

# The Correctional Association of New York

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## Report on Mental Health Programs and Services at Bedford Hills Correctional Facility

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## **Bedford Hills Correctional Facility – Mental Health Report 2007**

Located in Westchester County, Bedford Hills Correctional Facility is New York State's only maximum security prison for women. The current Superintendent is Ada Perez. Members of the Correctional Association's Women in Prison Project Visiting Committee conducted a visit to Bedford Hills on January 9, 2007. This report details our observations and recommendations regarding the facility's mental health programs and services based on information gathered from both inmates and staff.

### **Population Profile**

At the time of our visit, there were 815 inmates at Bedford Hills; the facility's capacity is 960. As of January 2006, roughly 49% of the population was African American, 28% was Caucasian, and 18% was Latina. Seventy-one percent were mothers and 59% were from New York City or its suburbs. About 63% were serving time for a violent offense (compared to 38% for women system-wide) and 21% were serving time for a drug offense (compared to over 34% system-wide). The median age was 37. Roughly 74% reported having a history of alcohol or substance abuse before prison. Seventy percent were first-time felony offenders. The median minimum sentence was seven and a half years (compared to roughly three years for women system-wide) and the median time to earliest release was almost three years.<sup>1</sup>

### **Mental Health Overview**

Bedford Hills is designated as a mental health level one facility, which means that it has the capability to provide women with the most intensive mental health services available in the state prison system. The facility has a 16-bed Intermediate Care Program (ICP), a 15-bed Residential Crisis Treatment Program (RCTP) with nine dormitory beds and six observation cells,<sup>2</sup> a 16-bed Therapeutic Behavioral Unit (TBU), a 50-person Mentally Ill Chemically Addicted (MICA) program, and a 60-person Network program. Bedford's MICA and Network programs, ICP, and TBU are the only programs of their kind for women inmates in DOCS custody.<sup>3</sup>

During our visit, we met with the Executive Director of Central New York Psychiatric Center (CNYPC), the CNYPC Clinical Director, Bedford's Associate Director of Operations, Mental Health Unit Chief, a psychiatrist, and a psychologist. Our visiting team included a psychiatrist and a mental health professional with a Masters degree in clinical psychology, both of whom contributed to this report.

As of January 2007, more than 50% of Bedford's total population (421 women) was on the Office of Mental Health (OMH) caseload. This figure represents an increase in the percentage of inmates on the caseload in July 2005 (42%). Of the women on the mental health caseload, 30% had been diagnosed with a major mood disorder (which includes depression, psychotic depression, and bipolar disorder) and 15% had been diagnosed with a

<sup>1</sup> Figures derived from *Hub System: Profile of Inmate Population Under Custody on January 1, 2006*, State of New York Department of Correctional Services.

<sup>2</sup> Bedford's RCTP is operated by DOCS and OMH provides clinical services on the unit.

<sup>3</sup> During our visit to Albion Correctional Facility in January 2007, DOCS reported that the facility has plans to build an ICP, a development which we wholeheartedly support.

psychotic disorder (which includes schizophrenia). A total of 44% of women on the caseload had an Axis I diagnosis.<sup>4</sup> Just over 72% were taking psychotropic medication; nearly half were taking neuroleptic medication.<sup>5</sup>

From January to June 2007, Bedford had 10 admissions to Central New York Psychiatric Center, an OMH-run secure psychiatric hospital located in Marcy, New York, with 17 beds reserved for state-sentenced women inmates. Nine of these admissions were from Bedford's general population and one was from the Special Housing Unit (SHU). During that same time period, Bedford had 197 admissions to its Residential Crisis Treatment Program (RCTP) which provides short-term housing for inmates in psychiatric crisis and intensive monitoring for inmates on suicide watch. Thirty-five of these admissions were from SHU; 42 were from TBU; and 120 were from general population.

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

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

- the opening of the TBU, the diversion of a number of otherwise SHU-bound inmates to the unit;
- the opening of the MICA program;
- the continued operation of the ICP and Network program;
- positive feedback from inmates about the quality of many mental health staff members;
- improved mental health assessments of women in the SHU;
- reports from inmates that psychotropic medication is distributed in a timely fashion and that medication side-effects are explained by mental health staff;
- the maintenance of a solid medication contraindication/reconciliation system;<sup>6</sup> and,
- aggressive recruitment of new staff to fill vacancies.

Our main concerns include:

- insufficient mental health services for women in Bedford's general population;
- the confinement of women with serious mental illness in SHU and inadequate mental health services for SHU-confined inmates;

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<sup>4</sup> Axis I diagnoses are defined mainly as "Clinical Syndromes" and include most psychotic disorders, anxiety disorders, mood disorders, cognitive disorders, dissociative disorders, and impulse control disorders, among others. See *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, American Psychiatric Association (2000).

<sup>5</sup> Neuroleptic medication is antipsychotic medication, used to treat patients with psychotic conditions.

<sup>6</sup> According to the Joint Commission on Accreditation of Health Care Organizations (JCAHO), medication reconciliation is "the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions." JCAHO recommends that medication reconciliation should be performed "at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner or level of care." See <http://www.jointcommission.org>.

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

### **Mental Health Staffing**

OMH staff explained that in the six months prior to our visit, Bedford Hills had experienced a turnover in approximately 50% of its mental health staff, with much of the transition concentrated in the MICA program. Staff attributed the high turnover to various circumstances in the lives and plans of individuals, not to any specific event or issue. As of January 2007, OMH had recruited permanent staff to fill almost all the vacancies created by the turnover: one nurse position and one clerical position were still vacant and two part-time nurse positions and one full-time clerical position were being covered by per diem staff. OMH attributed their recruiting success to “creative” and “aggressive” outreach and advertising.

At the time of our visit, Bedford was authorized to fill a total of 26.1 full-time equivalent mental health staff positions. Twenty-two positions were full-time and six were part-time. Two part-time positions were being covered by per diem staff and two full-time positions were vacant. The facility's staff consisted of: one Forensic Unit Chief; three psychiatrists; two psychologists (one of whom is assigned to reception and the other to the SHU and TBU); three associate psychologists (one assigned to the ICP, another to reception, and another to general population); 3.6 social workers (one assigned to reception and another to general population); 8.5 nurses (one of which was vacant); one recreational therapist; three keyboard specialist positions (one of which was vacant); and one secretary.

When compared to the OMH staffing breakdown in July 2005, Bedford maintained its level of social work, clerical, and recreational therapy staff; decreased its psychologist staff by one; and increased its psychiatrist staff by 0.3 and its nursing staff by 2.5 (not including the vacant position). Two OMH nurses are at the facility on nights and weekends and one psychiatrist is on-site at Bedford Hills roughly two Sundays per month. The weekend hours covered by the psychiatrist are paid as extra service. When there is no psychiatry staff on-site, one of the facility's psychiatrists is on call.

The ratio of women on the mental health caseload to psychiatrists is about 140:1; for psychologists and associate psychologists it is approximately 84:1; and for social workers it is almost 117:1. Bedford Hills would benefit from having additional mental health staff to lower its patient-provider ratios and to ensure that inmates are receiving adequate individualized attention and care.

## Recommendations: Mental Health Staffing

### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Conduct a mental health staffing needs assessment.<sup>7</sup>

### **New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds to allow the facility to expand its psychiatrist and mental health counseling staff.

