

Psychotropic Control of Women Prisoners: The Perpetuation of Abuse of Imprisoned Women

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Abstract

Adding to the multifaceted and interacting challenges that many imprisoned women endure are the high rates of mental health problems that are rising to a level of “special report” status and discussion (Bureau of Justice Statistics, 2006). Here, the mental health problems of vulnerable women are exacerbated by the stressful nature of prison and the questionable administering of psychotropic drugs to incarcerated women. The purpose of this paper is to explore the use and potential abuse of the drugging of women “doing time” in American prisons.

About the Author

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Introduction

U.S. prisons and jails, packed with over two million inmates, hold many people that society would be wise to keep elsewhere. With state budgets bankrupted by the high costs of mass incarceration, the need to reconsider the draconian sentences meted out to nonviolent drug offenders is obvious. There is, however, another sizeable group of prisoners for which wholesale imprisonment is even less appropriate: the mentally ill or those treated as if mentally ill.

Despite good reasons to limit the incarceration of the mentally ill, their numbers behind bars continue to grow. Over the past few decades, the country's prisons and jails have become the default mental health system. The closing of psychiatric hospitals (known as de-institutionalization), the lack of community-based services for individuals with mental illness and the concomitant boom in prison construction over the past several decades have led to the massive confinement of people with mental illness. It is estimated that more than 200,000 - perhaps as many as 300,000 of the incarcerated population suffer from mental disorders, including such serious illnesses as schizophrenia, bipolar disorder, and major depression (Abramsky & Fellner, 2003). However, when other mental illnesses are included (i.e., such as anti-social personality disorder, borderline personality disorder and depression) along with individuals with undiagnosed mental health challenges, the number would rise.

While mental illness impacts both male and female prisoner populations, the statistics for female prisoners are especially stark. A special report by the Bureau of Justice Statistics (2006:4) based on a survey of prisoners found that “Female inmates had much higher rates of

mental health problems than male inmates. An estimated 73% of females in State prisons, compared to 55% of males inmates had a mental problem...In Federal prisons, the rate was 61% of females compared to 44% of males; and in local jails, 75% of females compared to 63% of male inmates.” Further, 62% of white females, 20% of black females and 22 % of Hispanic females in State prison were identified as mentally ill. Nearly four in ten white female inmates aged twenty-four or younger were mentally ill. Striking as they are, the Bureau of Justice Statistics (BJS) figures may not fully represent the extent of mental illness among incarcerated women. The purpose of this paper is to explore the mental health care needs and experiences of incarcerated women with an eye toward potential abuses of this group of women “doing time” in American prisons. Attention to the gender-specific mental health programming needs of women prisoners is imperative; hence, in order to design system wide services that match women’s specific strengths and needs, it is important to consider the demographics and history of the female offender population, and how various life factors impact women’s patterns of offending.

Demographic and Crime-Related Characteristics of Female Offenders

Currently, women represent the fastest growing segment of prison and jail populations even though their crime rate is not increasing dramatically. At year-end 2005, 111,403 women were imprisoned in state or federal prisons - 7.2% of the total prison population. Incarcerated women are characteristically women of color, poor, unemployed, and single mothers of young children. Imprisoned women tend to have fragmented families, other family members involved with the criminal justice system, significant substance abuse issues, and multiple physical and mental health problems (Bloom, Owen, & Covington, 2003). Often, an underlying cause of these problems is trauma that is associated with abuse. Women in prison have typically experienced

some form of abuse in their lifetime, including sexual assault, domestic violence, and sexual, physical, and psychological abuse. Fifty-seven percent of these women report physical or sexual abuse before imprisonment versus 16% percent of men (Little Hoover Commission, 2004).

Over the past three decades, women have gone to prison in record numbers. This does not necessarily mean, however, that their involvement in criminality has increased. Nearly half of all women in prison are currently serving a sentence for a non-violent crime. The increased incarceration of women appears to be the outcome of forces that have shaped U.S. crime policy over the past two decades: government policies prescribing simplistic, punitive enforcement responses for complex social problems; federal and state mandatory sentencing laws; and the public's fear of crime (even though crime in this country has been on the decline for nearly a decade). "Get tough" policies intended to target drug dealers and so-called kingpins, has resulted not only in more women being imprisoned, but also women are serving longer and harsher prison sentences. Unfortunately, the rise in imprisonment of women for drug-related crimes has not been met by a rise in addiction treatment and rehabilitation programs for these women.

