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The Mentally Impaired In New York's Prisons

Problems and Solutions

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THE MENTALLY IMPAIRED IN NEW YORK'S PRISONS:

PROBLEMS AND SOLUTIONS

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THE MENTALLY IMPAIRED IN NEW YORK'S PRISONS: PROBLEMS AND SOLUTIONS

INTRODUCTION

In a February 1963 address to Congress on mental illness and retardation, President John F. Kennedy proposed the enactment of a comprehensive community mental health program for the country, which would shift the locus of care to the community and discourage the use of large state institutions. Deinstitutionalization, as the community mental health movement has become known, has had an enormous impact on U.S. society since President Kennedy made his proposal. Unfortunately, the nature of that impact has not been entirely beneficial.

The primary goal of deinstitutionalization is to treat individuals as much as possible in their natural environment near their peers. It is now considered highly preferable to help them adjust to that environment, rather than commit them to the traditionally over-sized, impersonal state institutions, which had received scathing criticism over the years. The well-documented problems ranged from patient abuse to non-therapeutic environments. The development of psychotropic drugs added to the feasibility of the deinstitutionalization movement, because, for the first time, symptoms of psychiatric illness could be controlled outside the institutional setting.

The movement resulted in an enormous reduction in the size of state mental hospitals, through a combination of tactics: discharging patients who had been long-term residents; releasing new admissions more quickly; and attempting to reduce the number of new admissions. The projected growth of community mental health centers did not occur simultaneously, however, so the care and support required by the former patients to adjust to life outside the institutions were not adequately provided.

As a result, there has been a dramatic increase in deviant behavior at the community level, ranging from what might be considered mere annoyance or inconvenience, to substantially more serious disruptions. Many people in fact contend that ex-mental patients are disproportionately responsible for serious crimes, and that it is not just a coincidence that the U.S. prison population grew by 65% during the same years that the census of the mental hospitals shrunk by 64% (1968-78).

At the same time, some researchers in the field dispute the validity of the widely-held assumption that the decrease in the size of the mental hospital population led directly to an increase in the number of prisoners. For instance, in one study entitled "The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978," the authors insist the theory that deinstitutionalization had contributed significantly to the rise in prison populations would be supported <u>only</u> it could be established that the proportion of prison admissions with a history of mental hospitalization had risen <u>at the same</u>

time that the populations of the mental hospitals fell. The authors of this study discovered, however, that during this period

> ...in New York, where the proportion of inmates with prior mental hospitalization decreased from 12.1% to 9.3%, the volume of admissions increased so much (58.3%) that the total number of inmates with prior hospitalization actually increased by 7.6%. (emphasis added.)[1]

Therefore, while it may be tempting to link the increase in mentally handicapped inmates with hospital release policies over the last 20 years, hard data is not now available to buttress that theory.

Since 1977, in order for an individual to be involuntarily committed to a hospital in New York for mental illness, it has been necessary to demonstrate that he or she "poses a clear and present danger" to self or others. Many current inmates who have periods of mental illness while in prison have not previously been institutionalized under that stringent criteria. Likewise, few retarded prison inmates in New York have ever been institutionalized within the OMRDD system, which generally accepts only individuals diagnosed as "severely" or "profoundly" retarded.[2] For the most part, it is the "mildly" or occasionally the "moderately" retarded offender who is incarcerated in New York,

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[1] Steadman, Henry J., John Monahan, Barbara Duffee, Eliot Hartstone and Pamela Clark Robbins, Journal of Criminal Law and Criminology 75:2, Summer 1984.

[2] OMRDD is shorthand for the Office of Mental Retardation and Developmental Disabilities.

and these lesser degrees of mental retardation are seldom considered institutionalizable by OMRDD in the first place.[3] As the above-referenced article indicates, at least in this state, it is apparently the skyrocketing growth of the prison population in general that accounts for the larger number of inmates suffering from various forms of mental disabilities, rather than the movement towards deinstitutionalization.

However, often perception is as important as reality. It is clearly the perception of those who work in the criminal justice system, and particularly those who work in the prison system, that the problems being presented by mentally impaired offenders are more difficult now, and different from what they once were. Whatever the cause of the problem may be, the fact remains that there is a problem, one that is deeply felt by correctional administrators, staff and inmates alike, although its full dimensions are incompletely understood at present.

As the only public interest organization in the state with legislative authority to visit prisons and to report its findings and recommendations to the State Legislature, the Correctional Association has visited many facilities throughout New York during recent years. In the course of those visits we became aware that institutional personnel and prisoners alike are very concerned that the number of mentally ill and retarded inmates is escalating

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[3] The Wechsler Scales, used by the Department of Correctional Services, assign the following numerical I.Q.s to these four gradations of retardation: Mild, 69-55; Moderate, 54-40; Severe, 39-25; Profound, 24 and below.

dramatically -- a situation they attribute to the deinstitutionalization movement and its aftermath. We were told repeatedly that the sizable number of these offenders within the prison population has seriously disruptive effects, and that the services and programs they require are either inadequate or, in some cases, completely non-existent. It was certainly clear that, as a class, mentally deficient inmates are probably the ones most easily lost and forgotten inside the prisons, and they are the ones least likely to be able to make a positive case for themselves.

Therefore, we decided an in-depth investigation should be undertaken, to determine the real nature of the problem, and to make viable recommendations to meet the needs of this special population. To that end, beginning in September 1985, Correctional Association staff visited: the Department of Correctional Services' (DOCS) four reception/classification centers; the maximum-security institutions which contain Office of Mental Health (OMH) Psychiatric Satellite Units; Great Meadow, a major maximum-security prison that does not have a satellite unit; and Central New York Psychiatric Center, the OMH forensic facility for sentenced inmates.[4] In addition, we met with, or occasionally interviewed by phone, officials and staff from the numerous state agencies which are concerned with some portion, or all, of this

[4] At the time of our research, the Sullivan Correctional Facility was not completely operational, so we did not visit its satellite unit.

special needs population.[5] Finally, our staff spoke with a number of mentally ill and retarded inmates, ex-offenders, prisoner attorneys, families of mentally handicapped inmates, correction officers, community mental health service providers, and experts in the field of mental retardation and developmental disabilities, as well as staff of the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, and various correctional agencies in other states.

The amount of openness and cooperation received from all these sources was both gratifying and enormously helpful. In particular, the assistance rendered by everyone encountered in both DOCS and OMH during the course of this study was exceptional, and deeply appreciated. It would have been impossible to complete this rather complex project successfully without that level of cooperation.

Everyone with whom we talked during this investigation seemed to share with us an appreciation of just how necessary it is to obtain adequate information on this subject and of how important it is that the significant actors in this drama find mutually acceptable ways of working together to meet the needs of these particularly vulnerable inmates. It is our hope that this report will be useful in providing some direction in that regard.

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[5] Those agencies included: Department of Correctional Services; Office of Mental Health; Office of Mental Retardation and Developmental Disabilities; Office of Vocational Rehabilitation; Commission of Correction; Developmental Disabilities Planning Council; Commission on Quality of Care for the Mentally Disabled; and the Division of Parole.

MENTALLY ILL INMATES

The Current System: Background

Until 1976, inpatient psychiatric services for inmates in New York were provided directly by DOCS at Dannemora and Mattewan State Hospitals. The residents of those two facilities included not only prisoners in the state correctional system, but also sentenced inmates from local facilities and unconvicted individuals committed under a variety of statutes, including those found incompetent to stand trial or not guilty by reason of mental disease or defect. Both hospitals were subjected to much criticism, and in the case of Mattewan, to a lawsuit (Negron v. Ward), which resulted in their eventually being phased out: Dannemora in 1972 and Mattewan in 1976 (Dannemora's building is now a prison {Clinton Annex}, and Fishkill Correctional Facility uses the old Mattewan grounds and buildings).

In 1976, statutory responsibility for mentally ill prisoners was transferred from DOCS to OMH, effective April 1, 1977. Although the general public often perceives "mental illness" to be a permanent, unchanging state, in reality there is an enormous variety among individuals regarding the symptoms they display; how often, if ever, a psychiatric crisis occurs; the intensity of such a crisis; the length of relatively stable periods, etc. Even individuals who are diagnosed as "chronically" mentally ill -- that is, they are seen as mentally ill on a relatively permanent basis, rather than temporarily or intermittently -- very often do

not fall under the legal definition of "dangerous." Therefore, OMH, through its Bureau of Forensic Services, provides a variety of inpatient care to those serving sentences in state and local correctional facilities. OMH also provides outpatient services to state prison inmates.

The most significant aspects of the OMH forensic system, as it relates to the state prisons, can briefly be summarized as follows:

Reception and Classification Centers: OMH provides DOCS classification staff with recommendations for the level of mental health service which an inmate may require.

Psychiatric Satellite Units (PSUs): At nine maximum security prisons, OMH operates outpatient units with short-term residential programs, which can be seen as the equivalent of crisis residences in the outside community.[6]

Intermediate Care Programs (ICPs): Jointly administered by OMH and DOCS, ICPs provide safe, less stressful environments for inmates who are experiencing severe psychiatric difficulties living in general population, but who do not require hospitalization.

Central New York Psychiatric Center: Located in Marcy, near Utica, this is a maximum-security hospital, with 207 beds available for sentenced inmates, from both state prisons and local

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[6] The nine PSUs are located at: Attica, Auburn, Bedford Hills, Clinton, Downstate, Elmira, Green Haven, Sing-Sing and Sullivan.

facilities, who become acutely psychotic, and are determined to be a danger to themselves or others.

Reception and Classification

OMH does not make an evaluation of the mental health needs of each and every inmate who comes into the system. Rather, at the four reception/classification centers -- Bedford Hills, Downstate, Elmira and Wende -- incoming inmates who have a known mental health history, or whose behavior indicates current problems, are referred to OMH staff, in order that an assessment can be made as to the level of mental health services required.[7]

All correctional facilities have been rated according to the level of mental health care provided, ranging from Level I, which contains a Psychiatric Satellite Unit, to Level VI, which has no on-site OMH service, but falls within a Satellite's catchment area. The level of care recommendation is sent to DOCS Central Office, along with other materials developed during the classification process, to be used as a basis for the decision as to where the inmate will eventually be housed.

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[7] Downstate is the largest of the reception/classification centers. During 1985, more than 8,000 inmates were processed at Downstate, which at least theoretically classifies all male inmates over the age of 21, except for those from the western area of the state, who go to Wende. In reality, because of the population explosion DOCS has been experiencing during recent years, many of the over-21 age group eventually are classified at Elmira, which should actually only be processing males under 21. Bedford Hills receives and classifies all female prisoners.

Problems With Reception and Classification

An individual inmate's mental health history consists of information found in a variety of records, some of which are available to DOCS or OMH, but often not to both. For instance, DOCS does not have access to records on a particular inmate's previous involvement with the OMH system, either in the community or during a previous term of incarceration.

At Downstate, OMH staff now have a computer terminal capable of plugging into a data bank to obtain an inmate's complete history with at least the OMH system statewide. (OMH does not have access to an individual's records with private or municipal hospitals and service providers). Unfortunately, at this time, Downstate is the only unit that has such a terminal, and OMH does not have sufficient staff there to provide inmate information to the other reception/classification facilities. An allocation for the system hardware for all OMH units within the prisons was approved in this fiscal year's budget but, at the time this report was written, it was unclear as to how long implementation would take.

Apparently, although an inmate's involvement with OMH forensic services during any previous incarceration does not appear in DOCS central records, it is reflected in the individual inmate's case folder. This information was confirmed by both DOCS and OMH personnel. Yet corrections classification counselors at Bedford Hills advised that an inmate's previous case folder is often inaccessible because the folders are frequently buried in

the archives. So, while a previous involvement with prison mental health services can be a signal that a woman should again be evaluated by OMH, DOCS often is unaware of its existence. Yet both DOCS and OMH personnel at the various reception/classification facilities express confidence that they rarely, if ever, "miss" anyone with serious mental health needs.[8]

DOCS and OMH agree that a significant gap exists at Downstate's Forensic Diagnostic Unit (FDU). This unit was originally designed only to provide mental health screening and assessment services, when it was assumed inmates would be there no longer than three weeks. However, because of the lack of space in the system, inmates now remain for a considerably longer period, occasionally as long as six months. Even though suitable program space is not available, the unit now functions as a pscyhiatric satellite unit. Specifically, this practice means the satellite unit at Downstate is the only one in the system which has no residential dormitory capacity; 12 individual cells are used for any inmate who requires more than out-patient services. In 1983 two suicides occurred in the FDU because, according to the unit chief's assessment, the visibility in the observation cells -- the

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[8] This whole question of who is, or is not, "missed" is actually being studied now by OMH, in conjunction with DOCS. The Division of Budget last year allocated $100,000 for OMH to do a Level of Care Study, to assess the scope of the entire forensic mental health system. The study is designed to identify whether there are inmates whose needs for mental health services are not being met, either because they are not being adequately diagnosed, or because the requisite services are simply not available. At present, OMH carries approximately 10% of the prisoner population on its active roster.

cells have steel doors and only a slot for viewing purposes -- make suicide prevention extremely difficult. His belief is that, for suicide watch purposes, it is best to have inmates in a dorm setting, where they can be easily seen and other people are around.

