Report to the New York City Board of Correction

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I. Introduction

The New York City Board of Correction (BOC) requested that we assess whether the City is in compliance with several sections of the Mental Health Minimum Standards, and, if not, in what respects. We also were asked what would need to change in order to bring the City into compliance.

Our findings are based on the following:

- Direct observations and conversations with correctional and health staff and with inmates at Bellevue Psychiatric Prison Ward and on Rikers Island, including: Anna M. Kross Center (AMKC) Restrictive Housing Unit (RHU); AMKC Mental Health Center, or C-71; Mental Health Assessment Unit for Infracted Inmates (MHAUII) at George R. Vierno Center (GRVC); MHAUII at Rose M. Singer Center (RMSC); and the Adolescent RHU at Robert N. Davoren Complex (RNDC).[3]

- Meetings and discussions between both authors and the New York City Department of Correction (DOC) Commissioner Dora Schriro; Department of Health and Mental Hygiene (DOHMH) Commissioner Thomas Farley, MD, MPH; Deputy Commissioner Amanda Parsons,

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[3] In addition the senior author made a general tour of Rikers Island in 2008 and the junior author worked on Rikers Island as a staff psychiatrist from 2007 to 2008.

MD, MBA; Assistant Commissioner Homer Venters, MD, MS; Executive Director of Mental Health Daniel Selling, Psy.D.; and Bellevue Hospital Center Director of Division of Forensic Psychiatry Elizabeth Ford, MD.; and Members of BOC. [4]

- Review of extensive documentation concerning past, present and proposed policies and practices, and data relevant to the causation, exacerbation and treatment of mental illness among the inmates at Rikers Island, provided us by BOC, DOC and DOHMH.

The proportion of mentally ill inmates in the New York City jail population is larger than ever before and growing, so DOC and DOHMH face special challenges. Correctional systems around the country are grappling with similar problems, and by addressing the issue, NYC could become a model for the rest of the nation.

The City jail system is currently transitioning to a new program intended to improve the mental health care of inmates and to reduce the incidence of violence between inmates and between inmates and correctional staff. We applaud the fact that the current DOC and DOHMH administrations are attempting to achieve these important goals.

The nation's jails and prisons have become *de facto* mental hospitals over the past half-century, in large part as the after-math and unintended consequence of the de-institutionalization of people with mental illness. The movement of the severely mentally ill from mental hospitals to prisons and jails has created a situation in which major jail systems, such as those in Los Angeles and NYC, house more mentally ill people than all the mental hospitals combined.[5] In fact, the proportion of people in this country who are currently housed in either a mental hospital or a correctional facility is almost exactly the same as it was 50 years ago, except that then approximately 75% were in mental hospitals and only 25% in prisons, jails and juvenile detention centers. Today, roughly 95% are in correctional institutions, and only 5% in mental

[4] The senior author has held meetings with the psychiatric residents, forensic psychiatry fellows, junior faculty in the New York University Department of Psychiatry, and administrators at Bellevue Hospital and Kirby Psychiatric Centers, from 1996 to 2013 and the junior author worked as a resident intern on the Prison Ward at Bellevue from 1995 to 1996.

[5] The failed attempt to "deinstitutionalize" the mentally ill - remove them from mental hospitals and treat them in the community- began on a large scale throughout the U.S. in the late 1960s. This resulted from a national, Congressionally-mandated decision to close down the failed state mental hospital system, which had degenerated into a nation-wide collection of huge, geographically isolated, over-crowded, under-staffed and under-funded "snake pits" (as some called them), which were doing more to exacerbate and prolong mental illnesses than to cure them, or at least render them treatable; and to replace it throughout the country with a substantial network of thousands of professionally staffed group homes and "half-way" houses, mental health clinics and substance-abuse treatment centers, in-patient wards in community hospitals, etc., each small in size and located as close as possible to the neighborhoods and communities from which the mentally ill individuals came. However, only the first half of these recommendations (closing down the "snake pits") were ever carried out; the second half (the creation of community-based housing and treatment facilities) were largely ignored and never funded. There were multiple reasons for this failure, among which was the emergence of a political climate that preferred reducing governmental expenditures on health, education and welfare, while at the same time appropriating massive increases in the size of governmental expenditures on penal institutions so that almost all mental hospitals in the country over the past half-century have either been closed down or transformed into prisons and jails, and those individuals who are acutely or chronically mentally ill have disproportionately become either homeless or imprisoned.

hospitals. In Rikers Island today, for example, roughly 40% of the inmates have a psychiatric diagnosis, and a third of them exhibit acute or chronic psychopathology severe enough to constitute major (psychotic, and in some cases life-threatening) mental illnesses.

II. Findings

A. Therapeutic seclusion vs. punitive segregation

1. DOC houses a large number of mentally ill inmates in punitive segregation

From 2007 through June 30, 2013, the number of punitive segregation beds in the City jail system has grown from 614 to 998, a 61.5% increase. On January 1, 2004, 2.7% of the inmate population was in punitive segregation. By June 30, 2013 the percentage had jumped to 7.5%.

During those same years, the rate of use of force incidents per 100 inmates per year more than tripled, from 7.0 in 2004 to 24.7, through the first half of 2013. In fact, in the first six months of 2013, there were 466 more use of force incidents than in all of 2004, despite the fact that the average daily population was lower by more than 2,000 inmates. This is at a time when the level of crime and violence in the city as a whole has been declining, whereas the percentage of mentally ill inmates in the Rikers Island jail has been steadily increasing.

Based upon a snapshot of the adolescent population on July 23, 2013, 140 adolescent inmates were in one form or another of solitary confinement, either in CPSU (43), PS and RHU in RNDC (73), or MHAUII 13B (24). Of that total, 102 (or 73%) were diagnosed as either seriously or moderately mentally ill, almost double the 39% in the jail population as a whole who have been so diagnosed.

Furthermore, 41% of the inmates housed in the Central Punitive Segregation Unit (CPSU) were mentally ill. On August 1, 2013, 26 women out of 31 (84%) who were in punitive segregation or MHAUII at RMSC were mentally ill. Thus, it is clear that inmates with mental illnesses are being disproportionately placed in solitary confinement in the New York City jail system.

2. DOC's use of prolonged punitive segregation of the mentally ill violates the Mental Health Minimum Standards.

In 1984, New York City enacted the "Mental Health Minimum Standards" in order to "improve the quality of mental health services delivered to inmates in New York City correctional facilities."