Over-reliance on incarceration affects more than the women prisoners. Families and communities have been devastated by women's imprisonment. Nationally, it is estimated that between 70% and 80% of female inmates have dependent children at the time of their incarceration (Greenfeld & Snell, 1999; Watterson, 1996). The separation of a woman from her children not only affects the mother but has a substantial impact on her child's future as well. Children of inmates are five to six times more likely to become incarcerated than their peers (Bloom, 1993). Approximately 10% of children with incarcerated mothers are forced into the

foster care system, and 11% change caregivers at least twice (Dressel, Poterfield, & Barnhill, 1998). Visitation policies and the distance to prisons from their home communities make it difficult for children to visit. Seventy-nine percent of incarcerated mothers in California never receive a visit during their incarceration (Powell & Nolan, 2003). For women prisoners who have been the primary caretakers of young children, incarceration not only has an impact on their current relationships but also can create problems upon release. Thus, the level of contact maintained between imprisoned mothers and their children is of utmost concern (Sharp, 2003).

Special Needs of Women in Prison

Women in prison have multifaceted, interacting needs resulting from abuse (childhood and adult), addiction, low education levels, poor work histories, family disorganization, and poor health care (Girshick, 1999; Zaitzow, 2006). Their health problems typically predate their involvement in the criminal justice system, are often exacerbated while they are imprisoned, and continue to deteriorate after release. The street lifestyle of many female inmates (e.g., drug and alcohol abuse, poor diet, possibly indiscriminate sexual behavior, restricted access to medical services, and the tendency to neglect medical problems) means that women entering prison are likely to require medical attention and education to help them take better care of themselves on release to the community (Acoca, 1998).

In addition to physical effects of drug use, addicted offenders may suffer from numerous psychological and emotional effects. Mental health problems including suicidal thoughts, attempts, or completion, depression, poor conduct, and personality disorders are but a few of the possible drug-related mental health challenges facing correctional mental health workers today. And for the women who “do the time,” with little or no effective mental health treatment and

support, they are forced to navigate on their own in prison environments that pose unique challenges for them.

For many women, prison may be the first circumstance in which they have been able to access resources, in particular substance abuse treatment, reproductive and physical, dental and vision health care, and mental health counseling. Even though women often receive better health care in prison than on the outside, service delivery in prison remains woefully inadequate and sometimes deadly. A review of existing studies on health care services for women inmates reveals that (1) access to treatment for both general and drug-related health problems is limited; (2) the health care provided to women prisoners is mediocre; and (3) prison medical professionals are often under-skilled (Maeve, 1999; Lindquist & Linquist, 1999). The implementation of innovative in-house medical treatment for women has been unable to keep pace with the diverse needs of the ever-increasing population. Such issues have been the subject of litigation. Even when the courts uphold the inmates' petition for better medical attention, however, prison administrators react slowly to the court orders (Muraskin, 1993).

Mental Health/Illness Issues

Numerous studies and surveys have documented the rise in the incarceration of the mentally ill. In any year, millions of American adults have a serious mental illness - about five to seven percent of the adult US population, according to several nationally representative studies (US Department of Health and Human Services, 2004). The overlap in the populations that the corrections and mental health systems serve is significant: the Bureau of Justice Statistics estimates that sixteen percent of adult inmates in state prisons and local jails are mentally ill. There are three times as many mentally ill people in prisons than in mental health hospitals, and

the rate of mental illness in prisons is two to four times greater than in the general public.

I have been superintendent of the Bedford Hills Correctional Facility in New York State for 17 years. During that period of time, I have seen the number of mentally ill women entering the prison system rise precipitously. Where once mental institutions kept patients for long periods in back wards, today the burden of providing for mentally ill people who have committed crimes has shifted to the correctional system. It is clear that prisons must adapt by creating more appropriate environments for these inmates — as long as society believes that is where mentally ill inmates should be maintained (Elaine Lord, superintendent, Bedford Hills Correctional Facility, New York, 2002:368).

Frequently, the symptoms of mental illness contribute to individuals becoming involved with the criminal justice system in the first place and keep them incarcerated longer than other people. In addition, the stressful setting of a correctional facility can exacerbate mental illness and disrupt treatment.

Not only is the number of prisoners with mental illness growing, but more persons are being incarcerated whose illnesses fall at the most severe end of the mental illness spectrum. Gloria Henry, warden of Valley State Prison for Women, California's largest prison for female prisoners, also points to the severity of the mental conditions of incarcerated women:

I don't know how [some of these women] were sentenced to prison. They have no understanding of why they are in prison. I don't know what purpose it serves. To some degree the services will be limited, because this is a prison, not a state hospital. We're having to adjust and make changes to accommodate mental health (Abramsky, 2008:3).