## **Gender-specific, Culturally Sensitive, and Trauma-informed Mental Health Services, and Family Violence Program**

Bedford Hills has a long history of offering inmates abuse counseling services through its Family Violence Program, a 12-week program for survivors of domestic violence. Unfortunately, there has been a dramatic drop off in participation in this important program: according to a 1994 DOCS report, there were 137 women in the Family Violence Program in December 1993;<sup>8</sup> at the time of our visit, there were only 13 women participating. The program had a capacity of 32 and was staffed by three social workers. These numbers call for an examination of the reasons for the decrease and the creation of a plan to revitalize the program.

A critical need exists not only for courses like the Family Violence Program, but also for mental health services that are developed and implemented with an understanding of the consequences of trauma, the particular mental health issues facing women inmates, the varied experiences of women from different racial and ethnic backgrounds, and the linguistic and cultural barriers individuals may face in accessing treatment and support.<sup>9</sup> An estimated 82% of women at Bedford Hills suffered severe physical or sexual assault during childhood and an estimated 90% have experienced violence in their lifetimes.<sup>10</sup> Being incarcerated, surviving in the prison environment, and being separated from children and/or other loved ones are often highly stressful, regardless of an individual's personal history. In addition,

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<sup>7</sup> We also urge that any staffing needs assessment include an evaluation of whether the facility has sufficient Spanish-speaking mental health staff. According to DOCS, as of January 1, 2006, almost 2% of Bedford's population was designated as "Spanish Only," meaning that they cannot communicate in English. See note 1, *DOCS Hub Report 2006*, at 53.

<sup>8</sup> *A Source for Empowerment: The Family Violence Program at Bedford Hills Correctional Facility*, State of New York Department of Correctional Services (1994).

<sup>9</sup> See Stephanie S. Covington Ph.D., LCSW, *Women and Addiction: A Trauma-Informed Approach*, Center for Gender and Justice, Substance Abuse Research Consortium Meeting, Pasadena, CA (May 21, 2007). See Barbara Bloom, Barbara Owen, and Stephanie Covington, *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*, National Institute of Corrections, U.S. Department of Justice (June 2003), at 43-46. See National Center for Trauma-Informed Care (NCTIC): <http://mentalhealth.samhsa.gov/nctic/>. NCTIC is a project of the National Mental Health Information Center, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. See *Gender Disparities in Mental Health*, Department of Mental Health and Substance Dependence, World Health Organization.

<sup>10</sup> Browne, Miller and Maguin, "Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women," *International Journal of Law & Psychiatry* 22(3-4) (1999). The U.S. Bureau of Justice Statistics reports that more than 37% of women in state prisons have been raped before their incarceration. *Prior Abuse Reported by Inmates and Probationers*, Bureau of Justice Statistics, U.S. Department of Justice (April 1999) at 2. The Bureau also reports that female inmates are at least three times more likely than male inmates to have been physically or sexually abused in their past. *Survey of State Inmates, 1991*, Bureau of Justice Statistics, U.S. Department of Justice (May 1993) at 6.

female inmates, including women at Bedford Hills, are at risk of being abused by correction officers verbally, physically, and sexually,<sup>11</sup> which can be deeply traumatizing.

The Department has recently taken the positive step of creating an executive level task force on issues facing women inmates. This task force represents an opportunity for the Department to initiate an effort to ensure that all women's facilities offer effective abuse counseling programs and gender-specific, culturally sensitive, and trauma-informed services. Such services would not only allow women inmates to more effectively access assistance and support, they could also help to reduce recidivism rates<sup>12</sup> and improve facility safety and efficient overall operations.<sup>13</sup>

**Recommendations: Gender-specific, Culturally Sensitive,  
and Trauma-informed Services, and Family Violence Program**

**Bedford Hills Correctional Facility and Office of Mental Health:**

- Integrate a gender-specific, culturally sensitive, and trauma-informed approach into all mental health programs and services at Bedford Hills.
- Work with Family Violence Program staff, current and former participants, and consultants with expertise in domestic violence and the criminal justice system to re-invigorate participation in the program and to ensure that women can receive the help they need without fear of being retraumatized.

**Office of Mental Health and Department of Correctional Services:**

- Include in the Department's women's task force agenda an initiative to develop effective abuse counseling programs and to implement gender-specific, culturally sensitive, and trauma-informed services in all facilities that house women in New York.
- Include in this effort experts in women's community and correctional mental health care, formerly incarcerated women survivors of abuse and trauma, and formerly incarcerated women with mental illness.
- Train all correction and civilian staff on the concept of gender-specific, culturally sensitive, and trauma-informed services.

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<sup>11</sup> See Correctional Association reports on Bedford Hills Correctional Facility, August 2007 and May 2006, and on Albion Correctional Facility, November 2006, available at [www.correctionalassociation.org](http://www.correctionalassociation.org). See *Amador v. Superintendents of Dept. of Correctional Services*, No. 03 Civ. 0650KTDGWG, 2005 WL 2234050, (S.D.N.Y. Sep. 13, 2005); Thomas Zambito, "Female Cons File Suit, 15 claim sex abuse from male guards," *Daily News*, July 3, 2006; "Bedford Inmates Allege Sexual Abuse," lawcore.com, April 7, 2006; Neil Shapiro (Executive Producer), *NBC News. Dateline NBC: Honor Guard?* (Television Broadcast Transcript), New York: National Broadcasting Company (November 1, 1998).

<sup>12</sup> For example, a DOCS study of women who participated in the Family Violence Program for at least six months from 1988 through 1994 had a recidivism rate of just over 10% versus almost 24% for non-participants. *Follow-up Study of Bedford Hills Family Violence Program*, State of New York Department of Correctional Services. The recidivism rate for women jail inmates participating in the Trauma, Addiction, Mental Health, and Recovery (TAMAR) Project in Maryland had a recidivism rate of less than 3%. The TAMAR Project provides "integrated, trauma-oriented services for women with mental illness and co-occurring substance abuse disorders" in local jails in Maryland. *Report of the Reentry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community*, Reentry Policy Council (January 2005), at 522.

<sup>13</sup> For example, according to the National Mental Health Information Center, trauma training and integration of trauma-informed services enabled the Corrections Center of Northwest Ohio to reduce recidivism and staff uses of force. "Ohio Corrections Facility Sees Immediate Results of Trauma Training," National Mental Health Information Center, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, <http://mentalhealth.samhsa.gov/nctic/ohio.asp>.

## **General Population**

As previously mentioned, more than 50% of the women at Bedford Hills (421) were on the mental health caseload as of January 2007. The combined capacity for the ICP (15), TBU (16), and RCTP (15) is 46; the combined capacity for SHU (24) and keeplock (67 at the time of our visit) is 91. It therefore seems fair to assume that, on any given day, upwards of about 280 women on the mental health caseload will be in general population.<sup>14</sup>

General population inmates on the OMH caseload meet with a mental health counselor only about once every month. The average meeting time is 20 to 30 minutes and the frequency of meetings is determined on a case-by-case basis. Inmates on psychotropic medication also meet with a psychiatrist at least every three months.

Women in general population on the OMH caseload generally had high praise for the quality of the mental health staff members with whom they met. Many women did report, however, that meetings with staff were not as frequent or as long as they needed and that there were often delays in meeting with an OMH staff person after placing a request. In addition, there are no groups or other activities specifically aimed at addressing mental health issues for women in general population. Some women we spoke with had declined to reach out to OMH because they feared being placed on medication without a thorough evaluation of whether other services and support would suffice.