Therefore, in 1983, OMH and DOCS developed a joint proposal that a dormitory be renovated at Downstate for OMH's use, and that six individual rooms be made available, where half the door would be plexiglas instead of heavy steel, so that anyone passing could see easily into the room. The estimated cost of such a renovation is $250,000. Until this change is made, it seems likely that the almost daily one-on-one suicide watches now taking place will continue, where the personnel costs are necessarily very high. Although the Division of the Budget eliminated this request from the items incorporated into this year's Executive Budget, the unit chief is hopeful that the new budget examiner will support this initiative in the coming round of budget negotiations for FY 1987-88.

Psychiatric Satellite Units

Psychiatric satellite units (PSUs) are operated by full-time OMH staff at nine prisons. Although the majority of inmates treated in PSUs are seen on an outpatient basis, separate housing areas (dormitory beds and/or individual cells) are available for use by acutely mentally ill inmates. The purpose of the PSU program is described as "assessment, stabilization, and return (of

the inmate) to the general prison population with appropriate aftercare services."

Currently, all PSUs are located in maximum-security prisons, for two reasons:

1) DOCS feels that any inmate, whose psychological condition has deteriorated to the point where he or she needs to be placed in a PSU, is not a candidate for minimum- or medium-security confinement; and

2) Any inmate can be moved to a higher security level facility, but the opposite is not true; that is, an inmate in a minimum- or medium-security prison can be transferred to maximum-security for treatment in a PSU, while a prisoner with a maximum-security classification cannot be moved to an institution at a lower security level, for any purpose.

Therefore, by placing PSUs exclusively in maximum-security facilities, it becomes possible to service the entire prisoner population. Each PSU serves a catchment area of other DOCS facilities, and inmates in the catchment area prison who experience acute mental health problems can be transferred to the PSU. Besides the PSUs, OMH maintains mental health units, with smaller staffs and no residential components, at several prisons: Great Meadow, Coxsackie, Eastern, Arthur Kill and Fishkill.[9] At the remaining facilities, OMH has part-time or no staff.

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[9] Originally, a PSU was placed at Fishkill, a medium-security facility. Restrictions caused by the Department's transfer policies, however, led to its closing.

At present, Great Meadow is the only major maximum-security prison without its own satellite unit. This situation creates a number of serious problems. At Great Meadow itself, mental health staff are physically separated from the client population, so it is impossible to establish the kind of intensive contact that high stress cases require; e.g., the observation cells in E Block are a 5-10 minute walk from staff offices. The lack of a residential space precludes providing a refuge and/or treatment to inmates whose psychological condition requires such for a few days or weeks. When it becomes absolutely imperative that an individual inmate be placed in a satellite unit, he must be sent to Clinton, some 200 miles away.

A major complaint of the OMH chief at Clinton is that the prison now has the largest catchment area of all the PSUs, so the demands placed on their mental health staff are enormous. We were told that 95% of all inmates transferred into Clinton's PSU end up being sent to the Central New York Psychiatric Center, and most are returned to the general population at Clinton, not the original facility.[10] If Great Meadow had its own satellite unit and catchment area, to include at least Washington and Mt.

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[10] When an inmate is transferred from a catchment area facility into a PSU, he or she is sent on what is called a 10-day "outcount," which means they are kept on the population roster of the sending facility for ten days, with the expectation that they will be returned to their home prison by the end of that period. For a number of reasons, including transfer to Central New York or to the population of the prison with the PSU, inmates often are not returned to the sending facility.

McGregor from Clinton's present catchment, the numbers of inmates transferred to Clinton could be greatly reduced.

Our staff heard no disagreement from DOCS or OMH regarding the need for a PSU at Great Meadow and, in fact, one has been planned for several years. Its opening is prevented by the lack of appropriate space, which would include a mental health dormitory, a dayroom, dining room, and staff offices. The major problem with providing that space is the physical limitations found at Great Meadow, and contradictory information and opinions now exist as to whether the necessary space can or will ever be made available.

Problems with the PSUs

At the facilities with satellite units, a number of problems exist which hinder the provision of adequate mental health services to the inmate population. These problems include:

1) Insufficient space: A 1984 Commission of Correction report indicated that the demand for mental health services at Clinton had increased 35% in the previous two years.[11] Since more prisons in Clinton's catchment area have opened since that time, the demand is even greater now. However, since the satellite unit contains only seven beds in its dormitory, OHM has to utilize an average of 20 "overflow" cells, in three different locations of

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11 State Correctional Facility Health Services: A System-wide Perspective. The Commission of Correction is the chief regulatory agency for all state prisons, county correctional facilities and local police lock-ups in New York.

the prison at some distance from OMH staff, to accommodate the increased caseload.

The eight dormitory beds in Attica's PSU are always full, according to the unit chief, and twice that number need beds on a daily basis. This situation is a reflection of the fact that the OMH caseload had increased by 25% during 1974-85.[12] The Commission of Correction report recommended dormitory beds for 12-15 inmates be provided at Attica, essentially a doubling of the size of the present satellite unit. In its response to the various Commission criticisms and recommendations, OMH indicated that, while mental health program space in correctional facilities such as Auburn, Attica and Clinton "is no longer adequate to meet the needs of the population," the "realities of overcrowding and dwindling program space within the correctional system preclude such expansion at this time."

2) Inadequate Observation Cells: In addition to a number of dormitory beds each satellite also contains several individual cells which are used to "observe" prisoners for a number of reasons such as: the inmate is a recent transfer into the unit who has not yet been assessed by staff; the inmate is fighting with others in the dormitory; the inmate is considered a severe suicide risk, who cannot be maintained in an open setting for the moment.[13] Usually, these observation cells have heavy metal

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[12] The OMH unit chief at Attica at the time our research has since retired.

[13] The number of dormitory beds in the PSUs varies widely by institution, ranging from five at Auburn to 16 at Sing Sing.

doors, and only a small window (in some cases as small as 8"x5") through which one can observe what is going on in the room. As indicated above, OMH staff at Downstate feel strongly that the use of this type of observation cell makes it more likely that suicide attempts will be successful.

Not all satellites are the same, however. For instance, the six observation cells across from the PSU dormitory at Sing-Sing are of a different type, where the top half is covered with a kind of mesh material, allowing complete visibility into the room for anyone passing by. The unit chief there believes this kind of observation cell is much better than the closed ones with heavy doors, because the latter limits the inmate's communication with the outside, and that very often only intensifies his problems. Actually, many OMH staff expressed similar feelings about the usefulness or wisdom of closed observation cells, but said they had to work with what existed before they arrived.

In the Fall of 1985, our staff were told that both Green Haven and Auburn expected the glass windows on the observation cells would be enlarged "fairly quickly." At least in the case of Green Haven, it was actually the DOCS security staff who approached OMH to have the windows enlarged, so that officers could more easily see into the cells, which is particularly important for suicide watches. However, no change had yet been made at either facility at the time this report was written.

3) Lack of Spanish-speaking staff: Latino prisoners now constitute almost 27% of New York's inmate population. Statisti-

cal reports from Downstate indicate that approximately 8% of the inmates received there during the period April 1984 - September 1985, over 800 inmates, were monolingual Spanish. As this population has rapidly grown over the past few years, it has become more and more evident that staff within the prisons need to have the ability to communicate effectively with these inmates. However, very few of the OMH staff within the prisons can speak Spanish; at many facilities, there is no mental health staff person fluent in this language. Very often, staff must depend on Spanish-speaking correction officers and inmates to act as translators. Both officers and inmates are very cooperative and helpful to OMH staff in this regard; nevertheless, as one of the unit chiefs commented, this system is "not good, not professional, and you may get inaccurate interpretations."

In mental health, the professionals often need to develop a rather intimate and personal relationship with individuals whose psychological make-up and defenses are unstable. The problems presented by the inability to communicate adequately, and the intrusion of outside, non-professional persons into the delicate balance required must be damaging, if not completely counterproductive.

Intermediate Care Programs

When responsibility for providing mental health care to prison inmates was transferred to OMH in 1977, the satellite units were established and Central New York Psychiatric Center was

opened to provide relatively brief inpatient treatment to those inmates who were so severely psychotic or suicidal that they could not be maintained within the prison community. It soon became apparent that there was another group of inmates who experienced severe psychological difficulties coping with confinement in the general prison population, but who were not acutely ill enough to be placed in either a PSU or committed to Central New York. It was for this latter group that the Intermediate Care Programs (ICPs) were originally designed.

The first ICPs were opened, as a joint venture of DOCS and OMH, late in 1980. They were modeled on a day program, known as the Academic Vocational Preparation Program (AVP), which had been initiated in April 1979 by OMH at Green Haven, with the complete support of that facility's Superintendent. AVP was primarily designed to meet the needs of the men in Green Haven's population who had extensive psychiatric histories, who had been treated in the PSU and Central New York, and who were having trouble adjusting to life in general population, with its inherent stresses.[14] The program, which consists primarily of participatory activities, such as community meetings, sports, music groups, arts and crafts, games, basic wood working skills, and individual academic tutoring, has as its goal "to raise the level of social functioning of the individual in the program to a point at which he can function in the general inmate population and participate independently in

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[14] During our visits to Green Haven in October 1985, we were told that 90% of the inmates enrolled in the AVP program had been at Central New York at least once.

regular institutional programs." The AVP program appears to be held in high regard by both institutional personnel and inmates.

In 1980, the first ICPs were opened, at Auburn and Bedford Hills. Subsequently, in 1984, another was established at Attica, and a fourth was opened at Sing-Sing in 1986. For all ICPs, the admission criteria are three-fold:

1) The inmate has a diagnosable mental disorder;

2) The inmate has a history of prior psychiatric hospitalization or a history of three months or more of mental health treatment; and

3) Due to a mental disorder, the inmate is functioning marginally in generally population, e.g., is withdrawn from social interaction, or lacks basic social, self-care skills.

The ICPs are programs focusing on socialization and task and skill training, with the goal of eventually reintegrating the inmate into the general population. How long that reintegration process takes depends entirely on an individual inmate's ability to progress through the phased approach of the program, ranging from complete isolation in the ICP, through part-time participation in regular facility programming, to eventual return to the general population.

Problems with the ICPs

Consensus exists that the ICPs are very worthwhile, and very needed, but that a number of problems remain with the system as it now exists. Most of those problems center around the fact that

the demand for ICPs far outstrips the current supply. The few prisons that have an ICP cannot accommodate the number of needy inmates in their own populations, much less those of other institutions. (DOCS' Assistant Commissioner for Health Services estimated that 10%-12% of all DOCS inmates could benefit from an ICP: "And that's a lot of people. We're talking about 3,500-4,000 people.")

Both Bedford Hills and Auburn have requested, unsuccessfully, that the size of their units be considerably increased (Bedford now has 28 beds, while Auburn has 50). At Bedford, we were told that occasionally the "least sick" inmates have to be discharged, before it is optimally advisable to do so, in order to make room for an inmate who is sicker. At Auburn, there is "always a waiting list," and the same is true at Attica, where OMH staff contends there are 120 inmates who need to be placed in the ICP, in addition to the 70 who are already there.[15]

At present, an inmate will be admitted into an ICP only from the population of the host prison. In other words, an inmate must be housed at Attica in order to be transferred into the ICP at Attica; an inmate will not be moved from the general population at Clinton into the Attica ICP. While this policy may make considerable sense from several standpoints, it does present difficulties.

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[15] At Attica, there are two galleries that are considered "pre-ICP," where inmates are housed who cannot be fit into the ICP.

Where there is an ICP, institutional personnel tend to believe their prison is inundated with "crazies," who are sent to them by DOCS in order that they can be moved into the ICP unit if needed. At Auburn, for example, the Superintendent, as well as mental health staff, complained that the mentally ill are "dumped" there, that the prison gets back two-to-three times as many inmates as they send to Central New York. An examination of the records substantiates their claim: in 1985, 34 inmates were committed to Central New York from Auburn, but 85 inmates made the trip in the opposite direction. The proportion of the inmate population on the OMH roster at Attica and Auburn -- 26% and 27%, respectively -- are also considerably higher than will be found at the other major maximum-security prisons for men: Clinton: 12%; Great Meadow: 13%; Green Haven: 10%-14%.