Many female inmates report experiencing previous abuse and trauma prior to any involvement with the criminal justice system. Distinguishing symptoms of mental illness from the trauma imposed on a female inmate by past adverse events may be impossible. In a recent survey of California female inmates, researchers found that women who reported childhood traumatic events were 40% more likely to receive mental healthcare services (Messina & Grella,

2006). Unfortunately, many prisons lack resources to provide mental health counseling to all female inmates who seek to recover from past trauma (Sobel, 1982).

The mentally ill in prison, as in the world outside prison, suffer from a wide array of mental disorders serious enough to require psychiatric treatment. The symptoms of some prisoners with serious mental illness are subtle, discernable only by clinicians. This is particularly true for prisoners suffering serious depression, who may just appear withdrawn and unsociable to other prisoners and staff. But the serious mental illness of some prisoners is easily identified even by the layman: they rub feces on themselves, bite chunks of flesh from their bodies, slash themselves, hallucinate, rant and rave, mumble incoherently, stare fixedly at the walls.

R.M. was twenty years old when Human Rights Watch interviewed her at Chittendon where she was being held in an administrative segregation cell. Inside the facility, R.M., who is a heroin addict and who was severely sexually abused as a child, hurts herself on a regular basis. Her arms are criss-crossed with raw, red cuts. One of her legs ... had a big, bloody, open wound. R.M. stated that she jabs pencils into her limbs, that she cuts herself with razors, and that she sticks staples, retrieved from the bindings of magazines, into her open wounds. She also smashes her head against the walls of her cell when she gets agitated. Ill with serious diabetes, R.M. confided her desire to kill herself by depriving herself of needed diabetes medications. "I'm going to kill myself here and they don't care...I know how to do it. I can. I swallowed a pencil the other day...That was fun. I shove things in my legs all the time and they don't care." R.M. expressed a desire to return to the state mental hospital. "I wish I could," she says, pouting like a child. "They don't have enough staff. It's ok. If they don't take me, I'm going to kill myself" (Human Rights Watch, 2002).

While many of the mentally ill in prison do not suffer major impairments in their ability to function, some are so sick they live in a world entirely constructed around their delusions. In such cases, it may be appropriate to prescribe psychotropic medications to female inmates who

display unquestionable mental illness symptoms. But, inmates should be assessed for other services as well. Prescribing psychotropic medication to an inmate complaining of depression may provide short-term comfort; however, psychotropic medications only treat biomedical psychological conditions, and may not have long-term therapeutic effects. Here, a well-managed, humane, treatment-oriented prison setting along with well-trained staff may provide a unique opportunity to provide inmates with psychological therapy and counseling to empower female inmates through healing.

Psychotropic Control of Women Prisoners

Most information regarding the control of women prisoners through psychotropic medications is learned through inmate self-reporting and reports by human rights groups. It is unlikely that institutions will reveal the purposeful drugging of female inmates as a means of coercion. Establishing that women prisoners are intentionally provided psychotropic medications for controlling purposes is difficult because few whistle-blowers have come forward (Valios, 2002). Still, various sources have expressed concern that psychotropic drugs - medication for the treatment of serious psychiatric illness - are sometimes used improperly to control and sedate inmates rather than as medication for psychiatric conditions. For example, women in a California prison reported that they were pressured into taking psychotropic medication while detained in jail before being tried. A number of women prisoners stated that drugs were often ordered by people - including correctional officers - who are not qualified to diagnose the psychiatric conditions for which the medications are appropriate treatment and who are not legally permitted to prescribe medications (Auerhahn & Leonard, 2000). Some of the women in the study reported that the amount and mixture of drugs made it difficult for them to

comprehend what was happening and adversely affected their ability to function during their trial.

Lawyers in California, Illinois and Pennsylvania have also told Amnesty International that they have had clients who were so heavily drugged the lawyers had considerable difficulty communicating with them. A lawyer representing inmates at Valley State Prison for Women has drawn the issue to the attention of the United Nations Special Rapporteur on Violence Against Women:

Rather than consistent treatment, women are prescribed heavy doses of psychotropic medications...I interviewed one mentally disabled woman who was so heavily drugged that she shook almost uncontrollably and could hardly speak throughout the interview. The relative incapacitation that accompanies such high doses of psychotropic medication renders women extremely vulnerable to sexual abuse and harassment (Shaylor, 1998).

Prison mental health services are strained due to limited staff and resources, and the growing population of female inmates. Providing psychotropic medications to “troubled” inmates may appear to be the sole strategy to treating mentally ill female inmates, due to convenience and limited therapeutic resources.

Four categories constitute psychotropic medication; (1) antipsychotic medications treating psychoses (such as schizophrenia); (2) anti-depressants; (3) lithium (bipolar disorder); and (4) anti-anxiety medications (Floyd, 1990). In addition to providing relief to specific symptoms of mental illness, psychotropic medications produce a highly sedative effect in users (Valios, 2002; Floyd 1990). The powerful effects of psychotropic medications can easily be used to subjugate female inmates.