Nine of Bedford's 10 admissions to CNYPC from January to June 2007 were from the facility's general population. During the same six month period, there were 120 admissions from Bedford's general population to the facility's RCTP. If these numbers keep pace for the rest of the year, Bedford will have had nearly 260 instances of inmates identified as needing acute psychiatric intervention or hospitalization within a 12 month period.

Overall, it seems that while services have increased – and appropriately so – for certain special populations, the women with mental health issues in Bedford's general population remain largely overlooked and underserved.

### **Recommendations: General Population**

#### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Increase the frequency of individual therapy sessions for women in general population on the mental health caseload.
- Implement small, regular group therapy sessions and other activities aimed at increasing general population inmates' social and emotional support structures.

#### **New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds needed to allow Bedford Hills to carry out efforts to increase mental health services for women in general population.

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<sup>14</sup> The figure is likely more than 280 as inmates in SHU and keeplock are generally not all on the mental health caseload. In July 2005, nearly 87% of inmates in SHU were on Bedford's OMH caseload; in January 2007, OMH estimated that 63% were on the caseload.

## **Intermediate Care Program (ICP)**

We did not visit Bedford's ICP during our tour and look forward to visiting the program again in the future. The ICPs are one of the Department's most effective programs for mentally ill inmates: the units provide enhanced mental health services for residents and help increase facility safety by placing inmates with difficulty functioning in general population in a more supportive and protected environment. The ICP at Bedford received consistently positive feedback from inmates during our previous tours. Our main concern is that Bedford's ICP – the only one in the state for women – was short of maximum capacity (15 of 16 cells were filled) and did not have a waiting list. With about 1,200 female inmates diagnosed with mental illness system-wide and more than 420 at Bedford alone, it is surprising that more women are not deemed appropriate candidates for the ICP.<sup>15</sup>

Additionally, while plans to build another ICP at Albion Correctional Facility are a welcome development, Bedford Hills still needs more ICP beds: the current program has space for only 1% of women in New York State prisons on the mental health caseload.

### **Recommendations: ICP**

#### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Take pro-active steps to ensure that inmates at Bedford are appropriately identified for and admitted to Bedford's ICP.

#### **Office of Mental Health and Department of Correctional Services:**

- Take pro-active steps to ensure that inmates at all women's facilities are appropriately identified for and admitted to Bedford's ICP.

#### **New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds to allow Bedford to expand the capacity of its ICP.

## **Mental Health Services in Special Housing Unit (SHU)**

At the time of our visit, 22 of Bedford's 24 SHU cells were filled.<sup>16</sup> OMH staff estimated that 14 of the 22 women (63%) in SHU were on the OMH caseload. Six of the 14 had applications pending for the TBU.

OMH staff informed us that all inmates admitted to the SHU are assessed by mental health staff within 24 hours and that OMH conducts rounds in SHU seven days per week. The women in SHU we spoke with confirmed the frequency of rounds and that they had been seen by OMH within a day after being transferred. OMH also reported that SHU inmates on the mental health caseload meet with counselors about twice per month and with a psychiatrist once per month, though the frequency varies on a case-by-case basis. These meetings are held in one of two private rooms in the SHU building. There are no group sessions for inmates with mental illness in SHU.

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<sup>15</sup> CNYPC *Patient Demographic and Diagnostic Profile, Year 2007*, Central New York Psychiatric Center (January 29, 2007), at 5.

<sup>16</sup> At the time of our visit, there were 67 inmates on keeplock status at Bedford Hills.

Most women in SHU had positive remarks about the quality of mental health staff members they met with. Even with these counseling services, however, many women told us that their mental health condition had worsened since being placed in SHU. Two situations warrant particular attention: one woman who had been diagnosed with depression and Post Traumatic Stress Disorder (PTSD) reported having tried repeatedly to harm herself while in SHU; she had an application pending for the TBU, but had not yet been approved for transfer. Another woman, who had been diagnosed with manic depression, reported that she had recently been transferred back from the facility's observation cells after trying to kill herself. This woman reported having met with mental health staff only a few times per month before the incident. In general, she seemed disoriented and was unsure if anyone had spoken to her about the TBU.

There is widespread recognition by mental health experts that inmates suffering from serious mental illness should not be placed in SHU.<sup>17</sup> The unit's restrictive setting aggravates most mental health conditions and can cause inmates to decompensate, even if they are able to meet with counseling staff on a regular basis.<sup>18</sup> In the beginning of 2007, one woman at Bedford who had been diagnosed with mental illness committed suicide while she was in disciplinary confinement. In 2006, Bedford reported two Unusual Incidents (UIs) concerning self-injury in SHU. That year, four women from SHU were admitted to CNYPC. From January to June 2007, one woman from SHU was admitted. During that same time period, there were 35 admissions to Bedford's RCTP from SHU.

Some inmates in SHU communicated that the lights inside their cells were too bright and disrupted their ability to sleep. Members of our visiting team observed that many SHU cell lights were half-covered by sanitary napkins – an attempt on some inmates' part to make the room darker at night. The Superintendent explained that the lights allowed officers to check on inmates to make sure they were “still breathing.” Although these concerns are understandable, sleep deprivation can have an acutely adverse affect on any individual, especially one already suffering from mental illness.<sup>19</sup>

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

### **Recommendations: SHU**

#### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Investigate reports of officer mistreatment in SHU, closely monitor those officers who are found to be problematic, and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.

<sup>17</sup> See *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, Human Rights Watch (October 2003); *Lockdown New York: Disciplinary Confinement in New York State Prisons*, Prison Visiting Project, Correctional Association of New York (October 2003); and *Mental Health in the House of Corrections: A Study of Mental Health Care in New York State Prisons*, Prison Visiting Project, Correctional Association of New York (June 2004).

<sup>18</sup> “Decompensation refers to the aggravation of symptoms of mental illness leading to a marked deterioration from previously adequate levels of functioning and coping in daily life.” See note 18, Human Rights Watch, at 3.

<sup>19</sup> See Siobhan Banks and David F. Dinges, “Behavioral and Physiological Consequences of Sleep Restriction,” *Journal of Clinical Sleep Medicine*, Vol. 3, No. 5 (2007) at 519-528.

- Allow SHU-confined inmates to significantly dim or turn off the lights in their cells while they sleep, and require officers to check on inmates during night rounds with flashlights.

**Office of Mental Health and Department of Correctional Services:**

- Forbid the placement of seriously mentally ill inmates in SHU and instead transfer inmates to the TBU or, if possible, to less a restrictive setting such as the ICP.
- Adopt a policy prohibiting women with mental illness who attempt to harm or kill themselves from being placed in SHU even as a temporary holding place before being transferred to the RCTP, the TBU or another unit.

## **Therapeutic Behavioral Unit (TBU)**

### **Program Overview**

Created in June 2005, Bedford's TBU is a 16-bed unit jointly run by DOCS and OMH for mentally ill inmates who have chronic disciplinary problems and who would otherwise remain in disciplinary confinement. CNYPC describes the TBU as a unit "designed to provide a therapeutic treatment environment for inmate-patients who demonstrate willful antisocial behavior and present with a history of chronic management difficulties." The unit is located on the third floor of Bedford's Regional Medical Unit (RMU) building; the ICP and RCTP are located on different sections of the same floor. Although the unit is brightly lit, the TBU cells have no windows. The cells line the side of the room directly opposite the room's only windowed wall.