The facilities which do not have an ICP also experience problems because of the policies regarding ICP transfers. In September 1985, Elmira had four men in its PSU who needed to be sent to an ICP; one of them had been there since March 1985, despite the fact that the OMH unit chief's general policy is to keep inmates in the satellite for no more than two weeks. It had previously taken Elmira four months to get a "pre-ICP" inmate transferred to Auburn, and they were counting on the fact that the ICP at Sing-Sing was scheduled to open in October 1985, where they would hopefully then be able to get their inmates transferred shortly. (Sing-Sing's ICP did not become formally operational until mid-1986.)

Unfortunately, thus far DOCS has been unsuccessful in gaining budgetary support for additional ICPs. It is the opinion of many corrections officials that there should be an ICP at every maximum security institution, because the need clearly exists.[16] For that reason, when DOCS submitted its budget request for the current fiscal year, it included expansion of the ICP program to that extent. However, the Division of the Budget (DOB) included no additional money for ICPs in the amended corrections budget it submitted to the legislature.

The specific reason why DOB eliminates a particular budget item apparently is something of a mystery to those most concerned. Putting together an Executive Budget as large and complex as New York's is of course a rather overwhelming task, but it is nevertheless considerably frustrating to personnel at the individual agencies when their requests for items that they view as urgently needed are ignored without explanation.

Although the ICPs are jointly operated by DOCS and OMH, the budget request for expansion of the program is made exclusively by DOCS, with the two agencies working out staff allocations and other pertinent matters at a later date. OMH is not privy to the specific request made by DOCS, so OMH personnel do not have any direct input in the development of the budget proposal. It is

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[16] However, OMH's Director of Forensic Services has said that OMH would not support the establishment of an ICP at a prison which does not have a satellite unit, because OMH believes the two units should exist together, to provide mutually supportive services. There are a number of maximum-security prisons which do not now have a PSU: Great Meadow, Eastern and Coxsackie; and there are no plans for a PSU in the new prison at Shawangunk.

quite possible that a cooperative effort in that regard would exert a positive influence on the eventual decision by DOB.

Central New York Psychiatric Center

Central New York Psychiatric Center is located on the grounds of the former Marcy Psychiatric Center; several of the other Marcy buildings have been converted into the medium-security Mid-State Correctional Facility. Central New York, which first received patients transferred from the old Mattewan State Hospital in September 1977, became fully operational in 1978. There are presently 207 beds, including 12 for women. Besides patients transferred from the state prisons who constitute the majority of the patient population, the hospital also receives sentenced inmates from county jails and a variety of pre-trial defendants.[17] All those to whom our staff spoke, ranging from mental health professionals to families and attorneys of inmates, uniformly praised the quality of treatment and care afforded by Central New York.

Section 402 of the Corrections Law provides for involuntary commitment of mentally ill inmates to Central New York, through an application made by the prison superintendent to the court, which then appoints two outside physicians to examine the inmate and report back to the court on the need for said commitment. This procedure is naturally an extended one, that in fact may take up to five or six weeks, during which time an inmate will usually be isolated in a mental observation cell at the petitioning prison.

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[17] In 1985, 743 of the 1,100 admissions were state prisoners.

The mental health professionals believe an inmate who is suffering a psychiatric crisis should not be kept under these conditions for such a long period of time. To do so is worse than counter-productive; it is in fact quite destructive.

As a result, during 1985 approximately 75% of the commitments to Central New York from the prison system were of an emergency nature, which means that two doctors, usually mental health staff psychiatrists and sometimes correctional medical staff, examine the inmate and determine that he or she "suffers from a mental illness which is likely to result in serious harm to himself or others." Within 72 hours of the inmate's transfer to Central New York, the court is petitioned for a conversion to a regular 402 commitment. If granted, the court issues an order to retain for six months, after which time a further petition must be made if the hospital wants to retain the inmate for a longer period. Inmates have the legal right to challenge their commitment at any time and approximately five such challenges are made in court each month.

The average length of stay at Central New York is 61 days, during which time the inmate/patient is assigned to a treatment team, consisting of a psychiatrist, psychologist, social worker, recreation therapist, occupational therapist, and treatment assistants, and an individual treatment plan is devised. A variety of therapies are used, besides the medication therapy which 94% of inmate/patients receive. The Executive Director of Central New York stated that the number of patients on medication is similar

to what would be found in any mental health hospital around the country at this time.

While at Central New York, individuals are treated as if they are "patients" rather than "inmates" because the facility is a hospital, not a prison. The attitudes and treatment they experience often contrast dramatically with those found back at prison. For instance, after a visit with family, the inmate back in prison will automatically be subjected to a strip search, including searches of body cavities. There are no such automatic strip searches at Central New York, which, as the Director pointed out, can only give conflicting signals to patients there. This particular issue was in fact raised to our staff by the mother of a schizophrenic inmate who now resides at Auburn, and who has spent relatively long periods, during several admissions, at Central New York. She wanted to know why her son had to be sub-jected to the humiliating searches now, when the only thing that had changed about their visits was the location.

The patients at Central New York, unfortunately, have the same problems with the community mental health system that patients in the outside world have, but considerably multiplied. The philosophy that now dominates the mental health field asserts that one needs only acute inpatient care, rather than overly long stays in mental hospitals, <u>if there are good supportive services in the community.</u> Forensic mental health has patterned itself on the community mental health system.

However, a major problem even with non-forensic mental health

care in recent years has been the failure of a good network of supportive community care to materialize. In this case, the prison is the community, and, as almost everyone interviewed during the course of this research concurred, not only are the requisite supports missing for the most part, but prisons by their very nature militate against good mental health.

The all-too-typical scenario followed by an inmate/patient at Central New York is as follows: at the hospital, the patient is maintained on medication, while receiving other therapeutic interventions. During that time, he or she appears to get better, and eventually reaches a point where a decision is made that he or she can probably function adequately back in the prison population. At the prison, the inmate refuses to take any more medication, quickly begins to decompensate, particularly if sent immediately into the stressful general population, or, in some cases, to a special housing unit for disciplinary segregation. Very often, the inmate will eventually decompensate to the point where he or she must be readmitted to Central New York.

Complaints about this "revolving door" were a constant theme heard by our staff. Approximately 62% of the commitments to Central New York during 1985 were readmissions, and hospital staff told us that one inmate received last year had been committed on

11 previous occasions, while several were temporary residents for the seventh or eighth time.[18]

General Problem Areas

During the course of our research, a number of problems generally related to the provision of prison mental health services were consistently raised by mental health and corrections personnel at each of the prisons visited. The most significant of these problems areas are outlined below.

I. Chronically Mentally Ill Inmates

Each of the services provided by OMH -- Psychiatric Satellite Units, Intermediate Care Programs, and inpatient care at Central New York Psychiatric Center -- have as their primary goal meeting the needs of those inmates who may periodically suffer a mental health crisis, and even require acute psychiatric care. None is designed to meet the ongoing, more permanent needs of those inmates who can be described as chronically mentally ill, that is, their mental illness stays with them, it does not "come and go."

The ICPs come closest to being able to provide the kind of extended care such inmates require; in fact, the units which currently exist contain many of these inmates:

1) Of the 78 men in the ICP at Attica, 40 were described as

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[18] The highest number of DOCS admissions to Central New York consistently come from Attica, which averaged 23% of all DOCS commitments, by quarter, for 1985. During that same period, 75% of the inmates sent by Attica were readmissions.

chronics, who will "be there forever;"

2) At Auburn, the unit chief told us that 40% of the men in the ICP were chronics who will remain in the ICP for the duration of their terms; and

3) At Bedford Hills, the OMH chief confirmed that probably 50% of the population now in the ICP will be there for their whole prison term.

However, according to DOCS, no program within a prison is seen as an end placement for the inmates in the program. Therefore, the stated program goal is to return all the inmates to general population as soon as possible, but often that return is not really a feasible alternative for the chronics. As Central New York's Executive Director emphasized, chronically ill inmates cannot ideally be housed in an ICP, because they simply cannot be "mainstreamed" into the general population, ever. Likewise, OMH's Forensic Services Director stressed that the inmates who require chronic care have to be taken care of and protected for the rest of their stay in prison.

The existence of such a large number of chronics in the ICPs is problematical because the number of ICP spaces currently available is very limited, far below what prison personnel contend is needed. If approximately 50% of those limited spaces are now permanently taken by the chronically mentally ill, the number of spaces that can be turned over to others who need them has been that much more reduced. This situation presents inevitable management problems, particularly since "pre-ICP" inmates are

being transferred into the prisons containing ICPs in the hope that a bed will soon become available for them.

In 1984, OMH developed a working document, a Forensic Services Plan, where considerable space was devoted to the need to develop a capacity to house and treat the chronically mentally ill inmate. According to that document, "currently OMH cannot provide extended care for inmates in the prison system who need long-term treatment while serving lengthy sentences." The number requiring such long-term treatment can only be estimated at present, but various corrections and mental health officials believe 200-300 extended care beds are required.

OMH and the Division of the Budget informally discussed the need to develop perhaps 200 beds to provide extended care for the chronically mentally ill inmates. As a result, DOB gave $100,000 to OMH in order for them to do the previously referenced Level of Care Study. The Forensic Services Director predicted that this study will clearly demonstrate the existence of a significant number of chronically mentally ill inmates, who need additional services, and for whom those services should be developed in an expeditious manner.

II. Correction Officer Training

At each prison we visited, as well as in conversations with DOCS officials, one refrain that consistently reappeared was that correction officers receive insufficient training regarding mentally ill inmates. New officers receive three hours of training

on "Recognizing Abnormal Behavior" at the Training Academy in Albany from a DOCS psychologist, who told our staff that federal law mandates three hours of such training.[19] The mental health and correctional personnel to whom our staff spoke uniformly contended that the training provided was insufficient, both for officers working the housing blocks, who are supposed to refer prisoners for mental health services, and even more so for officers assigned to special units, such as the satellites and ICPs.

The officers assigned to the ICPs when these units first opened received special training, but, over the years, there has been an entire turnover in those staffs. Officers newly assigned to these posts, and to the satellite units, no longer receive any special additional training to enable them to deal on a daily basis with inmates who are perhaps undergoing psychiatric crises. The only training received by new officers on the units is informal on-the-job training given by OMH staff, and by the more experienced officers who have been working on the unit for some time. An Assistant Commissioner at DOCS told us that, although the Department's Central Office has attempted on a number of occasions to mandate additional training for special unit

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[19] However, according to staff at the Albany Academy, the other training center, in Harriman, provides only two hours on this topic, and at present the two training curricula are not the same.

assignments, the correction officers union has always opposed those efforts.[20]

III. Security Staff

In New York's prisons, correction officers "bid in" to particular job assignments, based on seniority. In other words, officers choose where they work, for the most part. This fact of institutional life holds true for mental health units as well, despite the fact that it is clearly advisable to have individuals sensitive to the needs of the mentally ill working in these units. OMH staff confirm that, in the majority of cases, the officers who choose a job assignment in a satellite unit or an ICP are the appropriate kind of individuals, the kind of people they want working alongside them.[21] In many cases, the officers remain with the programs for a considerable time, and their work is invaluable to the mental health personnel.

Unfortunately, such a positive relationship is not always the case. In many of the prisons, what staff described as "inappropriate" officers have bid into the units from time to time. These individuals cause problems for mental health staff and inmates, as well as other corrections personnel. There is little, if any,

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[20] Our staff wanted very much to obtain the union's feelings on these disputed matters. Although we were assured on several occasions that union leaders also wanted to discuss the issues with us, we were never able to set up the necessary meeting.

[21] Similar sentiments were voiced by staff of Green Haven's AVP program, and Sing-Sing's STAR program, whose clients are similar to those enrolled in the ICPs. The STAR unit (Satellite Therapy Activities and Rehabilitation) became the fourth ICP in 1986.

formal recourse available in such a situation. Fortunately, in most cases, the other security staff on the unit have been successful in convincing inappropriate officers to bid out of the mental health units relatively quickly.

However, such gentle persuasion by fellow officers cannot be guaranteed to have the desired effect. When our staff was at Attica in the Fall of 1985, an incident occurred that dramatically underscored the inherent difficulties in providing a therapeutic, supportive environment for psychologically vulnerable prisoners when security staff do not share the goals of treatment staff.

On the day in question, an inmate in the ICP unit, who was described as particularly fragile, was summarily fired from his job on the unit by one of the day shift officers. When the inmate, who was visibly upset by what had happened, set a fire in his cell, the officer had him transferred immediately to an observation cell in another gallery, where he was stripped of all his clothing. Our staff, and counsel from DOCS Central Office, accompanied the OMH chief when she rushed over as soon as she learned details of the incident. The naked inmate was sitting on a steel cot, crying, when they arrived. It was possible for OMH to authorize the return of the inmate's clothes, and to promise him a bed in the satellite unit as soon as one became available, so he would not have to return to what was now perceived as the hostile environment of Attica's ICP. The unit chief indicated to our staff that she would work to have the inmate transferred to the ICP unit at Auburn, if at all possible.

