

# 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

*Mental Health in the House of Corrections*  
*Executive Summary*

## 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.

We extend our appreciation to the following individuals, each of whom have endorsed the report's findings and recommendations.

1. **Gail Allen, M.D.**, Psychiatrist, formerly of St. Lukes-Roosevelt Hospital in Manhattan; co-founder of the Addiction Institute of New York; Correctional Association board member.
2. **Heather Barr, Esq.**, Senior Staff Attorney at the Mental Health Project at the Urban Justice Center in New York City; co-counsel on *Brad H. v. City of New York*, a class action lawsuit that created a right to discharge planning for mental health consumers released from New York City jails.
3. **Ted Conover**, Journalist, author of *Newjack: Guarding Sing Sing*, finalist for the Pulitzer Prize and winner of the 2001 National Book Critics Circle Award for Nonfiction.
4. **Robert Corliss, MA**, Associate Director of Criminal Justice, National Alliance for the Mentally Ill of New York State (NAMI-NYS); former Assistant Director of Field Operations, New York State Commission of Correction.
5. **Nancy Duggan, Ph.D.**, Forensic and clinical psychologist; former clinician with Montefiore Hospital's Mental Health Unit at Rikers Island.
6. **Alan Felix, M.D.**, Associate Clinical Professor of Psychiatry at Columbia University.
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.
11. **Hans Toch, Ph.D.**, Distinguished Professor at the University at Albany of the State University of New York, where he is affiliated with the School of Criminal Justice; author of *Acting Out: Maladaptive Behavior in Confinement*, a study of 10,000 inmates with mental illness in the New York State prison system.

## 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 lockdown<sup>1</sup> system-wide are on the mental

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<sup>1</sup> 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.

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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.

*Because insufficient mental health care has a severe impact on the lives of those who live and work in New York State prisons, we have written an addition to the executive summary presenting some of the terrible human consequences we encountered while preparing this report.*

### **INADEQUATE MENTAL HEALTH SERVICES: NEGLECTED PRISONERS**

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 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.”

Our observations during tours of general population cellblocks frequently confirmed these reports. At Great Meadow we encountered several inmates in serious psychiatric distress languishing in their cells. A Correctional Association 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. 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, 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.
- 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.

### **Insufficient Training for Correction Officers**

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 “thrown at.” 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 who 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.

### **Prisoners with Mental Illness Languishing in Disciplinary Lockdown**

On nearly every site visit (but in some lockdown units more than others), we encountered individuals in states of extreme desperation: men weeping in their cells; men who had smeared feces on their bodies or lit their cells on fire; prisoners who cut their own flesh; inmates who rambled incoherently and paced about their cells like caged animals; individuals with paranoid delusions—"The COs are poisoning my food" or "The prison psychologist is drugging me." Nowhere in the prison system do the inadequacies of mental health care present as starkly as in disciplinary confinement where approximately 821 inmates with mental illness are housed.

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.

During our visit to Five Points Correctional Facility, 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 Special Treatment Program, but who were ultimately deemed inappropriate candidates.<sup>2</sup> 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 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, "No one does nothing. 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."

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<sup>2</sup> The Special Treatment Program (STP) is a therapeutic program that consists of two hours of group therapy daily for inmates with serious mental illness in disciplinary confinement. Currently there are 821 inmates with mental illness in disciplinary confinement, 480 of whom suffer from a major mental disorder. Systemwide there are only 43 STP beds.

## **Profile of an Inmate Suicide: Al Kirby**

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 Unit 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.”<sup>3</sup>

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 SHU’s 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.<sup>4</sup>

While some of Al Kirby’s actions were undeniably violent, they also reflect his extreme fear and paranoia, symptoms of the serious mental illness he suffered from. 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.

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<sup>3</sup> 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.

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