As of January 2007, a total of 21 women had been admitted to the unit since it opened: six were admitted in 2005 and 15 in 2006. At the time of our visit, the unit had nine beds filled. We were informed that an additional six TBU applications from inmates in Bedford's SHU were pending. TBU slots are most often filled by inmates serving time at Bedford Hills, with a small number coming from the SHU at Albion Correctional Facility. Staff from any DOCS facility housing women and from CNYPC can refer inmates to be considered for TBU placement. OMH staff estimated that the average census for the TBU was 14 and that the average length of stay for TBU inmates was six to nine months.

According to a CNYPC document describing the TBU, the unit's target population are inmates who have an Axis I and/or Axis II diagnosis, a demonstrated pattern of Axis II behavioral traits;<sup>20</sup> a "disciplinary pattern of disturbed, disruptive behavior with self-control deficits and violent or disruptive impulses;" and/or a pattern of "instrumental assaults on staff/inmates" and "custodial management challenges;" and, a profile that matches the "therapeutic mix of currently admitted inmate-patients for a balance of patients modeling appropriate behaviors with those needing more intensive treatment." When we inquired about which SHU inmates would be considered ideal candidates for TBU placement, staff explained that they look for inmates who need intensive mental health services and who have the potential to succeed in the program.

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<sup>20</sup> Axis II diagnoses are defined mainly as "Personality Disorders" and "Specific Developmental Disorders" and include: borderline personality disorder, mental retardation, obsessive-compulsive personality disorder, antisocial personality disorder, and paranoid personality disorder, among others. *See* note 4, *DSM-IV-TR*.

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

The TBU model is comprised of three phases, the first of which begins while inmates are still in SHU. Once an inmate is accepted into the program, Phase I consists of informing that inmate, while they are in SHU, about the TBU and the expectations of inmates in the program. In order to move to Phase II – and be transferred to the TBU – an inmate must have at least 30 days of “outstanding behavior,” including remaining ticket-free during that time period. After the 30 day period, staff estimated that it takes about two weeks to be transferred to the unit.

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

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

In addition to the individual meetings, Phase II inmates participate in therapeutic programming for four hours per day, five days per week: two hours per day are spent in “core groups” – Therapeutic Community, Relapse Prevention, Communication Skills, Medication Education, Anger Management, Positive Changes, Poetry, Spirituality, Change, and Art Group. The other two hours are spent in “leisure groups,” which consist of Yoga, Current Events, Bingo, and Art Therapy.

TBU inmates must remain ticket-free to earn their way into Phase III. Inmates in this phase are allowed additional out of cell time and can continue earning “privileges,” including the ability to participate in certain programs with general population inmates. The Case Management Committee decides on an individual basis when Phase III inmates are ready to move off the unit. Inmates can be discharged from the TBU to the ICP, to the MICA program, to the general population at Bedford Hills, or to the general population of the facility from which they were initially transferred. Inmates can also be transferred back

to SHU for more serious disciplinary infractions. If an inmate “maxes out” (finishes her sentence while in the TBU), she can be sent from the unit directly back to the community.

According to the CNYPC information packet we received during our visit, of the 15 women admitted to the TBU in 2006: six successfully matriculated back into general population; two were transferred back to SHU; one was sent to CNYPC; three “maxed out” and returned to the community; and three remained on the unit. According to CNYPC information we received after our visit, as of August 31, 2007, of the 10 women in the TBU in January 2007:<sup>21</sup> one graduated to general population; one was transferred to CNYCP; two were discharged directly to the community; one was transferred back to SHU; two were transferred to the facility’s ICP; and three remained on the unit. One of the women who remained on the unit is scheduled to be released to the community in October, another will matriculate back into general population in September, and one is scheduled to appear before the parole board in October.

There were a total of three incidents of self-harm in the TBU in 2006 and one in the first six months of 2007. Two women reported to us that they had engaged in acts of self-harm while they had been in general population and then again in SHU prior to their TBU placement, but not since they had been transferred to the TBU unit. As previously mentioned, Bedford reported one suicide in SHU in 2007 and two incidents of self-harm in SHU in 2006 and one in the first six months of 2007. From January to June 2007, there were 42 admissions to Bedford’s RCTP from the TBU – an average of three transfers to the crisis center per inmate if the average census for the TBU for the first six months of 2007 was 14.

Time spent in the TBU is considered part of an inmate’s SHU sentence and inmates can earn time off of their SHU sentence for good behavior. Tickets can also be given to inmates in the TBU. If an inmate receives a ticket, the circumstances of the ticket are evaluated by a “team” consisting of both mental health and DOCS staff. OMH staff reported that decisions about ticket penalties are made on a case-by-case basis and that no one entity or individual “overrides a decision” about what to do with a TBU inmate who receives a ticket. If the offense is serious, the inmate might accrue additional SHU time, lose TBU “privileges,” or be sent back to SHU. Minor offenses carry penalties that are less severe. OMH declined to give us specific data about whether any women in the TBU had accrued additional SHU time or earned time cuts, and, if so, how it was accrued or earned. OMH stated that this information would be available in the agency quarterly reports required by the recent settlement of a lawsuit on behalf of Disability Advocates, Inc. concerning people with mental illness in DOCS custody.<sup>22</sup>

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<sup>21</sup> The census at the time of our visit on January 9, 2007 was nine. Apparently, one woman was transferred to the TBU in January but after our visit.

<sup>22</sup> This lawsuit was brought by the Prisoners Rights Project of the Legal Aid Society, Prisoners’ Legal Services of New York, and Davis Polk & Wardwell on behalf of Disability Advocates, Inc. Among other things, the settlement requires DOCS and OMH to enhance mental health services for mentally ill inmates in general population and disciplinary confinement; increase mental health screening at reception; increase ICP bed capacity; conduct more intensive reviews of sentences for inmates with mental illness who are in SHU and who receive SHU sanctions; increase OMH input into the DOCS disciplinary process; and, prepare a variety of reports regarding various aspects of mental health care. It also requires DOCS and OMH to create new Residential Mental Health Units (RMHUs) for some mentally ill inmates with chronic disciplinary problems who would otherwise remain in SHU and a new 20-bed ward at CNYPC. *Disability Advocates, Inc. vs. New York State Office of Mental Health, et al.*, 02 Civ. 4002 (S.D.N.Y.) April 2007.

## Program Evaluation

Some women we spoke with had been in the TBU for a few months; others reported being in the unit for over a year. All the inmates had been transferred to the TBU from the SHU either at Bedford or Albion. Women had positive feedback about the quality of mental health services in the TBU, described the OMH staff as caring and accessible, and reported that, unlike their experiences in SHU and general population, they met with counselors in the TBU as often as they needed. Inmates' main concern regarding mental health staffing focused on their anxiety about interacting with and trusting new OMH staff members. Women also had positive remarks about the TBU's group sessions, especially because the groups allowed them to leave their cells without restraints and to interact with other inmates.

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

Our concerns about the program fall into five main areas:

- (1) The program's goals are undermined by the requirements:
  - that an inmate remain in SHU for more than a month (30 days for TBU Phase I and about two weeks to finalize transfer to the unit for Phase II) even after they have been deemed an appropriate TBU candidate; and,
  - that an inmate maintain "outstanding behavior," including remaining ticket-free, during the time in which they are waiting to be transferred to the TBU unit.

These requirements are highly problematic: first, spending an extended period of time in SHU's restrictive environment can be severely detrimental for inmates with serious mental illness;<sup>23</sup> second, particular behavioral traits associated with certain mental illnesses are not willful but symptomatic.<sup>24</sup> Without more intensive treatment and services, certain mentally ill inmates may not be able to refrain from engaging in the same type of behavior which led them to violate prison rules in the first place or may decompensate before they meet the requirement for transfer.