The BOC Standards specify that inmates placed in seclusion should be kept under constant observation; that *the need for continued seclusion should be reviewed and documented* in writing by nursing or mental health staff *at least every half-hour* (including by the attending psychiatrist at least once every two hours); that the individual's vital signs should be recorded at least once an hour; that he should be *released from seclusion at least every two hours* and

allowed to go to the toilet; that *the initial order* to place him in seclusion should be *valid only for two hours*, and that *if after the order has been renewed for an additional two hours* (i.e., a maximum total of four hours in seclusion) the inmate is still too disturbed and dangerous to self or others to be released from seclusion, he should be *transferred to a municipal hospital prison ward*. Section 2-06, *et. seq*.

One crucial difference between "seclusion" (as it is employed in acceptable psychiatric practice) and punitive segregation is that those who are placed in seclusion are never to be deliberately deprived of as many social relationships and contacts as possible, but on the contrary, are to be provided with as much contact with mental health consultants and therapists as they need and can benefit from. The point of it is not social and physical isolation for the purpose of, or as a form of, punishment; but rather, physical isolation and restraint, coupled with as many ongoing discussions with therapeutic staff members as possible, for purposes of diminishing the severity of the patient's mental illness and its symptoms, including the propensity to inflict harm and violence on him or herself or others.

Another difference is that seclusion is never to be imposed for a pre-determined duration. Indeed, that constitutes one criterion for distinguishing between "punishment" and "restraint." To be sentenced in advance for a pre-determined length of time, with the length of the sentence being proportional to the gravity of the offensive behavior (i.e., the degree of "guilt" of the "offender"), constitutes the use of seclusion as punishment, pure and simple. By contrast, those who have been temporarily placed in seclusion for therapeutic purposes, under acute emergency conditions, in order to prevent or restrain them from harming themselves or others, will be readmitted into the therapeutic community as soon as they have shown that they are able and willing to behave non-violently. And they will not be placed there at all unless there is no less restrictive way to prevent or restrain them from harming themselves or others.[6] Individuals with

[6] A clinical example can illustrate this. When the senior author was still in his psychiatric residency training at the Harvard Medical School, he was called to one of the wards in the psychiatric teaching hospital in the middle of the night to deal with a patient who was refusing to take his anti-psychotic medication, go to his room, and go to sleep. He was holding a large number of nurses, attendants and some security staff at bay by holding a chair over his head and threatening to club anyone who came near him. The senior author knew the man was paranoid, so he began by trying to reassure him that no one was going to hurt or attack him, and that he could safely return to his room and go to sleep. That had no effect. Finally, he looked around the room at the large number of staff members present, and reminded the patient that there were so many people there that he (the patient) could be sure they could prevent him from hurting anyone himself. At that point, the patient heaved a sigh of relief, put down the chair, went into his room, took his prescribed medication, and went to sleep. There was no question of punishing him by sentencing him to a week, a month, or several months of solitary confinement after the incident had been resolved. To do so would simply have been absurd, anti-therapeutic and counter-productive.

In saying that, we are not saying that seclusion should never be used; but we are saying that it is only very seldom necessary to use it in order to prevent violence. Words alone are always preferable to force, violence and coercion, as a means of preventing violence, when words alone succeed in doing so. But another point of this example is that the presence of the security staff was used not to threaten the patient with violence, harm or punishment if he did not drop the chair, it was used to reassure him that they could and would use their power only to prevent or restrain him from harming anyone himself. They were thus setting him an example of non-violence, not of counter-violence; and showing that they would restrain him, not punish him, if he did continue to threaten violence, but would not even resort to restraining him as long as he could show that he would restrain himself from becoming violent.

a pre-existing mental illness are particularly vulnerable to the pathogenic effects of solitary confinement, especially if they are already in the pathogenic setting of a jail.

3. Section 2-06(b)(1)(ii) should be amended to clarify that people with mental illness should not be placed in punitive segregation

Section 2-06(b)(1)(ii) states that "nothing in this part shall restrict the ability of the Department of Correction to limit the lock-out rights of inmates for *disciplinary* purposes (*punitive* segregation)." That statement would appear to contradict, and be inconsistent with, the preceding regulation, unless it is meant to apply only to those inmates who are *not* "being observed or treated for mental or emotional disorders." That is, we can only assume that that more limited applicability of Section 2-06(b)(1)(ii) is the intent of the Mental Health Minimum Standards, since otherwise they would be self-contradictory.[7] The prohibition on placing inmates who are being observed or treated for mental illness in seclusion for the purpose of punishing them, then, appears to be absolute and unqualified. If that were not the case, then paragraph 2-06.b.1.ii would render every other regulation in Section 2-06 meaningless and ineffectual, and the entire Section would be incoherent, and we take it for granted that that was not the intent of those who wrote it. Punitive segregation (seclusion used for purposes of punishment), when it is used at all, is to be limited to those inmates who are *not* being observed or treated for mental or emotional disorders, whereas it is *never* to be imposed on those who *are* being so observed or treated.

Section 2-06 goes on to specify that no one (in the latter group) should be placed in seclusion except on the written order of a psychiatrist, and even then, only when three conditions exist: 1) the inmate poses an immediate risk of injury to himself or others, as a result of the mental disorder for which he is receiving treatment; 2) it is believed that the seclusion will have a therapeutic effect; and 3) that no less restrictive alternative would be as effective in achieving therapeutic and violence-prevention goals.

One of the commonest mistakes made about punishment is that it prevents or deters violence. On the contrary, more than a century of research on the psychology of punishment has made it clear that punishment, far from preventing violence, is the most powerful tool we have yet created for stimulating violence.[8] Repeated studies of child development, for example, have shown that the more severely children are punished, the more violent they become, both as children and as adults.[9]

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[7] The Mental Health Minimum Standard was promulgated in 1984. MHAUII, the first punitive segregation unit for housing the mentally ill, was established in 1998.

[8] Gilligan, James, "Punishment and Violence: Is the Criminal Justice System Based on One Huge Mistake?," *Social Research 67(3):745-772,* 2000

[9] What the psychological research on punishment has found is that children and adults learn by the example that others set for them through their behavior, not by the preachments, moral commandments and legal orders they pronounce to them. Thus, those who punish others only teach the punished to do likewise – that is, to punish others who are weaker than they are (just as they were weaker than those who punished them).