The line between the treatment of mental illness and the chemical control of behavior is a fine one and the temptation to use psychotropic

drugs improperly in prison is great: drugs are more efficient than physical restraints and require less commitment of staff and time. Furthermore, prisons are closed institutions to which the public and the media have limited access, such that abuses can go unnoticed (Floyd, 1990:1254).

Many adverse side effects are attributed to psychotropic medications, including but not limited to altered sleep pattern, tardive dyskinesia, muscular rigidity, constipation, sexual dysfunction, seizures, depression, increased risk of suicide, dry mouth, diarrhea, abdominal pain, nausea, and vomiting (Valios, 2002; Floyd 1990). Inappropriate administration of psychotropic medications can further impair the functioning of the patient. Advances in the psychopharmacological field have produced a new generation of psychotropic drugs that result in less adverse side effects. Despite this innovation, however, most prisons employ the older medications which are less expensive (Auerhahn & Leonard, 2000; Council of State Governments, 2002).

In a 2006 briefing submitted to the United Nations Committee Against Torture, Dr. Christina Vogt described instances of negligence and abuse related to psychotropic medications distributed to female inmates. After interviewing several women seeking psychiatric services in prison, Dr. Vogt suspected some women were malingering in order to access psychotropic medications. Dr. Vogt reported that “most women would eventually reveal the truth: prison and jail doctors had prescribed them drugs without concern for the veracity of their symptoms.” In one instance, a physician jokingly called himself the “Candy-Man” because of his propensity to dispense unwarranted psychotropic medications to women prisoners. Dr. Vogt also reported instances where women were reportedly given medication by doctors so that the female inmates could “sleep their time away.” Dr. Vogt noted that many inmates that needed psychotropic medications were given erroneously high dosages which resulted in “drooling, falling asleep

during normal routines and staring blankly into space for long periods of time.”

The “war on drugs” targets substance abusers and has resulted in the incarceration of many addicted women. Mentally ill individuals may be especially susceptible to substance abuse resulting from attempts to self-medicate and control symptoms as access to legitimate health care resources are typically limited or unavailable. Many female inmates have stated that psychotropic medications are widely distributed to inmates by correctional personnel. In some instances, correctional officers even screen women inmates for possible mental health treatment. If correctional facilities are responding to the “war on drugs” by teaching female inmates to rely on psychotropic medications for daily coping mechanisms, then the criminal justice system is doing no more than trading one drug for another (Vogt, 2006).

In *Washington v. Harper*, the United States Supreme Court recognized the right of inmates to refuse psychotropic medication. However, the Court determined that the right to refuse medication is trumped if the government determines medication furthers a “legitimate penological interest. . . . [including] maintenance of order in the prison environment” (Auerhahn & Leonard, 2000). The Court determined that due process does not require a formal hearing to determine whether or not a prisoner may refuse medication, but an inmate is entitled to an informal hearing with the assistance of a layperson (Ibid.). This attempt at pseudo-due process is unacceptable for a civilized nation that takes great pride in bragging about the constitutional rights and protections afforded all individuals but especially for those who fall into the “protected class of citizen” category, namely, women prisoners.

The Prison Experience Exacerbates Mental Illness: Experiences/Voices >From The Inside

For people with serious brain disorders, the effects of being in prison are occasionally

positive, but more often negative. Interestingly, many of those who claim that it was positive, do so because they found being incarcerated was the only way they could get psychiatric treatment. Such cases are the exceptions, however. Prisons usually exacerbate psychiatric symptoms, both because individuals with serious brain disorders are frequently placed in solitary confinement and because they often are not given the necessary medication to control their symptoms.

In a series of disturbing passages, a Human Rights Watch report (Abramsky & Fellner, 2003) described the abuses endured by the mentally ill while incarcerated. To begin with, few prisons or jails have sufficient numbers of trained staff to accommodate prisoners' mental health needs. As a result, many mentally ill prisoners go untreated, or receive treatment that is extremely limited in both quantity and quality.

From other prisoners, who label them "dings" or "bugs," the mentally ill are vulnerable to assault, sexual abuse, exploitation, and extortion. From security staff, who frequently dismiss their symptoms as faking or manipulation, they may face physical abuse and mental harassment. Human Rights Watch cited numerous cases of correctional officers who taunted mentally ill prisoners, deliberately provoked them, physically mistreated them, used force against them maliciously, or turned a blind eye to abuses against them by others. Not only is the experience of imprisonment counter-therapeutic for such prisoners, many mental health experts believe that it dramatically increases their chances of psychiatric breakdown.