Ultimately, these regulations decrease the chance that some inmates in dire need of more intensive treatment will receive that treatment. That six of the 14 women in SHU on the mental health caseload had applications pending at the time of our visit and that the

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<sup>23</sup> See note 18.

<sup>24</sup> Many inmates with mental illness "have a combination of psychiatric disorders predisposing them to both psychotic breakdown and to extreme impulsivity.... [S]uch individuals [tend] to be highly impulsive, lacking in internal controls, and [tend] to engage in self-abusive and self-destructive behavior in the prison setting, and especially so when housed in solitary. [T]hey are among the most likely to suffer behavioral deterioration in supermax confinement." See note 18, Human Rights Watch, quoting Dr. Stuart Grassian, at 152.

TBU's estimated average census (14) is lower than its operating capacity (16) may be, in part, a result of the difficulty inmates have in overcoming this barrier to transfer.

Additionally, characterizing the month an inmate spends in SHU preparing for transfer to the TBU unit as "Phase I" is a misnomer. As SHU inmates do not receive the more intensive services offered to inmates in the TBU, time spent in SHU should not be considered part of the TBU program.

- (2) Despite its positive elements, the TBU model relies too heavily on the threat and/or use of disciplinary sanctions to motivate compliance with prison rules.

While the TBU and the Behavioral Health Units (BHUs) for men at Great Meadow and Sullivan Correctional Facilities are distinct in certain ways, both units employ a similar overall model: at its basic level, this model is one that punishes "bad" behavior and rewards "good" behavior.<sup>25</sup> On the positive side, the TBU disciplinary system is a modified version of DOCS' general disciplinary system: not all tickets carry automatic penalties, they are assessed individually by mental health and DOCS staff, and OMH is given a prominent role in determining the consequences. One woman we spoke with, for example, had received four tickets since her TBU placement but had not been sent back to SHU or accrued any additional SHU time. Instead, she explained, staff had "set a plan" to address her behavioral issues. Unfortunately, as evidenced by the fact that three women admitted to the TBU since 2005 were sent back to SHU, this scenario does not apply to all inmates.

Even with the individual assessments, the TBU's disciplinary system is likely to be ineffective and demoralizing for many of the inmates the unit was developed to aid. While the possibility of punishment might deter a healthy inmate from engaging in inappropriate behavior, certain mentally ill inmates may not be able to perform the same action-consequence calculus and/or stop themselves from engaging in inappropriate behavior even if the consequences are well understood. It is telling that every woman with whom we spoke had received multiple additional tickets since being placed in the TBU. One woman reported having received a ticket or a ticket-like document (she was not sure which) after she engaged in an act of self-harm. Although this inmate was neither sent back to SHU nor given additional SHU time, issuing tickets, or documents resembling tickets, in such situations is an inappropriate response and undercuts the program's goal of creating a supportive environment.

Additionally, that the TBU's disciplinary system retains transfer to SHU as a potential punishment option is misguided. From a mental health perspective, sending an inmate from TBU to SHU is counterintuitive: a person who is unable to conform to appropriate modes of behavior even in an environment like the TBU is a person in need of more help, not less. Sending that person to SHU – where there will be fewer mental health and other support services and more time in isolation – will likely cause her mental health condition to deteriorate and increase the chance that she will violate even more prison regulations.

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<sup>25</sup> Phase I of the BHU operates in Great Meadow Correctional Facility (a maximum security facility for men in Washington County) and Phases II and III of the BHU operate in Sullivan Correctional Facility (a maximum security facility for men in Sullivan County). See the Correctional Association's Prison Visiting Project reports on Great Meadow Correctional Facility and Sullivan Correctional Facility, available at [www.correctionalassociation.org](http://www.correctionalassociation.org).

(3) The TBU is under-utilized.

Whatever its flaws, the TBU's more intensive services and supportive environment are highly beneficial to the otherwise SHU-bound inmates who live there. We question why more women are not applying for, being accepted into, or being put on the waiting list for the unit. As previously mentioned, OMH staff estimated that the average TBU census was 14. During our July 2005 visit, eight women were on the unit. During our January 2007 visit, nine inmates were on the unit and six applications were pending. On any given day, there can be more than 200 women in SHU or keeplock system-wide. As of January 2007, approximately 1,200 female inmates were on the OMH caseload.<sup>26</sup> These numbers and the often disproportionate representation of mentally ill inmates in disciplinary confinement<sup>27</sup> indicate that more women should be appropriate candidates for TBU placement.

(4) Staff assigned to the TBU are not appropriately screened or trained.

On the positive side, inmates commented that many officers treat TBU inmates in a respectful and reasonable manner. Our interaction with one officer assigned to the unit reflected these sentiments: "We have a team approach on this unit," he stated, "no one person decides what happens when an inmate acts out." On the other hand, every TBU inmate we spoke with communicated serious distress about the treatment from certain officers assigned to the 7:00am to 3:00pm shift. They described these officers as verbally abusive, taunting and provoking inmates to misbehave. One woman stated that she would "rather be locked in" from 7:00am to 3:00pm because she did not want to interact with certain officers during that shift.

Officer mistreatment and harassment is objectionable in any location in any facility. It can be particularly damaging for mentally ill inmates, a vulnerable population that is generally more prone to violate prison rules as a result of verbal provocation. Mental health staff explained to us that all TBU officer positions are "bid positions" – meaning that more senior officers have the ability to pick whether they want to be assigned to the unit. Even though officers assigned to the TBU participate in additional mental health training, using a bid system ultimately makes it difficult to ensure that officers assigned to TBU posts are those best suited to work in the unit's difficult and sensitive environment.

(5) The TBU lacks comprehensive discharge planning services.

From the TBU's opening in June 2005, at least five inmates have been released directly from the unit to the community. OMH reported that inmates who "max out" receive basically the same discharge planning as other inmates, with additional emphasis on connecting them with community-based mental health services. OMH staff also noted that they do not collaborate very closely with Bedford's transitional services staff. Without comprehensive discharge planning services, TBU inmates are more likely to experience disruptions in the continuity of their care and to recidivate.

The Department's Community Orientation and Re-entry Program (CORP) program at Sing Sing Correctional Facility provides a model for discharge planning for mentally ill

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<sup>26</sup> See note 16.

<sup>27</sup> In July 2005, nearly 87% of inmates in SHU were on Bedford's OMH caseload. In January 2007, OMH estimated that 63% were on the caseload.

inmates. CORP is a special unit located in Sing Sing's 31-bed ICP. Inmates diagnosed with serious mental illness are placed in the unit to receive transitional services months before their release.<sup>28</sup> Implementing a similar program for women with serious mental illness at Bedford Hills would greatly benefit the inmates themselves, the facility, and society at large.

### **Recommendations: TBU**

#### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Allow inmates deemed appropriate candidates for the TBU to be transferred to the unit regardless of their ability to maintain good behavior and stay ticket-free in SHU.
- Substantially expedite the process for transferring approved TBU inmates to the unit.
- Provide at least two hours of out-of-cell therapy in addition to the one-hour recreation period at least five days per week for women in SHU waiting for TBU placement until the transfer occurs.
- Reconceptualize the TBU disciplinary system so that it relies even less on a traditional disciplinary model of tickets and punishment and remove return to SHU as a possible consequence for misbehavior.
- Eliminate tickets for acts of self-harm, both for women in disciplinary confinement and general population.
- Implement a program similar to Sing Sing's Community Orientation and Re-entry Program to provide comprehensive transitional planning for inmates with serious mental illness and begin these services significantly before an inmate's earliest release date.
- Conduct an investigation into reports of officer harassment in the TBU, closely monitor those officers who are found to be problematic and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.
- Expand the specialized training for officers assigned to the TBU and require officers to participate in training before their assignment begins and on an ongoing basis thereafter.