We later discussed this incident with the non-security staff from the ICP, which includes both DOCS and OMH personnel. We were told that the incident in question represented the fourth "inappropriate action" that had occurred in a month, involving this same officer, and one other. Staff stated that this officer had been charged with brutality on his previous assignment, and he and the other officer sadistically enjoyed "pushing the buttons" of these psychologically unstable inmates to make them "go off," which they could then use to justify their punitive actions.

With reference to this day's incident, they said the inmate in question was mentally retarded, beyond any other psychiatric difficulties he might have, and that he was just beginning to exhibit signs that he was gaining a measure of self-worth from doing his job on the unit. Staff claimed that everyone on the unit knew that setting fires was this inmate's usual response to situations that he found upsetting, and being abruptly fired from his job would almost inevitably bring about this predictable response. They also pointed out that there was no need to transfer the inmate to a strip cell, to await evaluation by the OMH staff, since the OMH-ICP offices were right outside the gallery where the incident took place. Staff could have been summoned immediately, so the inmate would not have to undergo the indignity and unpleasantness of being examined while naked.

The ICP staff members said the other correction officers, some of whom they thought were "terrific," had been unsuccessful in their attempts to pressure the trouble-making officers off the

unit. On the contrary, the officers in question insisted they were going to "get rid of OMH," so they could run things their own way. Female staff members related incidents of being locked into the unit without security staff who could come to their assistance if needed, and of being verbally harassed with offensive language by the same officers.

A Deputy Superintendent at one of the prisons we visited suggested that, for special assignments such as mental health units, correction officers should be required to undergo special training and pass test requirements after they bid the jobs, but before they actually begin working on the units. He felt that such a system would allow officers to retain the benefits of seniority by choosing the jobs they prefer, but could also work to protect special needs inmates within the prisons. It seems clear that some system needs to be established to effectively screen out individuals who should not be working with this kind of population.

IV. Special Housing Units

When an inmate is found guilty of a serious disciplinary infraction within the prison, he or she is usually placed in a disciplinary unit, often for a considerable period of time. Inmates confined in such a Special Housing Unit (SHU) must remain

in their cells 23 hours a day.[22] Those with a history of mental illness are subject to the same disciplinary procedures as other inmates.

Most mental health personnel feel quite strongly that it would not be a good idea to treat the mentally ill as if they were different from their fellow prisoners when it comes to disciplinary matters. Many unit chiefs said they believe most inmates do know right from wrong, that it is important for them to have to take responsibility for their actions, and that they should not come to feel that they can "use" their mental illness as a way to avoid disciplinary measures. Therefore, there was little argument on the principle that even prisoners with lengthy psychiatric histories should be sent to the SHU when the corrections' disciplinary process mandates it.

Nevertheless, no one went so far as to claim that serious problems do not result from decisions to place these inmates in the isolated and harsh environment of disciplinary segregated housing. Particularly for inmates known to suffer from periods of severe depression, and for those with a history of suicide attempts, the isolation of a punishment cell can be devastating. One OMH supervisor indicated he had seen cases of men "going over the edge" who probably never would have done so, except for the conditions found in SHU.

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[22] Actually, any unit which is maintained apart from general population housing is a special housing unit, e.g., ICP, Protective Custody Unit, Assessment and Program Preparation Unit (APPU), and the Merle Cooper Program at Clinton. However, it is disciplinary segregation that is specifically referred to as SHU.

For these reasons, it would seem obvious that access to mental health services and personnel is particularly important to prisoners housed in SHU. The ability of OMH staff to provide effective psychological interventions while the inmate is actually maintained in a segregation cell is minimal. In those cases, privacy is non-existent, and any personal conversation between client and therapist must somehow take place through the bars of the cell, despite the fact that other inmates and guards can easily overhear whatever is said, supposedly in confidence. The conditions under which clinical staff operate vary widely from one prison to another. The range includes:

Great Meadow: After ten months of negotiations between the facility and OMH, it was agreed in May of 1984 that an escort officer would accompany inmates from SHU to the mental health area for consultations and therapy. As the OMH unit chief described it, prior to the conclusion of this agreement, an inmate had to "get out of SHU before he could get therapy."

Green Haven: The old Great Meadow conditions still exist at Green Haven to a large degree, inasmuch as OMH does not provide real psychological therapy to inmates in SHU, because, as the unit chief indicated, it is "not possible to do there."[23] However, clinical staff from OMH do make rounds of SHU twice a week, which means staff pass by the cells and inmates are free to speak to

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[23] In the protective custody unit, which at Green Haven is now known as the "Unit for the Victim Prone," there is a room which OMH can borrow, if necessary, to provide private consultations or therapy. There is no similar space available at SHU.

them about any mental health problems they are experiencing.

Sing-Sing: Both a psychologist and a psychiatrist make weekly rounds at SHU, where a cubicle is available for individual therapy sessions.

Bedford Hills: No OMH staff is assigned to SHU. OMH personnel depend on a corrections counselor at SHU to contact them if she becomes aware of a mental health problem. In most cases, an inmate who requires mental health services will be brought to the OMH clinic area, rather than OMH staff trying to make what they refer to as a "house call" to SHU.

As the unit chief at Sing-Sing put it, with the isolation on SHU, coupled with the marginal state of many inmates who have a psychiatric history, it is not at all surprising that so many of those inmates end up being transferred from SHU directly into the satellite unit for crisis intervention. However, once the inmate emerges from the acute crisis state that brought him or her to the PSU, he or she must then return to the segregation unit in order to complete the disciplinary sentence there. The conditions in SHU will not have changed in the interim, of course, so often a marginally healthier inmate decompensates again, quickly.

It is very much akin to the scenario that is played out when inmates are returned from a stay at the Central New York Psychiatric Center to go back into the pressure-ridden general population. In fact, it is possible for an inmate to be removed temporarily from SHU as the result of severe psychiatric deterioration, and the condition will be so severe that he or she must be

sent from the satellite to Central New York. When the inmate returns from the hospital to the prison, the sentence in SHU must still be completed.

The difficulties involved with providing adequate mental health care to inmates confined in the segregation units are highlighted in Eng v. Smith, a class action lawsuit alleging unconstitutional conditions of confinement in Attica's SHU. In June of 1985, an inmate named Anthony Dzeilak committed suicide in SHU. Mr. Dzeilak had been incarcerated at Attica since September of 1983, following a transfer from Auburn, where he had twice attempted suicide. During his time at Attica, this inmate became well known to mental health staff. He was shuffled often between the general population, PSU, ICP, SHU and Central New York. Plaintiffs' attorneys contend that Anthony Dzeilak died unnecessarily, as a result of the fact that he was mentally ill and did not receive proper attention and care, from either DOCS or OMH.

Transcripts from the case indicate the mental health staff at Attica considered the inmate's several previous suicide threats and gestures manipulations, rather than serious suicide attempts. According to one of plaintiffs' expert witnesses, a major problem for mental health staff working in an institution like Attica is being able to discern what is really symptomatic of a deteriorating mental state, and what are simply efforts by manipulative inmates. However, this witness stated that one should never assume that talk of, or attempts at, suicide were manipulations.

This psychologist testified that it is only a popular myth that people who talk about suicide are not serious about it, that in fact the statistics indicate "people who talk about suicide do it," and that the best indicator of serious suicidal intent is "previous attempts, and the second best is verbalizations, the threat."

The OMH psychiatrist assigned to Anthony Dzeilak testified that, as a matter of policy, he never read an inmate's file before seeing the prisoner, because he felt the files were filled with "manipulations." As a result of this practice, the psychiatrist was not aware of this particular inmate's history of suicide attempts prior to the time he arrived at Attica.

Some of the other issues which plaintiffs' attorneys claim are raised by the Dzeilak case include:

1) The impossibility of providing adequate mental health services while an inmate is confined to a cell in SHU, e.g., the OMH staff must stand outside the cell and talk to the inmate, while other inmates are in the adjoining cells and correction officers pass by;

2) The problems and inherent dangers in procedures which involve placing an inmate back into SHU immediately upon discharge from the Central New York Psychiatric Center;

3) The need for specialized training for all correction officers assigned to the segregation units, who, according to the brief filed in this case, should be "trained to detect, monitor and interact with inmates with mental health problems"; and

4) The lack of, and necessity for, mental health screening of all inmates sentenced to do time in SHU.

Several prisoner attorneys told us of instances where inmates had been sentenced to time in punitive segregation as punishment for having attempted to kill themselves. In one instance, an inmate at Coxsackie was sent to SHU for a term of 18 months: 12 months for attempting to escape, and six months for attempting suicide after being recaptured. The hearing officer at the disciplinary proceeding stated that, although the inmate was clearly in need of mental health services, he was being sent to SHU as an example to the other prisoners, and that would simply have to learn to "face his problems."

A social worker at Central New York told us of his unsuccessful attempts to prevent a schizophrenic inmate with "a lot of psychiatric problems" from being returned to the SHU at Auburn. As of June 1986, the inmate had been at Central New York at least five times. Whenever he was discharged from the hospital, he was sent back to SHU to complete his sentence there. According to the social worker, "the psychological deprivation within SHU led to a relapse." Through the OMH staff at Auburn, the social worker attempted to convince the prison's Superintendent that it was impossible for this inmate to complete the 18 months remaining in his SHU sentence, and that he should be transferred to Auburn's ICP immediately. However, DOCS' policies and regulations do not permit the kind of flexibility the social worker's request demanded. There is, therefore, no alternative currently available

but for the prisoner to be returned to punitive segregation until his term there expires, no matter what the costs may be, in terms of his mental and physical well-being, or the financial burden borne by the State for his frequent terms of psychiatric treatment at Central New York.

DEVELOPMENTALLY DISABLED INMATES

Types of Disabilities

A developmental disability is a chronic impairment of a person which is manifested before the person attains age 18, is likely to continue indefinitely, and results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self Care

(2) Receptive and Expressive Language

(3) Learning

(4) Mobility

(5) Self-Direction

(6) Independent Living

(7) Economic Self-Sufficiency

Mental retardation and learning disabilities are two forms of developmental disabilities. Inmates suffering from either of these disabilities experience particular difficulties within the prison setting that can be ameliorated, and we therefore believe more can and should be done to help them overcome these obstacles.

Mentally Retarded Prisoners

The American Association on Mental Deficiency defines mental retardation as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behav-

ior and manifested during the developmental period." "Significant subaverage intellectual functioning" means an I.Q. of less than 70, but the I.Q. level itself is seen as only the first part of retardation assessment. It is equally important to assess how the individual can adapt to his or her environment, that is, to what degree do they possess the life skills, social skills, coping skills, etc. that could be expected of a person of their age? Many individuals who have less than a 70 I.Q. are capable of handling the everyday stresses of their environments quite adequately. For this reason, professionals in the mental hygiene field stress the importance of assessing both the intellectual and behavioral functioning levels when dealing with the problems of the mentally retarded, and especially when planning programmatic responses to those problems.[24]

Corrections officials stress the fact that the emphasis on these two equally important aspects of mental retardation is particularly important in the prison environment, because it is completely to the inmate's advantage that he or she not be labelled as "different" in any way, if it is not absolutely necessary to affix that label. Therefore, DOCS aims to "mainstream" these inmates into the general population if at all

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[24] "Mental Hygiene" is a broader term than "mental health," which refers only to issues of emotional disturbance/mental illness. "Mental hygiene" includes both mental health and developmental disabilities. The Department of Mental Hygiene includes the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities. (Although mental retardation is a type of developmental disability, it is usually separated out for treatment and discussion.)

possible, and not to separate them out for special treatment, because such a designation might mark them as vulnerable in the eyes of the rest of the inmates.

Most inmates identified as mentally retarded in the New York prisons have I.Q.s in the 60-70 range. The lowest I.Q. score that the senior correctional counselor at Downstate has seen since that facility opened in 1979-80 was 52; and he has seen perhaps 4-5 men with I.Q.s in the 50's during that period. For the most part, then, retarded inmates fall into the mild or moderate categories. Severely or profoundly retarded individuals will usually be diverted to OMRDD before trial, on a 730 commitment, which means they are "unfit to proceed to trial."

Not everyone agrees that the DOCS policy of mainstreaming inmates is the best alternative. There is actually considerable debate within the mental hygiene community over how mentally retarded inmates should be handled within the prisons. Miles Santamour, the Coordinator of the President's Commission on Mental Retardation, is a leading authority in the field. Santamour, and co-author Bernadette West, summarize a conflicting point of view:

> Proponents of "normalization" feel that mentally retarded citizens have the right to be treated as much like other citizens as possible, and that includes bearing responsibility for their own behavior. Very often this concern for normalization has led to advocacy for nonsegregated placement of retarded offenders within the correctional facility.

