in the program since it opened in 2005. Thirty-six out of 50 women in the first group to be assigned to MICA completed the program's full course. Counselors reported that inmates were most commonly removed for disciplinary infractions.

Program Evaluation

OMH staff estimated that approximately 80% of women on the mental health caseload also had a substance abuse diagnosis. We strongly endorse the concept of integrated treatment—a model proven to be more effective than separate substance abuse and mental health treatment (either "sequential" or "parallel") for individuals with dual diagnoses. At the time of our visit, the program had a number of serious deficiencies and problems, including an insufficient mental health component, the lack of both OMH staff and specially trained DOCS staff, the absence of a substantial residential component, and poor treatment from some correction officers. Overall, the program seemed to be operating as an ASAT program with a MICA population.

The inmates we spoke with generally praised the quality of the MICA counselors but expressed considerable disappointment with all other aspects of the program. In fact, during our tour, inmates were frustrated that MICA counselors had agreed to spend an entire meeting discussing the program's shortcomings and possible solutions—a conversation which members of our visiting team were grateful to have the opportunity to observe.

Officer Treatment. A primary concern for inmates was that certain officers on the unit called inmates derogatory names, made degrading comments related to their mental health status, and seemed loathe to respond when women requested to see mental health

staff. Many women reported that officer treatment was worse in MICA than in general population. Others mentioned that some women preferred to stay in their cells as a result of feeling unsafe around officers. One woman explained that she had not left her cell for the entire weekend (when there were no MICA programs and no civilian staff assigned to the unit) because she did not want to interact with one of the officers on duty.

Women also reported that they met with OMH only about once every month (the same meeting schedule for most general population inmates on the OMH caseload) and were unable to discuss mental health issues in group sessions because of the lack of trained staff. Many explained that group sessions lacked structure and that there were few other activities on the unit aimed at creating a sense of community and support among the inmates living there. That 15 of the 51 women in MICA's first group did not finish the program's full course and that several women from the second group had also been removed may be due, at least in part, to the program's inadequate mental health and support services and problems with officer treatment.

Restructuring Needed. Both the superintendent and the OMH unit chief agreed that more could and should be done to build MICA's mental health component. The superintendent informed us that Bedford Hills was planning to hire a full-time DOCS psychologist who would be assigned to MICA for at least some of his or her hours. The unit chief also mentioned that OMH hoped to reassign a staff person to work with the program. While we support these efforts, to provide truly effective services, Bedford must take additional steps to restructure the MICA program. Such steps involve the incorporation of principles of evidence-based treatment for individuals with dual diagnoses, including the "cross-training" of mental health and substance abuse staff, the provision of comprehensive mental health and substance abuse services, and the implementation of other services aimed at strengthening program participants' "immediate social environment" and support networks. ■