#### **Office of Mental Health, Department of Correctional Services and NYSCOPBA:**

- Remove the TBU assignments as bid positions and institute a more stringent screening policy for officers wishing to be assigned to the TBU, including an evaluation by OMH.

#### **Office of Mental Health and Department of Correctional Services:**

- Work with facility Superintendents and mental health and correction staff at all women's facilities to more vigorously identify and process women in disciplinary confinement who could benefit from being transferred to the TBU.

### **Mental Health Medication**

As of January 2007, more than 72% of inmates on the mental health caseload at Bedford Hills (304 women) were taking psychotropic medication; nearly half were taking neuroleptic medication.<sup>29</sup> No inmates were on forced medication. Most women taking psychotropic medication in general population, SHU, and TBU reported that they had not encountered delays in getting their medication and had received an explanation of side-effects from staff before beginning their regimens. As previously noted, a number of

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<sup>28</sup> See *State of the Prisons 2002-2003: Conditions of Confinement in 14 New York State Correctional Facilities*, Prison Visiting Project, Correctional Association of New York (June 2005), at 121.

<sup>29</sup> See note 5.

women we spoke with related concerns about over-reliance on psychotropic medication to treat women with mental health issues.

In SHU, keeplock, TBU, and ICP, OMH nurses distribute mental health medication to women cell-side during medication rounds. In general population, inmates sign up to get their medication at the “medication window” in Building 113. Mental health staff estimated that approximately 100 general population inmates pick up their medication during the AM time slot, from 8:30am to 10:15am, and about 200 get their medication during the PM time slot, from 6:30pm to 9:30pm. When we visited the medication area in Building 113 – essentially a window in a long hallway – we noted that the set up of the area might make it difficult for women to maintain confidentiality during medication pick ups.

OMH maintains a solid system for checking for medication contraindications: staff explained that CNYPC had recently installed a new computer system that allows OMH to monitor inmates’ mental health prescriptions, check for contraindications, and perform medication reconciliation.<sup>30</sup> Mental health staff also have bi-weekly meetings with Bedford’s medical staff during which they sometimes review medication regimes for individual inmates. In addition, each inmate’s mental health chart includes a section for medical doctors to fill in prescription information. We were pleased to hear about this process and hope that the bi-weekly meetings also include discussions about medication compliance.

### **Recommendations: Mental Health Medication**

#### **Office of Mental Health and Bedford Hills Correctional Facility:**

- Examine concerns about over-reliance on medication and reassess the facility’s balance between reliance on medication and other forms of therapeutic intervention and treatment.
- Take any necessary steps to ensure confidentiality for general population inmates during medication pick ups.

## **Mentally Ill Chemically Addicted (MICA) Program**

### **Program Overview**

Bedford’s MICA program is the only one of its kind for women in the state prison system. At the time of our visit, approximately 41 of 50 program slots were filled. Both MICA and the facility’s Alcohol and Substance Abuse Treatment (ASAT) programs share a waiting list. As of January 2007, the combined waiting list was 192 inmates. When we asked the Superintendent why only 41 of 50 slots were filled even though there was a waiting list of 192, she explained that several women had been removed for disciplinary reasons and indicated that six additional women were set to join the program soon.

The MICA program was staffed by one supervisor, three DOCS correction counselors, and one senior corrections counselor. At the time of our visit, no OMH staff were assigned to the program and DOCS MICA staff did not have a regular meeting schedule with OMH personnel. Although an OMH counselor had been assigned to MICA for a few hours each week to conduct 30-minute individual sessions with inmates, this counselor had left the facility a number of months prior to our visit and her position had not

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<sup>30</sup> See note 6.

yet been filled. MICA counselors informed us that if a situation requiring additional mental health assistance arises, they ask OMH to intervene. A three-day OMH training course for DOCS MICA staff does exist, but had not yet been implemented because of staff turnover.

To be accepted into MICA, an inmate must be on the OMH caseload and have ASAT completion as a requirement of her DOCS work and treatment plan. Inmates who complete the program are considered to have fulfilled their ASAT requirement. If an inmate has already successfully completed ASAT, she is generally not allowed to participate in MICA as well. Women can fill out a MICA application themselves or be referred by DOCS or OMH staff. There is no participation restriction for inmates with more serious mental health diagnoses and inmates are not required to have a particular diagnosis to gain entry into the program. Because MICA inmates are required to live on the same unit (building 112, units A and B), women in Bedford's ICP are not allowed to participate in the program.

MICA has a 39-week curriculum set by DOCS Central Office. The counselors we spoke with explained that the goal for MICA is to have the program operate like a therapeutic community (TC),<sup>31</sup> although the TC model had not yet been fully incorporated into the program structure. The program has two groups, each of which was comprised of about 20 inmates at the time of our visit. One group participates in MICA programming for three hours during the AM module; the other participates during the PM module. As of January 2007, programming consisted of one group session five days per week and brief individual sessions on an ad hoc basis. MICA inmates are allowed to participate in programs with the general population during their non-MICA modules.

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

## **Program Evaluation**

OMH staff estimated that approximately 80% of women on the mental health caseload also had a substance abuse diagnosis. We strongly endorse the concept of integrated treatment – a model proven to be more effective than separate substance abuse and mental health treatment (either “sequential” or “parallel”) for individuals with dual diagnoses<sup>32</sup> – and we commend the Department and Bedford Hills for launching this program. At the time of our visit, however, the program had a number of serious deficiencies and problems, including an insufficient mental health component, the lack of both OMH staff and specially trained DOCS staff, the absence of a substantial residential

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<sup>31</sup> The National Institute on Drug Abuse (NIDA) describes therapeutic communities as “drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility.” NIDA also states that TCs generally have a residential component, employ a model of using “the community, comprising treatment staff and those in recovery, as key agents of change,” and require staff and participants to “interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use.” National Institute on Drug Abuse, National Institutes on Health, *Research Report Series: Therapeutic Community*, U.S. Department of Health and Human Services, at 1 and 2.

<sup>32</sup> See note 9, Bloom, at 45, 76 and 80. See Holly A. Hills, *The Special Needs of Women with Co-Occurring Disorders Diverted from the Criminal Justice System*, The National GAINS Center for People with Co-Occurring Disorders in Contact with the Criminal Justice System and the TAPA Center for Jail Diversion, April 2004. See Robert E. Drake et al., *Implementing Dual Diagnosis Services for Clients with Severe Mental Illness*, *Psychiatric Services*, Vol. 52, No. 4 (April 2001) at 469-476.

component, and poor treatment from some correction officers. Overall, the program seemed to be operating as an ASAT program with a MICA population.

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

A primary concern for inmates was that certain officers on the unit called inmates derogatory names, made degrading comments related to their mental health status, and seemed loathe to respond when women requested to see mental health staff. Many women reported that officer treatment was worse in MICA than in general population. Others mentioned that some women preferred to stay in their cells as a result of feeling unsafe around officers. One woman explained that she had not left her cell for the entire weekend (when there were no MICA programs and no civilian staff assigned to the unit) because she did not want to interact with one of the officers on duty.