A woman inmate's feeling of inadequacy may be heightened by the constant surveillance under which she is kept. The prisoner is confronted daily with the fact that she has been stripped of her membership in society at large, and then stands condemned as an outcast and outlaw such that she must be kept closely guarded and watched day and night. She loses the

privilege of being trusted and her every act is viewed with suspicion by the guards. The experience of being incarcerated - of having one's self-esteem stripped away, of being deprived of regular contact with the outside world - plays havoc on one's mental and emotional well-being. Because of prior emotional problems or those induced by the stresses of incarceration, especially the separation from their children or loved ones, female inmates are more likely to engage in self-aggression, including suicide and self-mutilation (Pollock, 1998).

Serving time is, for anyone, a harsh and stressful experience. For incarcerated women suffering from mental illness, the experience can be nightmarish. Not only is the prison environment dangerous, loud and sometimes chaotic, but treatment resources are scarce. For many incarcerated women with mental illness, the "doing time" experience can be life-threatening. These inmates often prove to be ill equipped to cope with the stresses and rules of prison life.

Kristine Flynn is an inmate at Taycheedah Correctional Institution, the largest women's prison in Wisconsin. Flynn is diagnosed with bipolar mood disorder and social anxiety syndrome. A recent class action complaint filed on behalf of Taycheedah Correctional Institution inmates revealed that in one year, Flynn "was prescribed eight different psychotropic medications, taking many of them simultaneously, including Valium, lithium, Seroquel, trazadone, Haldol, Klonopin, Paxil, and Depakote." In 2002, the prison's psychiatric staff ceased all Flynn's psychotropic medication. When Flynn attempted suicide six days later, she was sent to a local hospital where she took a hostage and assaulted a security guard. A psychiatrist testified at trial that the assault should be attributed to the fact that she was suddenly taken off her psychotropic medications. Despite this assessment, she was sentenced to an additional four years of imprisonment, and moved to a segregation unit. In 2003, a correctional officer failed to deliver her psychotropic medicine and she attempted suicide again. In 2005, she requested treatment for battered women's syndrome and child abuse, but was refused. As of 2005, she had never received any group or individual counseling (American Civil Liberties Union, 2006).

Equally serious, a disproportionate number of prisoners with mental illness are housed in solitary confinement. In New York, nearly one-fifth of the inmates in disciplinary lockdown units suffer from mental illness, according to figures from the Office of Mental Health (OMH). They are locked in a cell 23 hours a day with little natural light, minimal human contact and few, if any, activities to occupy their time. Inmates whose prison sentences expire while they are housed in these units are released directly to society after months or years of isolation.

Supermax Control: America's Dirty Little Secret

In the past few years, many states have built "super-maximum security" (or "supermax") facilities designed to house prisoners in long-term isolation in particularly restrictive conditions. Viewing mentally ill or disturbed women prisoners as difficult and disruptive, many state correctional staff place them in these barren high-security supermax solitary confinement units despite evidence that has shown that prolonged isolation in conditions of reduced sensory stimulation can exacerbate their disorders and cause marked psychological and physical harm. Health experts who have examined prisoners in isolation have documented symptoms including acute anxiety and panic attacks, hallucinations, sudden violent outbursts, self-mutilation, difficulty with concentration and memory, deteriorating vision and weight loss. Moreover, the length of time inmates are assigned to such units varies, but some prisoners spend years, or even their whole sentence, in isolation. Held in small, sometimes windowless cells, these inmates are deprived of nearly all human interaction and have extremely limited mental stimulus as they are not allowed to work or participate in other programs. The facilities are designed to minimize contact between staff and inmates, and prisoners are often subjected to regimes of extreme social isolation and reduced sensory stimulation. Research shows that an extended stay in segregation

is harmful to such individuals and makes it more difficult to treat them successfully once they return to the general prison population or are released to the community (Haney 2003).

While the majority of prisoners in supermax units are men, several states have constructed similar facilities for women prisoners or rely on sections of the male supermax institutions to house women. According to prison experts, mentally ill prisoners are often more likely than other inmates to end up in such units because of behavioral problems and because prisons lack adequate mental health treatment programs. Women prisoners, especially, rarely fit the criteria most commonly given by the authorities for justifying such units (a history of prison gang-related activities, escapes or violent assaults).