To the authors, normalization

> ....does not mean treating the individual as normal. It means that the retarded offender will have normal opportunities...it should be recognized that a prison is not a normal setting. Therefore, there would be little benefit to the retarded offender in becoming "normalized" to that setting.
>
> In relation to retarded offenders, the negative impact of the prison culture upon their development must be stressed, and emphasis placed upon their delayed development. Given the retarded person's greater tendency to be persuaded and manipulated, the negative impact of the subculture is much greater than its impact on the average inmate. Because of the retarded person's delayed development, behavior learned in prison is less apt to be reversed.[25]

Assessing Mental Retardation

The first step in planning for the needs of mentally retarded inmates is identifying the population. The identification process within New York's prisons theoretically works as follows:

1) All inmates receive a group intelligence test, upon arrival at a reception/classification center.

2) Those scoring less than 70 on the group I.Q. test are sent to the Extended Classification Unit for further testing and assessment.

3) Those identified as mentally retarded, and requiring special services, remain in Extended Classification until an

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25 "The Mentally Retarded Offender: Presentation of the Facts and a Discussion of Issues," in The Retarded Offender, Miles B. Santamour and Patricia S. Watson, eds., New York: Praeger Publishers, 1982.

opening becomes available in the required program.

However, practice does not run as smoothly as theory, because of a lack of qualified testers and programs.

All newly received inmates do receive a group intelligence test, the Revised BETA, which is given in English or Spanish. The BETA is considered only a gross indicator of the level of intellectual functioning, since it contains a number of cultural biases, which is why any inmate who scores below 70 should be diverted into the Extended Classification/Special Needs Classification Unit for further intelligence testing and adaptive behavior assessment.

For English-speaking inmates, the test given after the BETA is the WAIS-R, the Wechsler Adult Intelligence Scale-Revised, which measures both verbal and non-verbal skills. An individual does not have to be literate in order to take the WAIS-R. The Spanish-language equivalent of the WAIS is the EIWA, the Escala de Inteligencia Wechsler para Adultos. These tests are extremely demanding on the examiners, requiring at least 1 1/2 hours to administer, and an hour to score. (The senior counselor at Downstate confided that he took an entire graduate course on how to administer and score the WAIS properly.)

It appears that, at present, DOCS does not have a sufficient number of individuals who are certified to give the advanced Spanish-language EIWA. Although DOCS Central Office advised that all reception/classification centers have individuals capable of administering this test, staff at the classification facilities

themselves offer a somewhat different view.[26] For instance, at Elmira we were told they have no one on staff certified to give the test, and, at Downstate, staff indicated they need a bilingual clinical psychologist certified to give the EIWA, because now they are "probably classifying too many Spanish-speaking inmates as mentally retarded based solely on their BETA scores."[27]

Besides assessing an inmate's real intellectual level, classification staff try to evaluate the individual's ability to adapt to his/her environment, that is, the prison. Does the inmate try to hide in his/her cell all day? Is the inmate subject to ridicule? Or can the inmate handle the everyday stress of general confinement? At least at Downstate, classification staff used to utilize an instrument called the Prison Functional Behavior Scale to assess an inmate's adaptive abilities. Even a quick glance at this instrument makes it clear that someone would have to follow the inmate around almost every minute of the day, to complete the

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[26] The discrepancy may reflect the difference between having staff members who can give the test, and having staff members who are actually certified to do so. For instance, Central Office staff explained that, while all classification centers can give the EIWA, in some cases that simply means having a Spanish-speaking counsellor working in conjunction with a psychologist, to properly interpret the test results, rather than having a psychologist who is certified to administer the test.

[27] The fact that such misclassification occurs at the reception centers is reflected in a comment by DOCS Education Director, Petrita Hernandez-Rojas, that one Hispanic inmate became class valedictorian despite the fact that he had originally been mistakenly labeled mentally retarded, "because of his halting English." Quoted in Williams, Susan Darst, "No Compendo: The Language Barrier in the Criminal Justice System," Corrections Compendium, October 1985.

extraordinarily detailed sections of questions on daily behavior, both individual and interactive.

The staff no longer has the ability to devote so much time to an individual inmate's evaluation; the population pressures are too great; men must be moved through the classification process faster than utilizing the detailed Behavior Scale would allow. Therefore, at present, a more free-floating kind of personal observation provided by both classification staff and correction officers is used to rank behaviors. Although staff would definitely prefer to have adequate time to utilize the detailed Behavior Scale, they feel confident that they are catching at least those inmates who have the most serious difficulties adjusting to the prison environment.

Programming for the Mentally Retarded

After an inmate has been identified as mentally retarded, then what happens? Is appropriate programming available, and will the inmate be able to take advantage of it?

Everywhere we went during the course of this investigation, we heard that the system has many mentally retarded prisoners, but that there are few programs or services for them. This situation creates significant problems for everyone: the retarded inmates, the other inmates, the correction officers, the prison administrators, and the program personnel. In fact, our staff regularly sought out opinions and comments in this regard, and not once did we hear anyone say the level of programming for these inmates was

adequate. However, although everyone says "something" needs to be done, it is not at all clear that agreement exists about what needs to be done, or how large the target group of inmates might be.

It is estimated that mental retardation affects approximately 3% of the U.S. population outside prison, and many articles on the subject reflect the widely held belief that the number of prison inmates who can be diagnosed as retarded is disaproportionately higher; some writers say it may be as high as 9%-10% of the total inmate population. This assumption is not borne out in New York, however, where the data indicate the proportion of retarded prisoners in the total population reflects their numbers in the outside world. According to DOCS' education division, mentally retarded inmates constitute approximately 3% of the total prisoner population at any one time.[28]

While the 3% figure is considerably lower than what might have been anticipated, it still means approximately 1,000 inmates now in the system have been diagnosed as being mentally

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[28] One staff person in this division pointed out that this number would be raised to 10% if all the learning disabled were included, indicating that the 9%-10% figure might possibly reflect the total number of developmentally disabled prisoners, not just the subdivision of mentally retarded. Staff at OMRDD advised us that the majority of developmentally disabled inmates in DOCS are not mentally retarded, and in fact they would expect to find the inmate population is not significantly statistically different from the general population outside.

retarded.[29] The important questions now become: what portion of those 1,000 individuals require programming different from that available to the general inmate population, and what form should the programming take? Frankly, we are unable to answer these questions at this time, nor does it appear that any of the staff people or officials with whom we met can supply a definitive response.

Whenever we raised the issue of appropriate programming for retarded inmates, the response inevitably reflected the speaker's belief that an inmate should not be placed into special programs that would label him or her as a vulnerable target for ridicule and exploitation. Although the level of functioning achieved by some of these inmates was described by one official as "positively primitive," that is definitely not the case for the vast majority of the retarded, and, unless they are extraordinarily unsophisticated, we were told that that it is best not to place them in a unit or program that is not available to the rest of the population.

But the question remains: how many of the 1,000 or so inmates with a diagnosis of mental retardation do need a specialized program? No one seems to know for sure. Inmates have not been identified for that purpose, beyond the 50 or so retarded

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[29] This number presumably includes only those inmates who have been fully evaluated by means of advanced intelligence testing, as well as adaptive behavior scores. The number of men scoring below 70 on the BETA I.Q. test at Downstate is approximately 5%-6% of the population, but that is before the gross intelligence score is modified by more sophisticated testing.

prisoners in the Assessment and Program Preparation Unit (APPU) at Clinton. The 250-man APPU is essentially a protective custody unit, but with full programming.[30] Many of the men in the unit, including the mentally retarded, are sent to APPU directly from reception/classification, because they are recognized to be too emotionally, physically, or mentally handicapped, or notorious, to go directly into general population.

The inmates are expected to move out from the unit to general population, after they have had an opportunity to adjust to prison in this secure setting, where they supposedly learn the techniques needed to survive in general population.[31] However, a number of corrections personnel confided the length of stay for inmates in this unit has been getting longer and longer, which is a source of concern for the Department. According to the APPU's Education Director, while the average time in the unit is one year, there

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[30] Protective custody (PC) means an inmate is locked up, in a type of special housing, with only minimal recreation for a program. In reality, this administrative segregation does not differ very much from punitive segregation (SHU), so an inmate who needs protection, for whatever reason, is treated as if he or she were being punished for committing an infraction. Historically, mentally retarded inmates have been assigned to PC status as the only effective way to keep them from being exploited.

[31] There is no APPU type unit for female inmates, and, therefore, no place which could serve a similar purpose for women who are diagnosed as mentally retarded. Of course, the female inmate population does not approach the size of the men's, nor would the numbers who are retarded. In the Fall of 1985, we were told there were three mentally retarded women housed in the ICP unit at Bedford Hills, which essentially provided protection for them. Of course, while providing a safe and secure environment for the mentally retarded may be an admirable objective, it is <u>not</u> the purpose of the ICP, and is yet another way beds in the program may be denied to other inmates who require them.

are now 35 men who have been there between three and five years. These men are really just "treading water," since the program was not designed for such a long residency. Both corrections and mental health personnel feel another APPU is badly needed, because the total inmate population keeps growing, as does the number of men who require such a program.[32]

We were told the Department does hope to open a unit specifically designed for the mentally retarded, but we were unable to obtain firm information about these plans. Several people in DOCS informed us that the proposed unit, with 56 beds, is to be placed at Wende, outside Buffalo, probably in 1987, but that the program design had not yet been prepared. We were unable to learn how the 56-bed figure was determined.

One official explained his feelings that these inmates should not be isolated, the Department should not take the attitude of

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[32] The matter of a second APPU underscores the difficulty of getting accurate information from the Department on these issues. APPU staff spoke very concretely about the new 64-bed unit that should open soon at Sullivan, to siphon off some of the long-term inmates from Clinton, and to provide a different type of programming. However, we were later told that, while an APPU was originally planned for Sullivan, the design of that facility mitigates against placing the unit there, so the Department is now considering placing it at the new Shawangunk prison. Finally, a Deputy Commissioner stated that to say the second APPU is "planned" is a misnomer, because that "implies some degree of concreteness," while all DOCS has done so far is "talk" about putting another unit somewhere, but nothing is really planned at this point. This example is not to suggest that DOCS officials deliberately provided our staff with inaccurate information at any point, because we do not believe that to be the case. Rather, we think it is but one indication of the amount of misinformation and rumors that exist in a department as large as DOCS, which necessarilys makes the gathering and analysis of accurate data extremely difficult and frustrating.

trying to protect them for the length of their term in prison, but should provide them with skills that would let them function in the general population. The general idea is that once these men go through the program at Wende, they can be placed in any facility across that state; in fact, one of the reasons for placing the unit at a reception center is the fact that such a facility "can ill-afford to keep them for any time on a long-term basis." However, others pointed out that, although all DOCS programs are considered open-ended and transitional, some of the target inmates will never gain sufficient coping skills to deal with everyday situations in general population, so they will undoubtedly have to remain in the unit for the duration of their time in prison.

To add to the confusion, the Deputy Commissioner for Programs told us that, although everyone in DOCS wants to see some sort of program address the unmet needs of retarded prisoners, no one in the Department can speak about the Wende "program" with much confidence at this point. As he put it, the Wende unit is more a "wish list" than a reality, and that the Department still needs to identify space, secure funding, get professional staff and expertise before discussing the plan with any real surety. In fact, he would ideally like to establish three units for the mentally retarded, one each at a maximum, medium, and minimum-security facility, so that the inmates' programmatic and security needs could be better integrated.

Clearly, there are many unresolved questions here:

1) How many of the total population of mentally retarded inmates really need a special program unit, i.e., how was the figure of 56 arrived at?

2) Are there female prisoners who require similar programming?

3) What kind of program do these inmates require?

4) Is it productive to consider a short-term program, that will permanently label the inmate as mentally retarded in the eyes of other prisoners, with all the liabilities such labelling entails?

We are naturally concerned that these questions be adequately resolved before a special unit is permanently established. The design of the program is of particular concern, since we spoke with a number of reputable individuals who took issue with the concept that any unit for the retarded can be seen as a short-term placement, where the inmates are provided with coping and social skills to "make it" in the general population.

An official at OMRDD stressed that the issues surrounding the mentally retarded in prison are very different from those involving the mentally ill, the biggest difference being the permanence of the condition. Mental illness is often a transient, fluctuating condition, and it is possible for an inmate to <u>become</u> mentally ill after entering prison. The same is not true for mental retardation, which is a permanent state. Therefore, programs designed to combat a temporary phenomenon, where the idea is to

cure the inmate enough to allow him or her to return to the general population, are not appropriate for the retarded, who cannot be cured, even temporarily. He further indicated that mentally retarded inmates who lack the ability to survive in the normal prison environment require specialized services, such as functional training, life skills training, pre-vocational programs, and protection from victimization, all on a long-term basis.

Programs in Other States

Often in the corrections field, significant efforts to improve conditions of confinement are not undertaken until an individual prison, or a state's entire prison system, becomes the object of prisoners' rights litigation. As a result of the far-reaching Ruiz v. Estelle case, the Texas prison system was found unconstitutional, and the court order which resulted mandated comprehensive changes throughout the system, including the establishment of a plan for psychiatric services as well as a plan for mentally retarded inmates.