We saw the same phenomenon on a daily frequency in the prisons and jails in which we have worked over the past several decades, namely, the mutually self-defeating vicious cycle that develops between inmates and correction officers, in which the more violently an inmate behaves, the more seriously he is punished, and the more seriously he is punished, the more violent he becomes.

By restraint, as opposed to punishment, we mean simply preventing people, by means of physical barriers (such as a locked door, or the walls of a jail, prison or mental hospital, or by the arms of a stronger person who restrains them physically) from inflicting pain, violence or injury on themselves or others, when – and only when – they do not restrain themselves from doing so. We restrain children, for example, by putting our arms around them when they attempt to run in front of traffic, or when they hit their little brothers, because they do not understand how much harm and injury that can cause to themselves and others; and we then try to explain to them how dangerous their behavior was. But we do not injure them for their behavior. Indeed, the whole point of restraining them is to prevent injury, not to inflict it. When children, or jail or prison inmates, struggle to injure themselves or others, then it may be necessary, in order to prevent injury, to restrain them physically, by means of physical force. But that does not mean, and does not require, physically injuring them. And it should always be accompanied by discussion with the persons involved, as soon as they are able and willing to talk.

The Mental Health Minimum Standards represent currently accepted standards for mental health care of patients being treated for mental illness in psychiatric hospitals in the United States. Outside the United States, however, there is an additional criterion for judging the use of prolonged punitive segregation, namely, the issue of human rights. Prolonged solitary confinement, even of those not deemed to be mentally ill, has been determined by both the United Nations Committee on Torture and the European Court of Human Rights to be a form of torture, and thus to constitute a significant violation of human rights.

The use of prolonged solitary confinement can only be seen by both inmates and staff as one of the most severe forms of punishment that can be inflicted on human beings short of killing them; that it can precipitate and/or exacerbate the symptoms of mental illness; that it can provoke suicidal, assaultive and homicidal behavior, self-mutilation, and other pathologic behaviors; and that it has been more or less universally recognized among the civilized nations of the earth as a form of torture and thus a most serious violation of human rights; that it therefore should not be imposed upon any inmates in the jail, whether they have yet shown signs and symptoms of mental illness or not; and that it is not enough merely to liberate an inmate from this form of torture only after he has already been tortured to the point of experiencing emerging symptoms of psychosis and/or suicidality. From a medical/psychiatric standpoint, no one should be placed in prolonged solitary confinement, as it is inherently pathogenic – it is a form of causing mental illness.

The mere refusal to obey an order by a jail staff member should not, in and of itself, constitute adequate reason to place anyone in seclusion, unless it clearly constitutes, or is the prelude to, violent behavior. The goal of mental health treatment (and also of correctional practice) should be to do everything possible to foster, enhance and encourage the inmates' ability to develop enough of the internalized and autonomous moral and cognitive capacities that

they will need in order to behave in constructive and non-violent ways after they have returned to the community from jail, that is, even when they are not surrounded, over-powered and controlled by external authorities, or even when those around them are provoking, endorsing, encouraging, or even ordering them to engage in violent behavior. That is why putting the emphasis, in any jail or prison, on coercing the inmates to obey whatever orders they are given, is self-defeating.

What we are talking about here is the difference between a monologue and a dialogue. Giving someone an order is a form of monologue. The person who gives an order is talking *at* a person (a monologue), not talking *with* him (in a dialogue). Mental health treatment cannot occur except by means of dialogue. Placing someone in seclusion is necessary, and can be therapeutic, if and only if it is necessary in order to create, or restore, the conditions in which a dialogue with the patient can become possible (which it is not if the patient is currently engaging in violent behavior or in threats of violence, which are other versions of monologues, as opposed to dialogues).

Any behavioral control that punishment purports to effect also becomes counter-productive when there is a long delay between the punishable behavior and the time when the person is actually locked up. We have seen examples at Rikers Island where inmates have waited a month or two before they are placed in punitive segregation – even if during that intervening time they had obeyed every rule in the book. By that point, the only lesson they will learn, at an emotional level, from being locked up is that they are being punished for having behaved themselves in the meantime. Thus, the use of punitive segregation in these circumstances is completely self-defeating, in that it stimulates instead of inhibiting antisocial behavior, by embittering the inmates, who can only feel that they are being punished arbitrarily and unfairly for pro-social, law-abiding behavior.

Another way in which behavioral modification through punishment can become counter-productive is the application of punishment for the violation of simple rules. To the extent that Rikers Island staff assumes that their job is merely to make people obey rules that they impose on them, and that is all, they are not allowing the person to develop the resources they would need in order to impose any rules, including pro-social ones, on themselves after leaving jail. In other words, what is currently being inculcated in the inmates is an authoritarian mentality, in which the only legitimate authority is external. This gives the message to the inmate: "We (the external authority) are imposing rules on you, and you have to obey our rules."

Far from promoting the individual's own autonomous moral and cognitive development, this produces the opposite effect: it teaches him only that what he needs is to gain enough power or guile to beat the system, or to find individuals over whom he can have power enough to impose his own rules on them. Others who become more docile through this system will be released to the community as easy targets for such individuals, not knowing how to behave outside of the restrictive setting, when external rules are no longer imposed on them. Inmates need to develop an ability to impose rules on themselves and to learn self-restraint in the absence of external enforcers. That is, they need exposure to the conditions that can enable them to develop an internalized conscience and an autonomous moral capacity, which they can only do

through dialogues with people whose own behavior gives them an example and a role-model of non-violent, non-punitive, pro-social, respectful and benevolent behavior toward others.

4. Plans for therapeutic units such as Clinical Alternative to Punitive Segregation (CAPS) should be expanded for the mentally ill.

The new Clinical Alternative to Punitive Segregation (CAPS) is described as a setting similar to a hospital psychiatric ward in which seriously mentally ill inmates will live in dormitory style units with other inmates or in more isolated cells – but not for a pre-determined duration. Assuming that the isolation cells are operated according to the principles specified by the Mental Health Minimum Standards that we have just reviewed, and that adequate therapeutic resources and opportunities are made available to the inmates, the proposed CAPS units would indeed seem to be in compliance with those standards.