A Real-Life Example: Helen

In order to understand the seriousness of the problems confronting women prisoners with mental health challenges, meet Helen. Helen is all too familiar with life in the control unit. For almost four years, she was subjected to the relentless monotony and sensory deprivation of isolation in the Security Housing Unit at Valley State Prison for Women:

Her only human contact consisted of taking food trays through a slot in her door and listening to lewd comments and threats of sexual violence from male guards. Basic human needs, such as toilet paper and sanitary napkins, were doled out at the whim of guards; often they were withheld. She was denied regular medical treatment and visits with her family. Initially confined to the unit for a nonviolent altercation with a guard, her SHU sentence was repeatedly extended.

Guards watched her while she showered, changed her clothes or used the toilet. She was subjected to humiliating strip searches in front of male guards and threatened with disciplinary actions if she complained. She grew increasingly depressed. Despite the well-documented psychological damage caused by SHU confinement, she did not receive regular mental health treatment. Instead, she was given several psychotropic drugs --

medications that require close monitoring in order to be effective. She received no regular follow-up care, however, and instead of helping her, the drugs caused extreme mood swings, anxiety and other symptoms that contributed to her deep depression and listlessness.

During her imprisonment, she worried about her four children constantly. At the beginning of her prison term she saw them rarely; once confined to the SHU, she could communicate only through letters. On the few occasions when she left her cell, she often returned to find it upended and photographs of her kids, the only link she had to the world outside, missing.

For Helen, confinement in the SHU replicated the abuse she suffered outside of prison. As a child she witnessed her father brutalize her mother, and as an adult she was severely beaten and raped by an abusive man. When she finally fought back and killed her batterer, she was given an 11-year prison sentence.

As a result of her SHU term, “I feel like I have been shattered into a million little pieces,” Helen said. “The threats of violence, the constant sexual abuse, the complete powerlessness that I experienced in an abusive relationship were still in my life, only in the SHU, it's the state that is doing it.”

After serving a decade in prison, instead of being released at the end of her sentence, Helen was charged with several counts of “battery on a peace officer.” These alleged incidents, which had been used to justify her SHU confinement, ranged from spitting to throwing water at guards. Despite the pettiness of the alleged offenses, they were referred to the district attorney's office to be prosecuted as felonies; each carried a potential six-year sentence. Helen found herself facing an additional 24 years, even though she'd served the last four years of her sentence in the SHU to “pay” for the incidents.

As the use of control units expands, such charges are becoming increasingly common. But psychologists say expressions of frustration are inevitable reactions to prolonged isolation. These behaviors, which in some instances represent challenges to the abuses of the system and in others signify the deterioration of mental health caused by the SHU itself, are used to justify keeping prisoners in control units indefinitely.

“In the SHU, I felt like they were trying to take away part of my identity,” Helen said. “Your sense of creativity gets lost, your sense of identity gets lost. All I could do was just try to hold on to those fundamental things. I was fighting so hard just to hang on to a sense of self.”

Only as the result of a consistent, coordinated advocacy effort was she eventually released. But most prisoners do not have such advocates working on their behalf. Helen was released at 5 p.m. on a Friday night with only \$3 in her pocket and a garbage bag full of her possessions. “I have suffered so much in my life and losing my freedom and time with my kids was punishment enough,” Helen said. “Now all I want is to try to pick up the pieces and move on, but the system made that almost impossible.”

“Letting someone out of prison with no resources and no place to go is clearly a set-up for a return to prison,” said Lauren Leslie, litigation coordinator at Legal Services for Prisoners With Children. “But this is what most prisoners face when they get out.”

Helen's transition to the world outside has not been easy. “Most people don't even know the SHU exists, much less understand what it does to you,” she said. “When I was in the SHU, I felt like I was on another planet. Now, just trying to adjust to the kinds of things people do every day is incredibly hard. You get very angry easily; you have a really short fuse. You're afraid of doing things that come so easily to most people. I haven't cooked a meal for myself in over 10 years. At this point, I am still afraid to use the stove.”

“In addition, your senses are so deprived in there. Your sense of touch, your sense of smell, get lost. I am slowly getting that back. Now, being able to pet a cat or hold a baby, things that most people do every day without thinking, are like small miracles” (Shaylor, 2000).

Although few recent studies have been undertaken of women in supermax facilities, the evidence in some states bears out the above concerns. A 1996 survey of 14 women held in a special unit in Colorado State Penitentiary (CSP), an otherwise all-male facility, found that 11 of the women were serving sentences for minor, non-violent felonies such as theft, forgery and substance abuse. Many of them had been sent to CSP for relatively minor disciplinary infractions and were mentally ill or had histories of mental illness. Yet, their conditions were extremely punitive and included 23-hour cellular confinement, with solitary exercise taken in a small cell

equipped (like those in the men's units) with only with a chin-up bar bolted to the wall. No outdoor exercise was provided. The shower unit had glass windows which exposed the women to the view of the predominantly male guards. The Security Housing Unit in Valley State Prison for Women, California, raises similar concerns.