When designing the latter plan, the Texas Department of Correction studied the various options, including mainstreaming all inmates with a mental retardation diagnosis within the general population. An official with the Department's Health Services Division told us that, in the end, they chose to maintain almost all the mentally retarded inmates, male and female, separately from the rest of the population, for reasons of their own

protection.[33] Education provided in the special unit concentrates heavily on life skills and adaptive behavior skills, and every inmate goes to school, from one to five days a week, according to an Individualized Education Plan. A case manager assists the inmate to develop a treatment plan which is expected to be followed so long as he or she remains within the prison system.

Attorneys for the plaintiffs in the Ruiz case say that, while they still seek to achieve improvements in the plan for retarded prisoners in Texas, they are firmly convinced the current program surpasses what is otherwise available in the U.S. The lawyers also emphasized that, although there is much dispute in the field about whether the mentally retarded should be kept together in a special unit, or mainstreamed as much as possible, many reputable people, including Miles Santamour -- who at first disagreed with Texas' choice of separation -- have now concluded that the system established in Texas is indeed very good. In fact, we were directed to the Texas program by Mr. Santamour, who assured us that, in his opinion, it is the best program that currently exists for this special category of prisoner.

Other states, e.g., Alabama and South Carolina, also provide special services, emphasizing basic living skills, for mentally

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[33] Any inmate who has a WAIS score of 73 or below, and whose adaptive behavior does not contraindicate a diagnosis of retardation, will be sent to the special unit, which will eventually have space for 1,000 men and 75 women. However, the mentally retarded are not excluded from generally population. An individual inmate will be moved into a general population unit, if a judgment is made that services would be better for him or her there.

retarded inmates in separate units. The Alabama unit is designed to maintain the inmates for the entire length of their prison sentence. At the Special Learning Unit of South Carolina's Kirkland Correctional Facility, staff indicate that inmates who successfully attain the skills needed to function independently within the general inmate population can be "promoted" to the unit's transitional phase, prior to permanently entering the larger population. However, the severe developmental disabilities of the client population have limited involvement in the transitional phase to only a small number of the inmates who have participated in the program since its inception in 1975.

South Carolina's Special Learning Unit is one of the oldest programs in the country for mentally retarded prisoners, and staff there have had an opportunity to develop mechanisms to assist clients in formulating release plans prior to parole eligibility or sentence completion. The plans range from institutional placement to independent living arrangements, depending on the individual's ability to function independently, as well as the family support available. Release plans include places to live, job placements and/or income subsidies, and community treatment services, such as vocational and educational training, medical care, psychological services, and social services. A staff member appears with all unit inmates at parole hearings, in order to help them inform the parole board about the case and the release plan that has been established. The unit's personnel contend the South Carolina Probation, Parole and Pardon Board has been very under-

standing of their clients' disabilities, and supportive of the release plans that have been developed.

The Richard Soule Case

At several prisons, individuals spoke to us of a current lawsuit, Soule v. Cuomo, which they thought could potentially have a considerable impact on the way the prison system in New York handles mentally retarded offenders.

Richard Soule is presently housed at Auburn, having been transferred from Clinton, where he was originally incarcerated after his conviction in June 1984 for attempted arson. Before his arrest, he was in the care of OMRDD, living at the Onondaga Community Residence in Syracuse, where he tried to set a fire in his room, the offense which lead to his eventual incarceration. Apparently Mr. Soule had a history of reporting fires because seeing fire engines excited him. His attorneys claim OMRDD and its agents, the Syracuse Developmental Center and Seguin Community Services, were grossly and willfully negligent and deliberately indifferent to plaintiff's needs, condition and predilections because they assigned him to a room with roommates who were smokers, thereby providing him easy access to matches and cigarette lighters.

Likewise, plaintiff's attorneys allege that DOCS officials are responsible for negligence, discrimination, and abuse suffered by their client since he was entrusted to their care. They claim Mr. Soule has deteriorated mentally and physically since entering

the prison system, because of alleged mistreatment received from correctional staff while at Clinton. Among other things, they claim:

a) Correction officers at Clinton regularly harassed and taunted Mr. Soule, in ways they knew would agitate him to the point where he threatened suicide, defecated and urinated on himself and his cell, and yelled, screamed and threw his food on the floor. The officers would then use these actions as a reason to physically abuse him.

b) Due to his mentally retarded condition, Mr. Soule was the object of verbal, physical and sexual abuse, as well as assaults and threats, by non-retarded inmates and correction officers.

c) Mr. Soule's plight was well known through the entire state corrections system.[34]

When Mr. Soule's intellectual ability was first tested years ago by means of the WAIS test, he scored a 45, a score which made him eligible for care in the OMRDD system. When he was given the same WAIS test by DOCS during the classification process, he scored 65, a score which allows OMRDD to claim he is not severely retarded and, therefore, no longer its responsibility.

However, several DOCS people questioned whether such a dramatic increase in an individual's WAIS score can be considered valid if the individual has taken the same test a number of times over the years, as Mr. Soule has. Classification staff told us

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[34] Amended Compliant in Soule v. Cuomo, date June 14, 1985.

that apparently this inmate had taken the test so many times prior to its administration at Wende, that he was able to answer the first few questions without even reading them completely. They felt this ability on Mr. Soule's part called into question the test/re-test validity. They stressed that the important question here was how the inmate rates on the Activities of Daily Living, and, on that basis, they cannot be convinced that Mr. Soule's I.Q. is higher than 40-45, despite the latest WAIS results.

Attorneys for the plaintiff are seeking to enjoin the State to establish a facility and programs for mentally retarded individuals such as Mr. Soule who are in DOCS custody. However, the State, in its answering Memorandum of Law, dated September 18, 1985, responded:

> Since plaintiff is a convicted felon, in prison, and not civilly committed to an OMRDD institution, the purpose of his incarceration is to redress his criminal behavior, not to afford him programs for his retardation. As a convicted felon, plaintiff has no constitutional right to "treatment" for his retardation.

Actually, the inmate's attorneys are concerned both that their client is not receiving appropriate specialized treatment while in prison, and that he will be the recipient of the same lack of treatment after his release. If his elderly mother is unable to care for him properly, and if OMRDD refuses to take him back into their system, then what will happen to him, his attorneys ask,

other than the probably inevitable return trip to prison?

OMRDD and The Prisons

Many DOCS officials, as well as prison administrators and staff, complained that OMRDD does not have any sort of presence in the prisons, that it has not established any viable programs to assist the growing number of retarded inmates, and that it should definitely be involved in this effort. However, at least one authority in the field of developmental disabilities with whom we raised this issue totally disagreed with this perspective. He expressed his strong opinion that this is a "corrections problem," and OMRDD should definitely be involved in helping DOCS set up programs, as consultants, but should not be involved in running them.

Staff members of OMRDD's Division of Program Operations concur with this assessment. They also emphasized that DOCS Commissioner Coughlin and OMRDD Commissioner Webb have a long-standing working relationship. Therefore, they felt completely confident the two Commissioners would work together on this issue, and that DOCS would not take any serious steps toward planning a unit for the mentally retarded, such as has been proposed for Wende, without discussing it in detail with Commissioner Webb.

Correction Officer Training

Because they have limited intellectual abilities, mentally retarded offenders often have trouble adjusting to the demands of

the prison routine and understanding precisely what is expected of them. Therefore, they are much more likely to violate prison rules, to be written up for those infractions, and to spend time in punitive segregation as punishment.

As one way to minimize this problem, staff in the special units for the mentally retarded in the Georgia and South Carolina prisons provide a training course for correction officers. (In South Carolina the course takes only two hours.) The purpose of these courses is to provide an overview of what retardation is and to enable the officers to better identify and handle these inmates appropriately. A basic function of the training is to make the officers more aware of the problems experienced by those with retarded intellectual development, so that those inmates will not be expected to perform as if they were average inmates. Officers are told that it is often necessary to repeat instructions to these inmates several times in very simple language in order to be understood, and the fact that an inmate does not respond positively to the first command given does not necessarily indicate that he or she is hostile or recalcitrant, rather merely limited in intellectual abilities.

The size of the mentally retarded inmate population in New York is significant, and providing similarly useful training for line staff in this state on issues relating to retardation would be a good management tool. At present, the curriculum at the Training Academy does not contain any material on mental retardation.

Learning Disabled Prisoners

Learning disabilities are another form of the life-long developmental disabilities which frequently appear in the inmate population. It is generally acknowledged that this is an area which has not received sufficient attention in the past, and the Department is really just beginning the effort to properly test, classify and program inmates suffering from this particular form of disability.

Actually, in this regard, it is not only DOCS, but rather our entire society, which has been slow to recognize these disabilities and to plan appropriately for them. In a December 1983 report, the New York Association for the Learning Disabled indicated that while hard data on the numbers of learning disabled within the state prisons do not exist, there is at least a partially credible explanation:

> One significant problem facing the Department is the definition of (Neurologically Impaired/ Learning Disabled) and subsequent identification of clients. To date, the professional community of NI/LD teachers, therapists, and practitioners could not even arrive at one common consensus of what learning disabilities meant. Correctional classification analysts have had difficulty, then, determining which inmates have been genuinely learning disabled, and until recently, diagnosis of learning disabilities has not been attempted at the Department's reception centers.[35] (emphasis added)

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[35] Final Report: Neurogolical Impairments - A Proposal for Service. Recommendations for a Comprehensive Service Delivery System for the Neurologically Impaired/Learning Disabled.

The same report indicated the Department had taken a number of steps to improve its performance in the area, beginning with the introduction of the definition of learning disabilities adopted by the National Joint Committee for Learning Disabilities in 1981:

> Learning disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to central nervous system dysfunction. Even though a learning disability may occur concomitantly with other handicapping conditions (e.g., sensory impairment, mental retardation, social and emotional disturbance) or environmental influences (e.g., cultural differences, insufficient/inappropriate instruction, psychogenic factors), it is not the direct result of those conditions or influences.

Classification staff at Wende advised that, until fairly recently, New York was not particularly concerned with, or attentive to, inmates with learning disabilities. That has changed, at least with respect to inmates under 21 years of age. Federal legislation, Public Law 94-142, the Education of All Handicapped Act of 1975, mandates that handicapped youths 21 years of age and younger receive a free and appropriate educational

program, and

> Correctional educational programs are specifically included in the implementing regulations for PL 94-142. the law defines handicapped individuals as mentally retarded, hard of hearing, deaf, orthopedically impaired, other health impaired, speech impaired, visually handicapped, seriously emotionally disturbed, or learning disabled requiring special education and related services.
>
> Despite this mandate, fewer than 10 percent of state departments of correctional education fully comply with the law.[36]

DOCS plans to comply with the federal law, as well as regulations issued by the NYS Department of Education, by establishing a Committee on the Handicapped at Elmira, which is the reception/classification center and major correctional facility for male inmates, 25 years of age and younger. The State Education Department recently provided DOCS with a grant to hire a school psychologist to expedite compliance with the federal mandates for the younger population (at least for male inmates).

DOCS' Assistant Education Director explained that, if classification staff at Elmira suspect an under-21 inmate has an educational handicap, the Committee on the Handicapped will do a full-blown assessment, and, if necessary, an Individualized Education Package (IEP) will be assembled for him. He also explained that the Department hopes eventually to provide a

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[36] C. Michael Nelson, Robert B. Rutherford, Jr., and Bruce I. Wolford, "Handicapped Offenders: Meeting Education Needs," Corrections Today, August 1985.

similar level of services to each inmate with these special needs, no matter his or her age.

The prisons undoubtedly contain a large number of the learning disabled, but no one knows exactly how large that number is at present. Therefore, plans call for extensive diagnostic testing and assessment of all inmates scoring below a 5th grade reading level, the level which indicates the ability to read independently. Twenty percent of the prison population reads below the 5th grade level, and we were told that probably the majority of them are either mentally retarded or learning disabled. It is somewhat disconcerting to realize that 20% of the current population is approximately 7,200 individuals.

Several DOCS staff people in the education division and at the classification centers explained that learning disabilities are extremely difficult to assess properly, requiring one-on-one testing that takes up to six hours per inmate. For that reason, the Department cannot adequately assess the potential learning disabilities of all inmates scoring below 5th grade levels on reading tests administered at the classification facilities; they simply do not have sufficient numbers of qualified testers to accommodate the size of the population to be tested. Although DOCS requested funding for five additional psychologists to fill this necessary function at the reception/classification centers, the Division of the Budget did not grant the request this year.

Counsellors at Downstate contend that, in order to test all inmates completely with regard to potential learning disabilities,

that facility alone would actually need 8-10 additional professional staff: psychometricians (psychological testers), psychologists and special education teachers. Then, half that new staff would need to be duplicated at Elmira, probably one-quarter at Wende, and they could not estimate what Bedford Hills would require.