Our main concern about this new plan is not with its proposed quality, but with its quantity. In other words, even if the mental health staff were able to correctly identify every single individual who was not able to follow the rules because of mental illness and transferred him or her to a bed in the CAPS unit, the projected capacity would not nearly fulfill the need. Even if mentally ill individuals broke one rule or another at the same rate as the general population, more than twice as many beds would be necessary, just for the seriously mentally ill – whereas in fact the Rikers Island records indicate that they break rules at least twice as often as those who are not mentally ill, and remain in isolation, and in the jail in general, far longer than do those who are not mentally ill.

The unit that is planned will contain only 60 beds for male inmates and 20 for females, in a jail system with roughly 1500 seriously mentally ill inmates, and another 4500 or so with less acute or disabling but still diagnosable psychopathologies for which they need treatment. The CAPS unit will have a more intensive therapeutic regime and a wider and more flexible ability to provide out-of-cell living arrangements (that is, in which the inmate-patients are able to live in open dormitory-style units, or at least to remain out of their cells during daytime hours, as long as they are harming no one). We are nonetheless concerned that as CAPS is implemented, there will not be enough beds to accommodate all who need them. We are concerned that the result of the small number of CAPS beds will be placements in an RHU or other more punitive segregation unit.

Prolonged solitary confinement (sensory deprivation and social isolation) can induce psychotic symptoms (such as hallucinations and delusions) and behavioral abnormalities (including suicidality and homicidality) in people who had not previously experienced such symptoms. While those with pre-existing symptoms may be more vulnerable to their exacerbation, those without pre-existing symptoms may also be vulnerable to experiencing such symptoms for the first time. Thus, the use of punitive segregation even among those not diagnosed as mentally ill is likely to increase the frequency of mental illness in the jail population, together with associated symptoms such as suicidal and assaultive behavior.

That is one reason, among others, we were disturbed to learn that MHAUII 11A has six inmates with over 1000 days of punitive segregation, and one inmate has nearly 3000 days. Our

understanding is that this means they were sentenced to solitary confinement for those durations and would presumably have to serve those lengths of time in solitary (i.e., from three years to eight years). We found this disturbing because the overuse and punitive misuse of seclusion increases, rather than decreases, the likelihood of developing symptoms of severe mental illness, of experiencing exacerbations of mental illness in those already meeting the criteria for a psychiatric diagnosis, and of experiencing one of the most dangerous symptoms of mental illness, self-injury, from self-mutilations to suicide attempts. This has been observed and documented repeatedly for more than two centuries now, beginning with the first uses of prolonged solitary confinement and social isolation in the first prisons and jails constructed at the very origin of the modern prison system. And this still appears to be true at Rikers Island today. According to data collected by DOHMH, from 2007 through 2012, the number of self-mutilations and suicide attempts by Rikers inmates increased dramatically (from roughly 480 to more than 850 per year, a greater than 75% increase), after the percentage of punitive segregation beds increased equally dramatically (from 5% to 8.5%, a 70% increase).

There is a danger in distinguishing between the seriously mentally ill (SMI) and those who are non-SMI if the distinction is used to justify limiting access to mental health care for those with so-called "non-serious" mental illnesses, which afflict 70 to 80% of the jail population, if we also count cases of mental illness masked by substance abuse. That is, it is generally true in American correctional populations that 70-80% of those incarcerated are addicted or habituated to chemical substances, and a large majority of those have co-existing mental illnesses – though those illnesses are often not detected because they are overshadowed by the rampant substance abuse (which is often a maladaptive form of "self-medication" by those attempting to get relief from symptoms of mental illness). Thus, these are largely overlapping populations, and both need mental health services.

It is also worth mentioning that the same individual can experience different psychiatric symptoms and ones of different severity at different times, depending on changes in many different variables, including their own capacity to successfully negotiate new developmental challenges as they mature, the number and intensity of the environmental stresses to which they are subjected, and the degree of environmental support and help that is available to them. Thus the dividing line between those who are "mentally ill" versus "seriously mentally ill" – and indeed between those who are mentally ill in any sense, and those who are not – are always fluid and variable. Just as with physical illnesses, a person can be sick at one point and well at another; some illnesses can be cured permanently, others vary between remissions and exacerbations, others are chronic but treatable, and still others are incurable and culminate in death. So two general conclusions are relevant and important here:

- The psychological principles to which we have alluded in this report are just as true for those who can be diagnosed as currently mentally ill as they are for those who can be considered not mentally ill, and they are as true for those who can be considered "not seriously" mentally ill as they are for those who can be considered "seriously" mentally ill.

- Prolonged solitary confinement (sensory deprivation and social isolation), as well as exposure to other traumatic stressors, whether psychological and emotional in nature

(such as public humiliation), or physical (such as beatings or killings), can induce psychiatric symptoms and behavioral abnormalities (including suicidality and homicidality) in people who had not previously experienced such symptoms. While those with pre-existing symptoms may be more vulnerable to their exacerbation, those without pre-existing symptoms may also be vulnerable to experiencing such symptoms for the first time. The distinction between "SMI" and regular "mental illness" is one that must be made on a clinical, case-by-case basis, as it is not an easy distinction that can be drawn based on diagnosis alone. Nor are these ever permanent distinctions: any diagnostic entity can turn into a serious illness, and then into a less serious one; and vice versa.

5. RHU should be eliminated because it is a punitive rather than therapeutic setting for people with mental illness.

DOHMH and DOC are replacing Mental Health Assessment Unit for Infracted Inmates (MHAUII) with Restrictive Housing Units (RHU) containing 175 solitary confinement cells. The RHU is designed, according to the April 2013 Executive Summary, "specifically for infracted inmates [i.e., those who have broken a rule or refused an order] at AMKC who *are mentally ill and have a history of suicidal gestures/attempts (or who are at risk for suicidal behavior or acute decompensation*)" – which means these are not just mildly ill inmates, they are rather severely ill. Yet: "Participation in the three tiers begins after *a one week lock in phase* [i.e., one week of solitary confinement] during which patients will have access to essential medical and mental health care but *not the rewards system or expanded out of cell time*" (i.e., they can neither "earn" nor be granted relief from solitary confinement) – and inmates may "earn" additional out-of-cell time, for only one hour at a time, only every two weeks, in general. This is a clear and unmistakable example of "Restraints or seclusion … used as a punishment" and the opposite of what the mental health standards mandate as the *only* therapeutic rather than punitive use of seclusion.