In addition to the harsh physical conditions, the operation of some high security units for women violates standards on privacy and human dignity, as the women are able to be observed at all times by male guards. The isolated nature of these units may increase opportunities for abuse. Some of the more oppressive conditions - constant surveillance, lack of privacy, the use of restraints and frequent strip searches - continue to be found in some high security units for women.

In such harsh conditions, some mentally ill prisoners deteriorate so severely that they must be removed to hospitals for acute psychiatric care. But after their condition stabilizes, they are frequently returned to the same segregation units until the next psychiatric episode occurs. Prisons were never intended to be mental hospitals, and fiscally strained Departments of Correction generally lack the funds to provide adequate treatment to the growing number of inmates with mental illness. Thus, inmates who enter the system with pre-existing mental disorders sometimes leave more ill than when they entered.

Three federal courts have determined that some conditions of isolation may constitute cruel and unusual punishment when the individuals being held in those conditions are mentally ill (*Jones 'El v. Berge* 2001, *Ruiz v. Johnson* 1999, and *Madrid v. Gomez* 1995). The American Correctional Association warns that "inmates whose movements are restricted in segregation units may develop symptoms of acute anxiety or other mental problems" and recommends

regular psychological assessments of these prisoners (Standard 4-4256). The ACA standards should be strengthened to specify what facilities must do when someone with a mental illness ends up in segregation.

Change is slow but corrections administrators in many cities and counties around the country (e.g., in Iowa, New Mexico, Ohio, Oregon, Pennsylvania, and other states) are making progress to improve both policy and practice by diverting mentally ill prisoners from segregation units, in part, by a promising collaboration of criminal justice, law enforcement, and mental health treatment and advocacy groups coordinated by the Council of State Governments (2002). Even though diversion works, the mentally ill can end up in therapeutic units where they are locked in their cells nearly all of the time because facilities lack staffing and other resources to treat them in a less restrictive setting. Correctional systems must build on achievements to date and expand the use of rigorous screening and assessment tools to identify mentally ill prisoners who cannot cope with the conditions in segregation. Caring for those who cannot be housed in the general prisoner population requires investing in secure therapeutic units inside prisons and jails staffed by mental health professionals who can handle troubled individuals without locking them in their cells all day. We must also expand the capacity of community mental health resources to care for mentally ill persons before they become mentally ill prisoners.

Prison Mental Health Care Should Be A Public Concern

Without a change in the culture of the American correctional mental health care system, policy recommendations are meaningless. The problems with prison health care in general and mental health care in particular are both well-documented and well entrenched. No policy recommendation has the power to reform the system; any attempt to fix the unconstitutional and

embarrassing state of the prison mental health care system must begin by repairing the system's culture of failure. Once the correctional system's culture of failure is replaced with accountability and responsibility, several other specific changes must also be implemented: (1) some form of diversion from the penal system; (2) flexible, fully-funded, coordinated provision of care in prisons, including information systems and managerial oversight designed to ensure compliance with standards of care; (3) an expansion of programs targeting the mentally ill and specific subgroups therein; and (4) an expansion of post-release programs as outlined below:

1. Promote Alternatives to Prison.

Because people with mental illness tend to get sicker in prison, all efforts should be made to divert them from incarceration where practical. These efforts should include implementation of programs encouraging diversion from the criminal justice system, expansion of treatment resources outside the penal context, and, perhaps most radically, treating mental illness as a public health problem whether the person with mental illness is in prison or outside it.

Diversion saves money and improves outcomes. Whenever the mentally ill come into contact with the criminal justice system, diversion should always be an option. Police should be trained to de-escalate conflicts with the mentally ill and should be encouraged to refer the individuals they encounter to the Department of Mental Health; 911-emergency dispatchers should also send trained mental health professionals to respond to calls believed to have a mental health component (Council of State Government, 2002). Before trial, some mentally ill defendants should be diverted from prosecution into treatment or from criminal court to a mental health court. Mental health courts in particular, by combining law enforcement and social services in a therapeutic approach, have proven particularly effective.

Non-penal forms of mental health treatment must receive greater resources than they do now if diversion is to work; currently, the non-penal mental health infrastructure is vastly underfunded and underutilized. At the same time, civil commitment laws make it difficult for local officials to force a person with mental illness to get treatment. Without turning a blind eye to constitutional protections, intermediate treatment(s) for those unable to consent is needed. After all we do not tell cancer patients to come back if and when their disease has metastasized. But we turn mental health clients away and tell them to return when their symptoms are so severe and persistent that they cannot meet their own needs, and may no longer recognize that they need care. And, by that point, by squeezing the mentally ill out of civil treatment, they are shifted to a place where treatment both must be provided and cannot be refused: prison. The ironic result is that a deinstitutionalization policy borne of a desire to treat the mentally ill using the least restrictive alternative now puts them in the most restrictive environment possible. For diversion to work, there must ultimately be greater resources devoted to non-penal alternatives and better legal mechanisms for steering people with mental illness toward treatment.