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

Both the Superintendent and the OMH Unit Chief agreed that more could and should be done to build MICA's mental health component. The Superintendent informed us that Bedford Hills was planning to hire a full-time DOCS psychologist who would be assigned to MICA for at least some of his/her hours. The Unit Chief also mentioned that OMH hoped to reassign a staff person to work with the program. While we support these efforts, to provide truly effective services, Bedford must take additional steps to restructure the MICA program. Such steps involve the incorporation of principles of evidence-based treatment for individuals with dual diagnoses, including the "cross-training" of mental health and substance abuse staff, the provision of comprehensive mental health and substance abuse services, and the implementation of other services aimed at strengthening program participants' "immediate social environment" and support networks.<sup>33</sup>

### **Recommendations: MICA Program**

#### **Office of Mental Health and Bedford Hills Correctional Facility:**

- Allocate enough mental health staff time to ensure that all MICA participants can meet with a mental health counselor at least once per week and attend regular group sessions where they can safely discuss mental health and other issues.

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<sup>33</sup> See *Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders, Overview Paper 3*, Co-Occurring Center for Excellence (COCE), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (2007). See note 32, Drake, at 469-476. See note 9, Bloom, at 5.

- Investigate concerns about officer harassment in MICA, closely monitor those officers who are found to be problematic, and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.
- Conduct specialized ongoing mental health training for civilian staff working in the MICA unit and specialized ongoing training on substance abuse treatment for mental health staff assigned to MICA, and require all MICA-assigned correction staff to participate in additional specialized training by OMH.
- Build more structure into the MICA group sessions and implement group activities and weekend therapeutic programming that help build a sense of community and support among program participants.
- Hold a series of meetings with DOCS Central Office, MICA-assigned DOCS and OMH staff, experts on providing effective treatment for MICA populations, and MICA Inmate Coordinators to discuss areas for program improvement and to develop a plan to implement necessary reforms.
- Expand materials available to MICA counselors and inmates.
- Institute regular meetings between DOCS MICA staff and OMH to review individual inmates' progress and to work together to resolve any challenges a particular inmate may be facing before removing her from the program.

**New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funding to allow Bedford Hills to expand its MICA and ASAT program capacity.

## **Network**

### **Program Overview**

At the time of our visit, Network was staffed by one Correction Counselor who had been working at Bedford Hills for 15 years and with DOCS for 20. We were impressed by this counselor's commitment and thoughtfulness and were sorry to learn that she has since left the facility. Network is supposed to operate as a "modified therapeutic community" to allow inmates with less serious mental health issues to be in a supportive environment and learn "self-reliance" and daily living skills, such as cooking for themselves on the unit. The counselor explained that Network's services had been reduced a number of years ago, primarily as a result of cuts in staffing. Although Network participants have mental health issues, the program is run by DOCS, not OMH.

Women who participate in Network live in building 120, one of Bedford's dormitory-style units. The building holds a total of 76 women: 60 spaces are reserved for Network participants and the rest are usually filled with general population inmates who have returned to prison on parole violations. In January 2007, Bedford had 56 Network slots filled, roughly the same number of inmates in the program in July 2005. Thirteen women were on the Network waiting list.

Although many inmates in Network come from the ICP or MICA and/or are on the OMH caseload, program eligibility is not restricted to any one group. Network inmates participate in regular general population programming for their AM and PM module. Three times per week, the counselor runs a life skills/emotional support group with all participants.

There is no set time for inmates to complete the program; some women leave after one year, others have been in the program for more than five years. Instead, the counselor assesses whether inmates are ready to matriculate back into other general population units on a case-by-case basis. Approximately three to four inmates are removed from the program per year, usually for disciplinary infractions.

### **Program Evaluation**

Inmates had generally positive feedback about the Network program: they praised the quality of the counselor, thought that groups and program materials were useful, and valued living in a “less isolated” community setting. Women did report, however, that although relations were fine with most officers on the unit, a small number of officers recently assigned to the program regularly harassed inmates and used derogatory and disrespectful language. Many women commented that because the groups were open to the entire unit, they were too large and sometimes too unstructured. Inmates also expressed the need for additional programming and more frequent meetings with mental health staff.

Network did not have any Inmate Program Aide (IPA) positions at the time of our visit. Creating IPA positions would supplement Network’s small staff and enhance the program’s services while providing an opportunity for inmates to gain valuable skills and serve their time productively. When we spoke to the Superintendent, she was open to the idea and noted that she would speak with Network staff to follow-up.

Living in a more supportive environment seemed to be of significant benefit the women participating in Network. Because it lacked adequate staffing and more intensive programming, however, Network’s services were not as robust as they could or should be.

### **Recommendations: Network Program**

#### **Bedford Hills Correctional Facility:**

- Assign additional counseling staff to Network and create Inmate Program Aide (IPA) positions for the program.
- Investigate concerns about officer harassment in the Network program, closely monitor those officers who are found to be problematic, and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.

#### **Office of Mental Health and Bedford Hills Correctional Facility:**

- Integrate a stronger mental health component into the program, including individual counseling sessions and more frequent and smaller group sessions.
- Require officers assigned to Network to participate in additional training about working with inmates who have mental health issues.

#### **New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds to allow Bedford Hills to assign additional counseling staff to Network.

## **Correction and Civilian Staff**

The New York State Correctional Officer and Police Benevolent Association (NYSCOPBA) representative we met with noted that although the opening of the TBU had been helpful, officers continued to face difficulties associated with guarding and managing mentally ill inmates in general population and in SHU. DOCS has one required mental health training for officers each year, with supplementary voluntary mental health training each quarter. The representative reported that many correction staff members found these trainings helpful and noted that officers might benefit from additional training as well.

Although we have not fully investigated the incident, one inmate we spoke with related an account that presents a troubling scenario. After having been repeatedly harassed by an officer, the inmate requested to meet with OMH to express her anger and regain emotional stability in a “safe space.” On the way to OMH’s offices, the inmate told her escorting officer the reason for her mental health meeting request. During the OMH meeting, the inmate reported that the escorting officer entered the office to listen for a period of time. Because the inmate was afraid of acting out or engaging in self-destructive behavior, she apparently asked to be, and was, placed in an observation cell. Shortly after being returned to her cell, the inmate reported that she was given a ticket based on the incident and taken to SHU for two months. Issuing tickets in such situations serves to inappropriately punish inmates for reaching out for help and can make it more likely that inmates will refrain from seeking assistance and suppress emotions instead.

PEF communicated that the training they received on mental illness was sufficient and helpful because it focused on ways to identify inmates with mental health issues and refer them to OMH staff. Similarly, CSEA reported that members felt adequately trained on mental health issues. CSEA also noted, however, that they might not require as much training as other staff because their members had less personal interaction with the women incarcerated at Bedford Hills.

### **Recommendations: Civilian and Correction Staff**

#### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Require more intensive mental health training for correction staff and allow staff time off from work to participate.
- Ensure that Bedford Hills fully enforces Department regulations stating that “mental state shall be deemed at issue” for ticket hearing officers when “the incident occurred while the inmate was being escorted to or from an OMH satellite unit or intermediate care program, as alleged in the misbehavior report.”<sup>34</sup>

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<sup>34</sup> Official Compilation of Codes, Rules and Regulations of the State of New York, Title 7, Department of Correctional Services, Section 254.6 (b)(1)(vi) (June 30, 2007).