At present, extended classification staff assess learning disabilities the "best they can," working with limited resources, and recommend inmates identified as possibly having learning disabilities be assigned to a facility with a resident special education (special ed) teacher, who can then complete the needs assessment. There are currently 18 special ed teachers working in prisons across the state, but almost all of them are at medium-security institutions. Of the maximum-security facilities, only Green Haven, Eastern, Elmira, and Bedford Hills have a special ed teacher on staff.

The special ed teacher at Bedford Hills told us that, while 80% or more of the women she tests have great problems, she does not test that many women. The reason is she is the only one who is qualified to do the testing, but she must conduct special ed classes and program women through a newly established resource room, in addition to doing the testing.[37] When our staff interviewed this teacher in October 1985, she expressed concern that

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[37] In a special education resource room, an individual student receives direct one-on-one attention, for a one-hour period. The ratio of students-to-teacher is 5-1 (in a regular special ed class it's 15-1). The resource room is devoted to remediation of learning deficiencies.

the advent of the resource room program meant even less testing would occur, since she anticipated being able to devote only two days a week to testing, instead of five. Since that time, Bedford Hills has expanded its capacity by 200, which could only have exacerbated the problem.

For these reasons, this particular teacher was quite adamant about the institution's need for more special ed teachers, as well as a school psychologist, who would be able to administer tests that the teacher is not qualified to give and interpret herself. The need is perhaps particularly evident at Bedford Hills, since it is a reception/classification facility as well as the only maximum-security institution for women in the state. As this teacher asked, "How can you program if you can't test properly?"

Special ed staff are currently concentrated in the medium-security facilities because that is where expansion is occurring, so new staff lines are established. In the older maximum-security prisons, DOCS does not have additional staff lines available to hire special ed teachers, and they must depend on attrition in program staff to open up a line for this purpose. Education division staff explained that they do not believe these programs need to exist at <u>every</u> prison, but rather should be placed at strategic medium- and maximum-security facilities, into which the inmates who require them could be transferred. Unfortunately, at present the system for allocating programs to meet the needs of learning disabled prisoners does not follow such a logical plan.

POST-RELEASE SERVICES

What happens to mentally handicapped inmates once they are released from prison? What kind of services are available to them, and what problems do they face in availing themselves of those services? This is an area of particular concern, inasmuch as the community mental health movement has thus far been unable to adequately meet the needs of even the non-offender population. It can therefore be safely assumed that individuals who bear the additional stigma of having been incarcerated, often for a violent crime or with a history of violent behavior, are apt to find even less doors open to them. In the following section, we examine what we have learned regarding the operation of the Division of Parole, the Office of Vocational Rehabilitation, and the community mental health network, as they relate to this population.

Parole

When an inmate is approaching a Parole Board hearing, the Board may request a mental health status report, to be included in the inmate's file. An Executive Order mandates a formal evaluation by two psychiatrists for individuals convicted of first and second degree homicide, certain sex crimes, or who were confined in a mental hospital during their incarceration, such as the Central New York Psychiatric Center, or the old Dannemora or Mattewan State Hospitals.

Where a psychiatric evaluation is mandated, OMH does not have to secure the inmate's permission to release confidential information to the Board. In all other cases, psychiatric information is privileged, and OMH will not provide the Parole Board with any data beyond the fact that an inmate is being seen by mental health staff, unless the inmate waives his or her right to confidentiality. The Parole Board is advised when confidential information cannot be provided because an inmate refused to sign a waiver form, and, in those cases, the inmate is almost invariably denied parole release. Not surprisingly, most inmates consent to waiving this right.

Mental health personnel voiced fairly vociferous objections to the demands placed upon them by the parole authorities. Parole officials complained equally vigorously that OMH does not provide them with sufficient information to allow them to do their jobs properly, both in assessing the readiness of an inmate for release and in providing adequate supervision in the community.

Several mental health unit chiefs felt that either Parole has unrealistic expectations of what mental health professionals are capable of assessing, or that parole officers simply want OMH to do their job and relieve them of a lot of the criticism they receive when a parolee commits a particularly violent crime. The general opinion seemed to be that the Parole Board is not really interested in an inmate's course of treatment, but simply wants OMH to take the responsibility for saying whether the inmate <u>should</u> be released.

The contrasting viewpoint from Parole is that OMH incorrectly views relationships with patients inside the prisons as ordinary doctor-patient relationships, and, therefore, sees itself as having no obligation to share information with anyone else. Parole officials say they would be able to do their job more responsibly if OMH would provide them with a statement that more clearly addressed the issue of the inmate's "dangerousness."

Fortunately, a September 1985 amendment to the Mental Hygiene Law facilitated a better working relationship between the two agencies. Based on the changes effected in that law, a memo of agreement, implemented on June 1, 1986, stipulates that OMH will provide institutional parole officers with the following information five days prior to an inmate's release from prison, <u>even without</u> the inmate's consent:

a) Statement of the inmate's current problem(s);

b) Current medications the inmate is taking, if any;

c) Arrangements made for aftercare services for the inmate; or

d) Possible need for aftercare services at some future time; and

e) Special precautions regarding the inmate, if any (e.g., immediate need for intervention when patient expresses delusional ideas suggestive of danger to self or others).

Providing this information <u>after</u> the Parole Board has made its decision to release the inmate clearly does not resolve the

conflict over the issue of predicting future dangerousness prior to the Board decision. However, it should eliminate much of the dispute which has existed between the agencies regarding how much practical assistance mental health can and should provide to field parole staff, who require as much information as possible on the parolees who are their daily responsibility.

Mental Health Services for Parolees

New York City

Seventy-five percent to eighty percent of inmates released from prison facilities return to the New York metropolitan area. To meet the needs of the majority of parolees, OMH has established a New York City Parole Clinic, in the parole offices in Manhattan (for Manhattan, Brooklyn, and Staten Island), Queens, Bronx, and Nassau and Suffolk counties.

The Parole Clinic provides:

> psychiatric and psychological evaluations, therapy (individual, group and family), chemotherapy, crisis intervention, liaison with psychiatric centers, parole evaluations, referrals to other agencies, and follow-up of patients who are released from Central New York Psychiatric Center and Satellite Units.[38]

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[38] Description from the Bureau of Forensic Services Directory of Services. Services to Correction and Parole: 1985-86. The unit chief coordinates the delivery of mental health services to all New York City DOCS facilities, in addition to the New York City region's parole offices.

Parolees are directed to the mental health unit through several mechanisms:

1) The Parole Board can mandate a parolee see OMH as a condition of parole. This requirement is most likely to occur when an inmate has had a two-person psychiatric panel review prior to the parole hearing. In these cases the parole officer schedules an appointment with OMH for the parolee.

2) OMH issues "Alert Referrals," a mechanism which flags the parole officer that the parolee has a history of psychiatric treatment, and that he or she should be referred to OMH if there are signs of poor adjustment, acting out behavior, depression, etc.

3) Individual parole officers can refer a client to the mental health unit at any time.

4) When OMH prison personnel feel a client on their roster requires mental health intervention on the outside, the parole clinic is sent a transfer summary on the inmate/parolee, as well as his/her mental health folder. The clinic unit chief then prepares a memo to the appropriate parole officer, advising that the parolee has a history of mental health problems, and suggesting the parole officer make a referral to the OMH office.

It is OMH's philosophy that they have an obligation to any individual under its care, even after the individual is released from parole. Therefore, a parolee who desires to continue seeing a therapist in the clinic office after completing the parole period can do so; they are not automatically terminated. On the other hand, anyone who is not satisfied with the level of service

provided at the clinic can avail themselves of an out-patient clinic at a city hospital, or the free out-patient services found at state hospitals.[39] In cases where OMH cannot provide a specific type of program required by a parolee, e.g., resocialization therapy, they will make a referral to an appropriate hospital out-patient clinic.

Outside New York City

The New York City metropolitan area is the only place where OMH has established the system of parole clinic offices. This is not surprising, since the number of parolees requiring mental health services in most other areas of the state does not justify similar resource investment. Unit chiefs at various prisons told us that, in a case where one of their clients is released to an area other than New York City, they coordinate with Parole and the relevant county mental health facility, to whom they provide the same kind of discharge summary that would otherwise go to the New York City Parole Clinic. However, Parole officials stated that, outside the New York City area, their ability to secure similar levels of service for their clients from the local mental health organizations is minimal. In some areas of the state, such services simply are not available.

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[39] To qualify for these out-patient services, an individual must have a major psychiatric disorder. They do not require prior hospitalization. Mental retardation does not qualify an individual for service in such programs.

According to Parole's Central Office staff, one of Parole's most significant responsibilities is to do a better job of brokering services for their clients. Parole personnel also point out that, since Parole recently established a differential supervision system, whereby some parole officers will supervise only 38 parolees, it should be possible for the Division to provide better services than it has in the past. In addition, the parole system throughout the state has now been regionalized; there are five regions, two of which are New York City and Long Island. In each region, a Client Services Specialist should soon be available, whose function it will be to establish profiles of the region's parolees, to determine what gaps in service delivery exist, and arrange for those gaps to be filled -- whether they be mental health or any other.

Office of Vocational Rehabilitation

The Office of Vocational Rehabilitation (OVR), a division of the State Education Department, describes itself as an agency which "helps persons who have disabilities and different needs get their passport to a job and to independence." In order to become an OVR client, an individual must meet two basic criteria:

1) He or she must have a physical or mental disability which results in a substantial handicap to employment, and

2) There must be a reasonable expectation that vocational rehabilitation services may help make the person more employable.

OVR used to have programs in several New York prisons, the largest of which was at Attica from 1968-83. Smaller units existed at Clinton, Albion and Coxsackie, working with inmates about to be released, assisting them to make connections with OVR services in the community. Budget cutbacks over the years resulted in the elimination of the OVR in-prison programs, and now inmates who are potentially eligible for OVR services must be evaluated after release.

Clients must provide OVR with mental and/or psychiatric evaluations, after which they are interviewed, assigned a counselor, and finally sent to an outside agency for a formal evaluation to determine whether they have the ability to perform a particular kind of work. Only after these procedures have been completed will the client actually begin to receive services. Pre-service procedures are extremely time-consuming, taking as long as two months.

Several people from OVR, DOCS, Parole, and ex-offender organizations indicated the length of pre-service time is a real problem for anyone just leaving prison, because it is simply a fact of life that, the longer parolees have to wait before receiving services, the more they are put at risk. However, we found a measure of disagreement among these individuals regarding the efficacy of current links between the prisons and OVR. DOCS program staff indicated the Department now operates on an informal, case-by-case basis with OVR, whereby DOCS contacts OVR's central office when an OVR-eligible inmate is ready to leave the

system, and OVR arranges placement for the inmate through the appropriate local office. A DOCS official indicted that, although OVR does not do much while the inmate remains in the prison system, the informal relationship the two agencies now maintain is actually more effective than what existed when OVR was working within the prison system.

Others clearly disagree with this assessment, pointing out that many OVR-eligible inmates reach the street without <u>any</u> prior agency contact, and then have to undergo the long process of testing and evaluation. Just about everyone seemed to feel the testing process should be accomplished <u>inside</u> the prisons, <u>before</u> an inmate's release, thereby saving much-valued time.

OVR's Rehabilitation Management Services Unit (RMS) staff recently proposed introducing a process of short-term screening and assessment within DOCS facilities, followed by referrals of eligible individuals to appropriate field offices for OVR services, because:

> Waiting for an individual to be released from a DOCS facility to obtain these services may not be the most appropriate course of action. There may be costly time delays in securing the assessments through traditional sources, the assessment may require 4 to 6 weeks to complete and the assessment summaries may not provide specific job or program recommendations. These delays frequently result in attendant delays in the start of a job search or training program. Using an assessment system requiring only 4 to 6 hours to complete will all but eliminate delays in obtaining data and, therefore, significantly reduce the amount of time needed for any program implementation.

However, a fundamental objection to the OVR proposal is the fact that OVR-RMS expects to become a fee-collecting agency. DOCS and Parole strenuously object to one state agency having to pay another in order to receive services.

We are not aware whether the relevant agencies have come to any conclusion regarding these issues and the proposed in-prison testing program. However, the Director of OVR's Manhattan office advised us that, while evaluating an inmate for OVR services in prison might solve one current problem, in that the client could then be sent to a training program immediately upon release, other, greater problems would remain. He explained that the training programs into which OVR clients are placed range from 6-8 weeks to a year in duration, during which time clients receive no stipend for the most part, and only $3.80 per day for carfare and lunch. It was almost unnecessary for him to say that, since an individual newly released from prison wants and needs to earn money, the agency is not particularly successful in retaining these clients.

Community Service Providers

If a mentally handicapped ex-offender requires residential services, or non-residential programs beyond those offered at OMH's parole offices and state, county and municipal hospital out-patient clinics, do they find the requisite services to be available? For the most part, unfortunately, the answer is a resound-

ing "no." We could find no one who would disagree with this assessment, and for good reason.