Even the DOC's own description of the new RHUs acknowledges that they constitute a form of punishment for mentally ill inmates. The Department's "Timeline for Alternatives to Punitive Segregation for Mentally Ill Inmates" describes the planned changes as follows: "220 MHAUII…beds will be replaced with 175 RHU beds for a net reduction of 45 *punitive segregation beds for infracted inmates with mental illness*." Furthermore, our visits to both MHAUIIs and RHUs revealed that the one hour of recreation per day was provided in individual cages with no space for exercise or equipment, so that it amounted to no more than a transfer from "one cage to another."

The confusion between punishment and suicide prevention is evident also in the plans for the RHU: "It is anticipated that patients will need 1-4 days [in solitary confinement] to acclimate to the unit before progressing to Level 1 though some may take longer. Total lock-in time is 22 hours per day. Inmates may be held on Intake Level if they are unable to participate in group sessions or other aspects of RHU programming. All inmates must be cleared from suicide watch before moving from the intake level to level 1." If the cells are adequate for suicide precaution, then moment-by-moment determinations are necessary to know when to let the inmate out, in order to meet the mental health standards of least care – determinations should *not* occur at

weekly, even daily, intervals. The suicide-provoking effects of solitary confinement – especially in those already at heightened risk – should be considered and holding cells seen as a temporary, physical means of restraining an individual in situations where verbal means are insufficient.

One incident we observed while visiting the adolescent Restrictive Housing Unit (RHU) was a youth banging on the door of his cell, which grew increasingly louder over twenty minutes or so. One could hear that he was initially using his arms and legs but later his whole body, while personnel walked by him, ignoring him. When he failed to gain attention, we observed him tearing his sheet into strips, wrapping it around his arms and legs, and then his neck (as if preparing to hang himself). When we told the staff what he was doing, they did not call the mental health staff (even though this was supposedly occurring in a mental health-oriented RHU) but security. The security staff's first response was to arrive as a group and to tell us to step back, as they were going to spray him, and they proceeded to pull out a can of Mace. We insisted that this was not necessary and requested that they call mental health staff, at which time the inmate was asked if he wished to see the psychologist, to which he nodded "yes."

There were many points during the escalation of this incident in which staff could have intervened to prevent its reaching the point of a suicide threat (or attempt): (1) to talk with the youth when he first began banging in order to find out what the problem was; (2) to intervene in whatever way the initial interview indicated would be appropriate and effective, to relieve his distress; (3) to interrupt his suicidal gesture if it continued to escalate, in a manner that would make it clear that we cared about him enough that we would not permit him to harm himself; (4) to restrain and contain him in a safe environment, for the purpose of protecting him from himself, rather than arriving in a brigade and threatening him with a weapon that could cause intense pain and discomfort; and (5) before all this, to anticipate and prevent the acting out in the first place, which, depending on the staff's expertise in behavioral management, can be diminished drastically, and could potentially have made it unnecessary for him to feel that he needed to bang his door and threaten suicide in order to get someone to talk with him and listen to him.

As the RHU currently stands, these conditions violate the Mental Health Minimum Standards, and could be expected to lead to an exacerbation of psychiatric symptoms, since prolonged solitary confinement can induce psychotic symptoms, including hallucinations and delusions, and in some cases suicidality, even in those previously regarded as healthy. Those who are already "mentally ill and have a history of suicidal gestures/attempts (or who are at risk for suicidal behavior or acute decompensation)" will be especially vulnerable to the harmful effects of solitary confinement. For them, the RHU will function as punishment, pure and simple, in a form that is virtually guaranteed to be anti-therapeutic and even pathogenic. In other words, it is going down the same path that has been proven over and again to be a failed approach.

B. Environmental Preconditions for Adequate Mental Health Care

The Mental Health Minimum Standards mandate that "[A]dequate mental health care is to be provided to inmates in an environment which facilitates care and treatment, provides for maximum observation, reduces the risk of suicide, and is minimally stressful." § 2-04(a).

1. Group therapy is not provided confidentially, and is observed and interrupted by non-participants.

In the group therapy session we observed in the AMKC RHU, five inmates and two therapists were sitting in an open area, not a room exactly but merely an open space between the hallway and the windows, which was open to the hallway and contained no door or walls to provide privacy from the constant traffic and noise of inmates and staff members as they walked through the hall conversing and sometimes yelling out to each other. Thus they and the therapy group were in full view of each other, by sight and sound. It was at times difficult for members of the therapy group to hear each other because of the noise of the talking and sometimes yelling going on in the hallway. Whatever the group members were saying to each other was equally audible to those in the hallway.

In addition, the windows were open because there was no air-conditioning. As a result, airplanes taking off from LaGuardia Airport and landing there every few minutes created a deafening noise during which neither the therapy group members nor the mental health staff could speak or be heard, for a minute or so at a time.

This is not an environment that facilitates care and treatment, especially mental health care and treatment, which relies so heavily not only on speaking, listening, and being heard, but also on doing so under conditions of privacy and confidentiality, so that whatever is being said to one's therapist cannot be overheard by others. On the contrary, the environment we observed makes it almost as difficult as possible to provide adequate care and treatment.

2. Punitive segregation diminishes and interferes with the mental health practitioners' opportunity to observe patients

Evaluating the mental status of patients, both at each specific time they are seen and as it changes over time, is an ongoing, indeed central, component of mental health treatment. Clinicians assess the mental status of their patients by observing and paying close attention to both verbal and nonverbal cues, such as a patient's posture and demeanor, facial expressions, physical movements, and the state of their attention to their personal hygiene and grooming. But the equally important component of the mental status examination consists of observing, by listening to, both the form and the content of their speech, as well as the tone of their voice and its volume, as they express their thoughts and emotions both spontaneously and in response to remarks from the therapist and other group members. But if their speech and that of everyone else in the group is constantly interrupted, so that communication is effectively minimized, then the observations that are a central component of mental health treatment are not being maximized; they are being minimized.