**Summary of Key Recommendations**  
**Bedford Hills Correctional Facility Mental Health Services, January 2007 Visit**

We recognize that, in many cases, the authority to institute facility-specific and system-wide changes rests with multiple institutions. We have made an effort to pinpoint the agencies that are most directly responsible for making decisions regarding the various issue areas in our report.

**1. Mental Health Staffing**

**Bedford Hills Correctional Facility and Office of Mental Health:**

- Conduct a mental health staffing needs assessment.

**New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds to allow the facility to expand its psychiatrist and mental health counseling staff.

**2. Gender-specific, Culturally Sensitive, and Trauma-informed Services, and Family Violence Program**

**Bedford Hills Correctional Facility and Office of Mental Health:**

- Integrate a gender-specific, culturally sensitive, and trauma-informed approach into all mental health programs and services at Bedford Hills.
- Work with Family Violence Program staff, current and former participants, and consultants with expertise in domestic violence and the criminal justice system to re-invigorate participation in the program and to ensure that women can receive the help they need without fear of being retraumatized.

**Office of Mental Health and Department of Correctional Services:**

- Include in the Department's women's task force agenda an initiative to develop effective abuse counseling programs and to implement gender-specific, culturally sensitive, and trauma-informed services in all facilities that house women in New York.
- Include in this effort experts in women's community and correctional mental health care, formerly incarcerated women survivors of abuse and trauma, and formerly incarcerated women with mental illness.
- Train all correction and civilian staff on the concept of gender-specific, culturally sensitive, and trauma-informed services.

**3. General Population**

**Bedford Hills Correctional Facility and Office of Mental Health:**

- Increase the frequency of individual therapy sessions for women in general population on the mental health caseload.
- Implement small, regular group therapy sessions and other activities aimed at increasing general population inmates' social and emotional support structures.

**New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds needed to allow Bedford Hills to carry out efforts to increase mental health services for women in general population.

#### **4. Intermediate Care Program (ICP)**

##### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Take pro-active steps to ensure that inmates at Bedford are appropriately identified for and admitted to Bedford's ICP.

##### **Office of Mental Health and Department of Correctional Services:**

- Take pro-active steps to ensure that inmates at all women's facilities are appropriately identified for and admitted to Bedford's ICP.

##### **New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds to allow Bedford to expand the capacity of its ICP.

#### **5. Special Housing Unit (SHU)**

##### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Investigate reports of officer mistreatment in SHU, closely monitor those officers who are found to be problematic, and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.
- Allow SHU-confined inmates to significantly dim or turn off the lights in their cells while they sleep, and require officers to check on inmates during night rounds with flashlights.

##### **Office of Mental Health and Department of Correctional Services:**

- Forbid the placement of seriously mentally ill inmates in SHU and instead transfer inmates to the TBU or, if possible, to less a restrictive setting such as the ICP.
- Adopt a policy prohibiting women with mental illness who attempt to harm or kill themselves from being placed in SHU even as a temporary holding place before being transferred to the RCTP, the TBU or another unit.

#### **6. Therapeutic Behavioral Unit (TBU)**

##### **Bedford Hills Correctional Facility and Office of Mental Health:**

- Allow inmates deemed appropriate candidates for the TBU to be transferred to the unit regardless of their ability to maintain good behavior and stay ticket-free in SHU.
- Substantially expedite the process for transferring approved TBU inmates to the unit.
- Provide at least two hours of out-of-cell therapy in addition to the one-hour recreation period at least five days per week for women in SHU waiting for TBU placement until the transfer occurs.
- Reconceptualize the TBU disciplinary system so that it relies even less on a traditional disciplinary model of tickets and punishment and remove return to SHU as a possible consequence for misbehavior.
- Eliminate tickets for acts of self-harm, both for women in disciplinary confinement and general population.
- Implement a program similar to Sing Sing's Community Orientation and Re-entry Program to provide comprehensive transitional planning for inmates with serious mental illness and begin these services significantly before an inmate's earliest release date.

- Conduct an investigation into reports of officer harassment in the TBU, closely monitor those officers who are found to be problematic and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.
- Expand the specialized training for officers assigned to the TBU and require officers to participate in training before their assignment begins and on an ongoing basis thereafter.

**Office of Mental Health, Department of Correctional Services and NYSCOPBA:**

- Remove the TBU assignments as bid positions and institute a more stringent screening policy for officers wishing to be assigned to the TBU, including an evaluation by OMH.

**Office of Mental Health and Department of Correctional Services:**

- Work with facility Superintendents and mental health and correction staff at all women's facilities to more vigorously identify and process women in disciplinary confinement who could benefit from being transferred to the TBU.

**7. Mental Health Medication**

**Office of Mental Health and Bedford Hills Correctional Facility:**

- Examine concerns about over-reliance on medication and reassess the facility's balance between reliance on medication and other forms of therapeutic intervention and treatment.
- Take any necessary steps to ensure confidentiality for general population inmates during medication pick ups.

**8. Mentally Ill Chemically Addicted (MICA) Program**

**Office of Mental Health and Bedford Hills Correctional Facility:**

- Allocate enough mental health staff time to ensure that all MICA participants can meet with a mental health counselor at least once per week and attend regular group sessions where they can safely discuss mental health and other issues.
- Investigate concerns about officer harassment in MICA, closely monitor those officers who are found to be problematic, and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.
- Conduct specialized ongoing mental health training for civilian staff working in the MICA unit and specialized ongoing training on substance abuse treatment for mental health staff assigned to MICA, and require all MICA-assigned correction staff to participate in additional specialized training by OMH.
- Build more structure into the MICA group sessions and implement group activities and weekend therapeutic programming that help build a sense of community and support among program participants.
- Hold a series of meetings with DOCS Central Office, MICA-assigned DOCS and OMH staff, experts on providing effective treatment for MICA populations, and MICA Inmate Coordinators to discuss areas for program improvement and to develop a plan to implement necessary reforms.
- Expand materials available to MICA counselors and inmates.
- Institute regular meetings between DOCS MICA staff and OMH to review individual inmates' progress and to work together to resolve any challenges a particular inmate may be facing before removing her from the program.

**New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funding to allow Bedford Hills to expand its MICA and ASAT program capacity.

**9. Network Program**

**Bedford Hills Correctional Facility:**

- Assign additional counseling staff to Network and create Inmate Program Aide (IPA) positions for the program.
- Investigate concerns about officer harassment in the Network program, closely monitor those officers who are found to be problematic, and, if there is no change in their conduct, work towards removing or reassigning them to non-contact positions.

**Office of Mental Health and Bedford Hills Correctional Facility:**

- Integrate a stronger mental health component into the program, including individual counseling sessions and more frequent and smaller group sessions.
- Require officers assigned to Network to participate in additional training about working with inmates who have mental health issues.

**New York State Governor, State Legislature, Office of Mental Health, and Department of Correctional Services:**

- Allocate funds to allow Bedford Hills to assign additional counseling staff to Network.

**10. Civilian and Correction Staff**

**Bedford Hills Correctional Facility and Office of Mental Health:**

- Require more intensive mental health training for correction staff and allow staff time off from work to participate.
- Ensure that Bedford Hills fully enforces Department regulations stating that “mental state shall be deemed at issue” for ticket hearing officers when “the incident occurred while the inmate was being escorted to or from an OMH satellite unit or intermediate care program, as alleged in the misbehavior report.”