In New York City, we were able to uncover only one program which specifically addresses the needs of mentally disordered offenders: the Community Reintegration Program of the Bedford-Stuyvesant Mental Health Center, which describes itself as "an outpatient program with the mandate to assist the mentally disordered offender in making a transition from the role of inmate to that of community member of Bedford-Stuyvesant." Clients are either referred by parole officers or they come in voluntarily. The program consists of crisis intervention services, a brief therapy option (8-12 weeks), and a long-term option for therapy. The one important component that is not available is a residential placement.

In general, residential services are probably the greatest unmet need. In general, the acute shortage of community residences for the mentally disabled is one of the biggest failures of the community mental health movement.[40] As a result, residential programs can afford to be selective regarding whom they accept as a client. Fairly stringent criteria have been developed that usually disqualify anyone with a history of drug or alcohol abuse,

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[40] In a New York Times article, "Mentally Ill Homeless: Policy at Issue," dated November 22, 1985, Dr. Steven E. Katz, the Commissioner of Mental Health, was quoted as saying the state has begun building more community residences for the mentally ill, "although it now has only a little more than a third of the 10,000 that are needed." Similarly, we were advised that the waiting list for community agencies for the mentally retarded approaches 7,000.

a violent criminal record, or a history of violent acts. Those prohibitions effectively eliminate most of the ex-offender population from program participation, along with the majority of patients released from state psychiatric hospitals.[41]

While discussing the important issue of residences, and lack thereof, for the population in question, the director of one community service agency raised an issue that had been frequently broached by others during the course of our study. Many members of the mentally impaired inmate population are multiply handicapped, that is, they suffer from more than one disability. For example, they may be mentally retarded and mentally ill; they may have psychiatric problems and be a substance abuser; they may have a learning disability and be physically disabled. On numerous occasions, the rhetorical question was asked: Who has responsibility for this individual? Many people we interviewed expressed their frustration that multiply handicapped clients tend to be bounced from one agency to another, because no one wants to take responsibility for them, and everyone tries to pass the responsibility off to someone else. In the end, of course, it is the client who suffers.

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[41] This latter fact was confirmed by one Psychiatric Center Community Relations Director, who told us that hospital patients requiring residential placement upon release are often hospitalized longer than needed because a residence cannot be secured, and eventually they are moved out to a setting that hospital administrators know is unsatisfactory, e.g., their own apartment, or a room in a hotel, where they cannot get the services and/or supervision they need.

The tendency of agencies to overlook the plight of mentally impaired prisoners, possibly because officials feel someone else "should" be held accountable for dealing with the multiply handicapped person, has become very evident to us as this project developed. If we accomplish nothing else from the publication, dissemination and discussion of our findings, we trust we will at least have been successful in bringing this major problem area to light.

RECOMMENDATIONS

Throughout this report, a number of problems were highlighted which significantly hamper the delivery of adequate services to mentally impaired prisoners. Our recommendations for change are outlined below. In some cases, we urge expeditious action be taken to complete changes already anticipated; in others, we incorporate suggestions which have previously been made by the agencies themselves or other public bodies; and, finally, we offer our own considered opinion as to how the State needs to proceed to substantially improve services to this population.

I. Psychiatric Satellite Units. Space currently available for the satellites is inadequate, resulting in patients being inappropriately discharged back into general population, or held in overflow areas far away from mental health staff. Some maximum-security facilities do not contain a PSU, which puts additional pressures on the prisons which do have such a unit, particularly as the population continues to expand. Finally, observation cells constructed of heavy steel with tiny viewing slots are inadequate for mental health purposes, particularly when utilized for suicide watches. Therefore, we urge the following steps be taken:

1) Increase PSU space, either by expanding existing dormitories, or by opening additional satellite units. The promised opening of the satellite at Great Meadow should receive the highest priority, and a new unit at the new Shawangunk

facility should be established.

2) Dormitory space should be renovated for the Forensic Diagnostic Unit at Downstate, so that this important reception/ classification center will have a real satellite unit, where potentially suicidal inmates can be observed more effectively in a dormitory setting, and the almost daily one-on-one suicide watches in the observation cells will no longer be necessary.

3) All heavy steel doors on observation cells should be modified, to enlarge the viewing area through which correction officers and mental health staff observe inmates, as has already been recommended at Auburn and Green Haven.

II. Intermediate Care Programs. The number of inmates requiring placement in ICPs far exceeds the amount of space presently available in them. The discrepancy between demand and supply causes a variety of problems, including "dumping" of the mentally handicapped on the few facilities containing a unit. The solution to the lack of appropriate bed space is to provide additional units. Inasmuch as DOCS and OMH share responsibility for the functioning of these units, the two agencies should design plans for program expansion together rather than relying on initiatives prepared exclusively by DOCS. Such a joint enterprise would maximize chances for Division of Budget approval.

III. Chronic Care Program. There currently is no program -- either inside or outside the prisons -- to care for inmates

suffering chronic mental illness. Some of these inmates are placed in the Intermediate Care Programs, thereby eliminating much of the scarce space needed for those who should be placed in an ICP. There is little argument from those working in the prison system that something needs to be done for this population. Therefore, a plan must be developed, funded, and implemented to meet the care and custody needs of the chronically mentally ill inmate population.

IV. Spanish-Speaking Staff. With the proportion of Latinos in the inmate population exceeding 25%, there can be no question that Spanish-speaking therapists, as well as psychometricians qualified to administer the Spanish-language EIWA intelligence test, are necessary. There is also no question that recruiting qualified and competent professional staff to work in the prisons is an exceedingly difficult task, even with fairly competitive pay scales. Finally, at some facilities, the number of Latino inmates who require these specialized services may not be large enough to justify utilization of full-time professional staff. For all these reasons, both DOCS and OMH should attempt to develop a pool of Spanish-speaking professionals in the vicinity of relevant prisons, who can be contracted on an "as needed" basis, to fill existing service gaps. In addition, monolingual Spanish inmates should be housed only in those prisons located in any area where such a Spanish-speaking professional pool exists.

V. Special Housing Units. The environment of disciplinary segregation is generally acknowledged to be particularly harsh and to impose intense isolation on all inmates on the units. That isolation often has a severe negative impact on individuals whose mental stability is marginal, as the history of inmates who undergo psychiatric crises and breakdowns on these units, as well as the number of attempted and successful suicides, attests. Some inmates bounce back and forth between segregation, psychiatric satellite units and Central New York often enough to indicate they are probably incapable of withstanding the pressures of segregation for an extended period of time. In an attempt to balance the sometimes conflicting requirements of correctional policy and mental health needs, we recommend:

1) Any inmate who has received OMH services be screened by OMH prior to being placed in punitive segregation. If OMH determines that placement in SHU will be seriously detrimental to the inmate's mental health, alternative housing arrangements should be made, at least until such time that OMH determines the inmate's mental health status has improved sufficiently to tolerate confinement in SHU.

The suggestion that mental health evaluations be performed before a prisoner is moved to solitary confinement is not completely novel. The Mental Health Standards for New York City Correctional Facilities, effective February 1, 1985, mandate: "Any inmate to be placed in punitive segregation who has a history of mental or emotional disorders shall be seen by mental health

services staff before being moved to punitive segregation."

Likewise, the psychiatric services plan developed in Texas as a result of the Ruiz decision provides for mental health screening of inmates before they are assigned to either punitive or administrative segregation status. (The concern regarding the potential damage that may be suffered as a result of placement in punitive segregation is particularly striking, since the maximum sentence to such a unit in Texas is 15 days, as compared with the virtually limitless disciplinary sentences that can be meted out in New York.) In Texas, when the end result of the mental health screening process is that the inmate cannot be sent to punitive segregation, the correctional authorities must utilize less restrictive punishment options, such as taking away good time, or requiring extra work assignments, that do not have the same potential for causing long-term psychological damage.

2) For troubled inmates housed on punitive segregation units, either private space should be provided to facilitate the provision of adequate mental health services, including therapy, or escort officers should be designated to take inmates from the unit to the OMH area when mental health services are required.

VI. Correction Officer Training and Screening. Training for correction officers is generally held to be inadequate with regard to issues of mental illness and retardation. Formal, specialized training is not provided on a regular basis for mental health units such as satellites and ICPs, and there is no screening

procedure to ensure inappropriate officers cannot bid into the posts. Therefore, we recommend the following:

1) An appropriate training module on the identification and appropriate treatment of mentally retarded inmates should be developed and integrated into the curriculum at the Training Academy for new correction officers as soon as possible.

2) OMH should develop and provide a formal training program for correction officers newly posted to special mental health units, such as PSUs and ICPs, rather than depending on informal on-the-job training to occur, as is presently the case.

3) Negotiations should be opened with Council 82, the correction officers union, to design and implement a mechanism to screen the appropriateness of officers who apply for job assignments in mental health units.

VII. Programs for Mentally Retarded Inmates. There is no dispute that not enough is presently being provided for those mentally retarded prisoners whose adaptive behavior is inappropriate for general population confinement. It is essential that DOCS, in conjunction with OMRDD, assess the scope of the problem, and design one or more programs to adequately meet the needs of this neglected population. The program designed for the Texas Department of Correction -- whereby a relatively large unit has been established, where mentally retarded prisoners are housed and programmed separately from the general inmate population --

should be thoroughly investigated with reference to its applicability to New York's situation.

VIII. Learning Disabled Prisoners. This is another area where consensus exists that not enough is being done, often due to a lack of resources and personnel. In addition, DOCS has been accused of failing to plan for the system as a whole, utilizing a piecemeal approach, e.g., in attempts to secure additional psychometricians and special ed teachers for the population.

DOCS should develop a plan to address the issue of learning disabilities within all the prisons. The Department should make a realistic assessment of the total number of qualified testers needed to staff each reception/classification center, in order to properly determine the scope of inmates' disabilities. DOCS should then decide at which prisons -- maximum- as well as medium-security -- special ed teachers need to be added.

The Division of the Budget should fairly evaluate the DOCS system-wide plan. Additional funds should be made available, so that DOCS can hire the necessary staff immediately. The Department should not be forced to rely on personnel attrition in order to meet even the minimum needs of these disabled inmates.

IX. Parole. Parole's ability to supervise and service clients properly has been impeded by gaps in information and community resources. Both these problems areas should at least be somewhat alleviated by immediate implementation of changes that have already been projected. For instance, it is anticipated that a

number of newly designated Client Services Specialists, working within the five parole regions of the state, will determine where service gaps currently exist and make arrangements to fill those gaps. In the mental health area, we would expect OMH to ensure that OMH facilities, especially in areas outside the New York City metropolitan area, cooperate in developing and providing services to Parole, as needed.

X. Office of Vocational Rehabilitation. Problems involved with coordinating OVR services to qualified handicapped individuals within the prisons or on parole apparently are two-fold: the testing and assessment process prior to assignment to a job-training program may be as long as two months, and no stipends are paid to clients in training programs lasting as long as a year. For one or both reasons, individuals who have spent time in prison tend to become discouraged and drop off the OVR roster. Therefore, we recommend the following:

1) A system should be established whereby eligible inmates can be evaluated for OVR services while they are still in prison, rather than after they are released. Valuable time can thereby be saved and the chances that services will actually be received when needed will be increased. DOCS, Parole and OVR should reach a decision regarding the practicality of the current OVR/RMS proposal to achieve this purpose, or another arrangement should be negotiated between the relevant agencies in the near future.

2) A mechanism should be established whereby parolees will be eligible for financial stipends during the period they are enrolled in OVR job-training, in order to increase the numbers of eligible handicapped parolees who participate in these programs.

XI. Residential Community Programs. Residential services are probably the biggest gap in the community mental health delivery system, and it is essentially impossible for mentally impaired offenders to qualify for residential services once they are released from prison, particularly if they have been convicted of a violent crime. Although the State is developing additional community residences for the total at-need population, there is no indication that special residential services will be developed for mentally ill and/or mentally retarded ex-offenders.

The only way this population is likely to receive these needed services any time in the future is if the State establishes special residential programs for them. Clearly, developing a system for this population will not be easy, but it is necessary. In addition, there is no indication that such a residential system need be particularly large. We therefore urge the State to assess the scope of the need and to develop appropriate residential spaces accordingly.

CONCLUSION

Implementation of these recommendations will help insure that mentally impaired inmates within New York's prisons receive the level of care they require, humane and practical considerations demand, and the State is capable of providing. We do not believe these proposals represent the only, or necessarily the best, means to provide such insurance. However, there is no question that a well-planned course of action for these handicapped offenders needs to be developed which will demand the cooperation and coordination of a number of agencies and departments.

Therefore, we urge State officials to make an immediate commitment to this goal, and to implement the proposals we have made, or design others to achieve these ends. The prison system, and ultimately society as a whole, will reap enormous benefits as a result.