Another practice at Rikers Island that provides for minimal rather than maximal observation of inmates is the overuse of solitary confinement, or punitive segregation. To provide maximum observation of and attention to the mentally ill inmates, there has to be a person actually being with and talking with the patient so as to learn what is happening with him psychologically. Seclusion, even when it is not punitive, does not allow for optimal observation,

for one can only speak through a glass window or a hole in the door. We were very disappointed to learn how frequently mentally ill inmates in MHAUII who wanted to participate in their weekly individual and/or group therapy sessions, could not do so because they could not be released from solitary confinement because there was no escort (from the correctional staff) available to accompany them to their appointments; and to learn how frequently these men could not be interviewed outside their cell, during the time periods for which we have data. During the last week of January, 2013, a third of individual therapy appointments and 30 percent of group visits had to be cancelled because of lack of an escort. Also, during the same time period, 38 percent of the men currently being held in seclusion were not able to be seen outside their cell – which effectively precludes any possibility of an adequate diagnostic evaluation, mental status examination, or psychotherapeutic intervention. Comparable figures regarding all three of those deficiencies in care and treatment were recorded during the second and third weeks of February as well.

We have already documented the increase in the incidence of self-injuries, from self-mutilations to suicidal behaviors after the percentage of punitive segregation beds increased. Those are among the many reasons why seclusion, as it is imposed on inmates at Rikers Island, does not facilitate the care and treatment of the mentally ill, and does not provide for maximum observation of them. Rather, it achieves the exact opposite of those requirements, and represents another respect in which the jails there are not in compliance with the Mental Health Minimum Standards.

3. Other treatment modalities should be used by the mental health staff, other than Dialectical Behavior Therapy (DBT)

In the therapy group described just above, the inmates were handcuffed and sitting on a bench attached to the wall. The therapists, instead of engaging the inmates in the group in individualized examination and analysis of their interactions with the therapists and the other group members, as well as the life histories and experiences of each of them, their goals for their lives and relationships, the assumptions and beliefs they had learned as to how to achieve those goals, and the successes or failures of their strategies for achieving them, were merely reading to them from a book of "rules for living." They called this "Dialectical Behavior Therapy" (DBT), as adapted for Rikers Island.

We are not at this point interested in offering a detailed critique of DBT as a form of therapy. Our experience and that of others who have worked with the inmates of jails and prisons is that they have almost always had so little opportunity for either therapeutic or educational experiences, or have taken so little advantage of whatever opportunities they have had, and have had so few experiences of having relationships with people who are trying to help them rather than to punish them, that almost anything they can be offered in a spirit of cooperation and benevolence is likely to have a positive and constructive rather than a negative and destructive effect on their thoughts, feelings and behavior. So we would not be surprised to find that this adaptation of DBT, as a form of therapy, is better than nothing. But we would be astonished to find that the creators of DBT ever imagined that therapists would be limited to offering this form of therapy in the conditions under which the therapists we observed were forced to operate, or that it could possibly realize its full potential, whatever that might be, to

help inmates remake their lives, when offered under those conditions. (We hope it is clear that we are offering no criticism of the therapists we saw and heard, who seemed to be doing their best under virtually impossible conditions.)

But we do want to express two clinical judgments: (a) that some adaptations of related therapeutic modalities, including cognitive behavior therapy and psychodynamic individual and group therapy, as we observed them in the jails of San Francisco (see below), can be much more powerful and effective than DBT as it is currently practiced at Rikers Island; and (b) that even if the practice of DBT could be improved so as to maximize its therapeutic potential, neither DBT nor any other therapeutic modality alone could constitute an adequate therapeutic and re-educational experience for men whose lives have been as damaged by deprivation, trauma and violence as they have been among the inmates we have seen in every jail and prison we have gone into. As we said, almost any positive experience for these men is better than nothing; but a corollary of that is that they need the widest possible variety of positive experiences, not just an exposure to one form of it. Only a jail environment that provides that range of opportunities can be said to facilitate care and treatment and maximize the opportunity for observation of the patients' initial and changing mental status.

We learned from the experience of observing and evaluating the jails of the City and County of San Francisco over a ten year period that no single therapeutic and re-educational modality, in and of itself, would reach every individual in the group, or even every aspect of the psychological functioning of any one individual. We also believe, however, that the success the program had in preventing violence (and the cognitive distortions and maladaptive behavioral strategies that lead to violence) can only be understood by realizing the following principle: because every member of the dormitory in which it took place was required to participate, and the various different components of the program were in operation twelve hours a day, six days a week (minus meal breaks), the effect of the program was not only to change the mental, emotional and behavioral functioning of the individuals in the program, but in a larger sense, to bring about a fundamental change in the "culture" of the jail. For example, since everyone was a member of one large community (constituted by the whole population of the dormitory unit), there was no "splitting" of the group into those who were participating, and non-participants who could ridicule, criticize or threaten the participants. They were all in it together, as equals, so that they were all treated with equal respect by the mental health team, and were expected to (and did) treat each other and the staff members with equal respect also. No one was judged to be too superior to need to be in the program, and no one, as too inferior to be able to do so.

We cannot overemphasize the importance, in the treatment both of the mentally ill and of those who have become violent, of treating them with respect, and providing them with non-violent means of gaining self-respect (such as education and jobs). We believe that shaming and humiliating people, in all the different ways in which that can be done (disrespecting and dishonoring them, insulting and assaulting them, ridiculing and rejecting them) are among the most potent causes of both mental illness and violence[10].

[10] To understand the importance of changing the culture of the jail, it is useful to remember the concept of a "sub-culture of violence," which the dean of American criminologists in the mid-twentieth century, Marvin Wolfgang, formulated to describe the criminogenic families, neighborhoods and communities from which most violent criminals were drawn; and the concept of the "code of the streets" which the Yale sociologist Elijah Anderson

The relevance of this to Rikers Island is that we heard several officers describe the importance of teaching the inmates to respect the officers, and the absolute unacceptability of allowing any inmate to disrespect an officer. Indeed, any sign of disrespect toward an officer appeared to justify, indeed require, the use of physical force and punishment (ranging from solitary confinement to the kinds of beatings that we will describe just below). But we did not hear any corresponding obligation on the part of the officers to treat the inmates with respect. For example, we observed repeated incidents in which officers spoke to inmates (or yelled at them, shouted orders to them, cursed them, insulted them, and called them liars) in a manner that can only be described as contemptuous, provocative and disrespectful, almost as if they were daring the inmates to be disrespectful in return (perhaps without realizing that that was the effect of their manner of speaking at them).

Many corrections officers we observed were appropriately respectful and polite. But that appeared to us to be a voluntary mode of behavior on the part of individual officers, not a generally accepted obligation that was required of everyone. Indeed, one officer (who had worked in a profession whose very essence involved human service and benevolence, prior to becoming a correctional officer) commented that "this jail is simply inhumane; it is just inhumane."

4. Many of the inmates with mental illness are housed in a stressful environment.

Section 2-04 of the Mental Health Minimum Standards states that "adequate mental health care is to be provided to inmates in an environment which … is minimally stressful." Our tours of the facilities at Rikers did not provide assurance that this standard has been followed. For example, when we visited a MHAUII unit that housed adolescent inmates, several of them told us how upset they were about an incident they had been able to witness a few days before through the slots in their cell doors, in which they observed several officers "beat up" an inmate in his cell. They stated that while the inmate was handcuffed from behind, standing outside his cell while the officers searched it, they saw the officers exit the cell and push the inmate into his cell, after which he emerged with his face and arms "full of blood." One of them, a 17-year-old, said that he wanted to be transferred to CPSU because he was so scared that the same thing could happen to him. He was going to tell the mental health staff that he did not have any

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developed in order to describe the ethos, and the social and emotional underpinnings, of the sub-culture of violence. Wolfgang, Marvin E. and Franco Ferracuti, *The Subculture of Violence*, London & New York, Tavistock Publications, 1967, Anderson, Elijah, *Code of the Street : Decency, Violence, and the Moral Life of the Inner City*, New York : W.W. Norton, 1999. As Anderson emphasized (and as the senior author of this report has also emphasized), violence is motivated by the fear or the experience of being "disrespected," and is resorted to as the only means that is perceived as available by which to maintain or regain respect from others (and, correspondingly, pride and self-respect), which is especially likely to be the case when, in the culture in which the individual is living, respect, and non-violent means of gaining respect, are both in short supply. Gilligan, James, "Shame, Guilt and Violence," *Social Research* 70 (4):1149-1180, 2003. For example, when the senior author has asked inmates why they had assaulted or even killed someone, they would almost always tell him that it was because "he disrespected me [or my mother, wife, girl-friend, fellow gang member, etc.]." Indeed, they used that word so often that they abbreviated it into the slang term, "he dis'ed me." Whenever a word is used so often it is abbreviated, while its meaning remains clear to everyone, we can infer how central it is in the moral and emotional vocabulary of those who use the term.

psychological problems so that he could get out of MHAUII. He also told us that he was so upset by the incident that he had written a statement describing it, hoping that someone would come by to collect it. No one did, so he gave it to us. Another inmate, who was 16, stated that he has been trying to get out of MHAUII since he has seen 20 people being beaten in the unit (including the incident just mentioned).

The inmate who had been injured told us that he was handcuffed with his arms behind his back, standing outside his cell while it was being searched. When the cell search was completed, two officers pushed him into his cell, slamming him face down onto the floor. He reported that his head was slammed into the toilet bowl as the officers made comments about his having splashed them in the past. The inmate also said that he was kicked and stomped and at one point lost consciousness. After they beat him, he said they sprayed him with mace. His face was bloody, his ribs ached, a front tooth was knocked out and another one broken. He was taken by EMS to the hospital, admitted, and diagnosed with an upper jaw fracture and traumatic injuries to the face, back and kidneys. He said that he had urinated and vomited blood on the day on which we spoke to him. The incident started, he said, when an officer would not let him open the slot in his door to get his food, and when he finally was able to get his food, the officer refused to give him any utensils with which to eat it.

We realize that many of the inmates are as disrespectful and provocative as some of the officers are, both toward each other and toward officers. But that only calls to mind the advice that one of the senior author's medical school professors gave him and his classmates regarding child-rearing: "Never forget that you can always politely decline an invitation to a fight." Some of the officers, such as the one who recognized how inhumane the jail was, appeared to us to have learned that lesson. The problem at Rikers, however, was that that attitude appeared to be a function of the individual character of particular officers, not a generally accepted norm that was part of the ethos of the "culture" at Rikers Island. All too many of the officers that we observed appeared to us to make it clear that they were quite willing to accept an invitation to a fight, or to regard it as a normal response within the cultural norms of the jail.

What was even more pathogenic and violence-provoking was the way the inmates were treated by the correctional staff. We spoke with a man in the AMKC Mental Health Center, who needed to wear a diaper because of urinary and fecal incontinence (from an injury and/or surgery), who needed more diapers as well as clean pajamas and bed-sheets, and a shower. When he requested these things, correction officers told him flatly, with no explanation as to why they would not even attempt to do anything to help him, that they did not have the equipment he wanted because they had run out of it, his sheets could not be laundered, he could not get clean blankets, and he could not take a shower. When several inmates complained that there was no soap or toilet paper available to the inmates, a correction officer said, in a contemptuous voice loud enough to be heard throughout the room, that they "were lying." (We had just used the staff bathroom, and discovered that there was no soap, paper towels or toilet paper there either.) Ironically, the correction officer then opened a cabinet that was filled with those items.

5. The physical environment is not conducive to facilitate care and treatment

"Broken windows" theory suggests that broken windows or other signs that the community is uncaring, neglectful, and disrespectful toward its inhabitants, visitors and workers, provokes destructive, antisocial and pathological behavior. By contrast, to the degree that the Department of Correction can communicate its intention to provide care, treatment and education, rather than hostility, danger, and humiliation, from physical structure to personnel, it will be able to minimize the stress of the jail experience (for both inmates and staff) and achieve better outcomes in the behavior of both groups.

We might note that jails and prisons are designed the way zoos used to be designed, when animals were kept in concrete cells with bars on the windows. That is no longer permitted by humane societies, because it became clear that animals restricted to such living conditions exhibited behavioral abnormalities or simply died. Thus we now allow animals to be kept only in "zoological parks" designed to recreate the kinds of environments that they had evolved to survive in. But when it comes to human beings, we house them in physical environments in the likes of which no zoo director would be permitted to place wild animals. We are convinced that this is damaging to inmates and staff alike, and contributes to the tendency of both groups to become angry, impatient, irritable, on edge, and develop a lowered threshold for violence. But perhaps the most irrational of all the aspects of this self-fulfilling prophecy is that after we have treated our jail and prison inmates worse than we treat animals, some people then act surprised when the inhabitants of these abnormal and pathogenic living conditions actually act "like animals," and conclude that we must have been right to treat them like animals (or even worse) because lo and behold, we can see that they do indeed behave like animals (or even worse).

The buildings we toured were littered with trash and vermin, soap and paper towels were not present even in staff bathrooms, and mental health offices for one-to-one patent encounters were filled with overturned or broken chairs, bags on the floor apparently filled with inmates' clothing, broken mops and miscellaneous other forms of litter. The floor of one unit was covered with cracked, peeling linoleum which inmates would break off and use to cut themselves or others.

The building conditions communicate the message (not only to the inmates, but also to the staff members, whom we should not forget spend most of their waking hours in these environments) that those who are consigned to these "living" spaces are not worth as much as the animals we keep in zoos. But they not only constitute an assault on the self-esteem, indeed the human dignity, of everyone who lives in and everyone who works in them. They also fail to provide the inmates with an opportunity to learn how to live in the kind of environment in which we hope and expect them to live after they leave the jail. That is, living in a jail of this sort does not prepare anyone to return to the community.

Recommendations

Review of Minimum Standards. In light of the DOC and DOHMH plans to revise the housing for people with mental illness, the growing population with mental illness, and the increase in the use of punitive segregation for people with mental illness, the time has come for the Minimum Standards to be reviewed, in order to ensure they provide adequate clarity and guidance**.**

Prohibit prolonged punitive segregation for vulnerable populations. Inmates with mental illness should not be housed in punitive segregation. Since prolonged solitary confinement can cause symptoms of mental illness to appear even in previously healthy individuals, we strongly recommend against imposing it as a punishment for a pre-determined duration even on those inmates not deemed to be mentally ill. Seclusion should be used only as a last resort when no less restrictive alternative appears to be capable of preventing violence, and then for only as long as the inmate appears to continue to represent an immediate or short-term danger to himself or others. Repeat violent offenders should be referred to mental health staff for a psychiatric evaluation to rule out the possibility that psychopathology is contributing to the violent behavior, and the possible need for a referral to a prison ward at Bellevue or Elmhurst Hospital. Seclusion should be used as seldom and for as short a duration as possible, i.e., only when, and for as long as, that is the least restrictive means by which to prevent an inmate from harming himself or anyone else, or from behaving so provocatively and inconsiderately toward others as to provoke them to do so.

Expansion of the Clinical Alternative to Punitive Segregation (CAPS) or other therapeutic non-punitive housing programs. The CAPS unit is a laudable first step, but the proposal for 60 to 80 beds does not constitute nearly enough beds for the currently estimated and growing population with mental illness (1500 per day with serious mental illnesses, and an additional 4500 vulnerable to decompensation and/or suicidal behaviors). Many if not most of the former group, and a variable proportion of the latter, should have available to them a treatment setting fully equivalent to a prison mental hospital, a prison psychiatric ward in a general hospital, a locked residential substance-abuse treatment center, or, for those less acutely or chronically disabled, a living arrangement comparable to a half-way house or assisted-living group home (but, of course, with all the security restrictions of a jail that isolate them from the community, as long as they are required legally to be in a jail).

The RHU should be eliminated for people with mental illness. The Restrictive Housing Unit (RHU), especially with its predetermined sentencing, is essentially just another version of punitive segregation and will be pathogenic and anti-therapeutic, especially for adolescents, women, and mentally ill inmates. We therefore recommend strongly against the plans currently being proposed for the RHU, and propose increasing the size of the CAPS program as suggested above.

The exclusive reliance on DBT should be supplemented with other treatment modalities. As discussed above, there is no single therapeutic program that will fit all inmates with mental illness, and no single program that will solve all problems of violence. Successes have been had in other jurisdictions, such as in the San Francisco jails, by embracing a pluralistic approach to service delivery.

Seclusion should only be used for therapeutic purposes. When an inmate does engage in violent, threatening or violence-provoking behavior (such as injuring himself or assaulting other inmates or prison staff members), despite the best efforts of the staff to anticipate and prevent this, an alternative to prolonged, punitive and pathogenic solitary confinement would be 1) for mental health professionals on the unit to function as diagnosticians and mediators by talking with all of the individuals involved, singly and collectively, in order to assess the conflicts or the perceived grievances that motivated the inmate to engage in violent threats or actions; 2) to begin the process of resolving the conflicts and redressing the grievances, on all sides, to the greatest degree possible; and 3) to place the inmate in a locked seclusion room only if no less restrictive intervention appears capable of preventing further violence, and for no longer than the inmate needs in order to desist from further violence.

Training should ensure compliance with Minimum Standards. We recommend that all officers who work on any of the units devoted to the treatment of mentally ill inmates have significantly more prolonged, detailed and recurrent training and supervision in understanding and intervening in the care and treatment of the mentally ill than those who work with the general population, including recognizing the signs and symptoms of mental illness, the risk and protective factors that influence the likelihood of suicidal behavior or other forms of violence toward themselves or others, and the difference between interventions that reduce and those that increase the frequency and severity of mental illness and violence; that they be considered a special, and specialized, category of officers within the hierarchy of the correctional staff; that the degree of their educational attainment be considered as one of the major variables used in favoring their being chosen to work on these units (with a college degree being considered especially favorable); that they be required to participate in a detailed clinical case conference examining every incident of violence toward self or others by inmates and every "use of force" by correctional or mental health staff (analogous to the "morbidity and mortality" reviews convened in teaching hospitals to examine every incident of post-surgical complications), in meetings attended by both clinical and correctional staff; and that only officers specially trained to work on the mental health units should ever work there and each one should always work on the same unit, so that the trained officers will not be alternating with officers from the general population units, and the inmates will be dealing with the same officers throughout their residence on the unit.

Clarification of section 2-06(b)(1)(ii). We recommend review and clarification of the section of the Mental Health Minimum Standards, Section 2-06(b)(1)(ii), which states that "nothing…shall restrict the ability of the Department of Correction to limit the lock-out rights of inmates for disciplinary purposes (punitive segregation)," whether or not this is meant to apply only to those inmates who are not (yet) mentally ill, or to all inmates, including those who have already been diagnosed as suffering from either a moderate or a serious mental illness.

The environment and plant should be improved and made more consistent with delivery of mental health care and treatment. Ameliorating the physical plant issues we have discussed above would improve delivery of mental health services. A respectful, clean, and therapeutic milieu could improve the comportment of those who are housed and work in the City jails.

Partnering with academic institutions. In order to assure adequate staffing, training, and mental health care for the extraordinary volume of mental illness in the City jail system, we recommend that the DOHMH and DOC explore contracting with NYC medical school and HHC to meet this critical need, including setting up a more intensive mental health unit, comparable to the existing program at Bellevue Hospital.