Perhaps the most radical reform would be to treat mental illness as a public health problem—not as a criminal problem—regardless of the custodial status of those involved. Such an approach would encompass graduated sanctions and harm reduction in parole, but would extend to other factors as well. For example, if prisoners who suffer from mental illness were treated through Medi-Cal or Medicaid, just as they were before and/or after incarceration, administration costs would decrease and continuity of care would improve. Prisoners would no longer need to face medication and therapeutic shortages as they got lost in the shuffle. Given the high rates of communicable diseases such as AIDS and hepatitis in the prison community,

coupled with the fact that most prisoners do eventually return to society whether their diseases are contagious or not, an epidemiological approach that treats prison populations as a subset of the larger population could gain traction.

Recent mental health initiatives, many of which exclude mentally ill offenders, indicates that there is a great need for leadership and education on this issue. The mentally ill do not somehow stop being ill once they are incarcerated; the fact that some people with mental illness commit crimes as a result of their mental illness does not make them less deserving—or less in need of—treatment. Focusing on the treatment needs of mentally ill offenders does not mean they should be “let off” and released from prison: they should not be and are not. They should be provided with the treatment necessary to address their unique challenges without compromising their dignity.

2. Implement a Flexible, Fully-Funded, Coordinated Mental Health Program in Prisons That Uses Data and Management Oversight to Ensure Quality Care is Provided.

Medical and therapeutic care programs must be flexible enough to accommodate the diverse needs of prisoners, funding must be secured to ensure that prison health care and programming is fully staffed, corrections officers must coordinate their priorities and operations to ensure that needless suffering is avoided, and information technology and management systems must ensure that programs are providing positive outcomes.

First, state-specific information technology and data collection needs to be revamped. Without better information, an accurate diagnosis of the system’s ills is impossible. In general, more data needs to be standardized and shared, both within the prison system and among social service providers. Sharing information avoids duplication of effort and can realize efficiency

gains in a resource-strapped system; it also means that prisoners don't have to wait for treatment. Jails and prisons, in particular, must integrate their information since there is so much population migration between the two systems. The state should consider funding mental health screenings in county jails: this would eliminate the need for duplicate tests at reception centers and would help to standardize the information collected. Standardized information is of great assistance in maintaining effective release programs.

For those prisoners with pre-existing diagnoses, information must be shared between jails and prisons, or between social service providers and prisons. If the prisoner has been on medications outside the prison, every effort should be made to continue the identical medication; though many drugs perform the same function, side effects can be different. Since most patients' dissatisfaction with psychotropic medications focuses on the side effects of drugs, not their intended effects, changing drugs is both disorienting (in an already disorienting environment) and may lead to a decreased willingness to take medication.

Individual states need to track mentally ill county inmates, state prisoners and parolees across jurisdictions. The state should consider piggybacking mental health information onto one of the existing criminal justice databases—e.g. the Parole Automated Tracking System or the California Law Enforcement Telecommunications System (which tracks criminals across jurisdictional lines) - or apply for funds from the National Criminal History Improvement Program to computerize criminal history records. Any attempt to reform the state's correctional information technology must standardize databases and have a central administrator oversee the project, as recommended in 2004 by the Corrections Independent Review Panel. Ultimately, the information should be used to assess program effectiveness on an outcome basis.

The prison system must also screen prisoners already in custody to account for late-onset mental illness. Prison can trigger mental illness in some inmates who do not present symptoms at the time of intake, and protocols should be developed to ensure that late onset mental illness is identified and treated. This will include (1) streamlining administrative procedures to ensure prisoners easier access to treatment and (2) implementing systems for more accountability on the part of service providers.

Second, more resources for mental health treatment and programming in prison must be provided. It is clear that the mentally ill, once imprisoned, do not get the care that they need. One collateral effect of resource scarcity is that there are fewer resources to address inmates with non-acute psychological needs. “Inmates who need treatment for lesser problems, such as anger management and borderline personality disorders, rarely get it. That contributes to the great stress within the prison, and it frustrates inmates' opportunities for parole. One ingenious solution proposed to deal with staffing shortages would be to condition state medical education grants (or reduced rates on student loans) on recipients' agreeing to work in prison health care for a set period of time. In addition to providing needed services, the community at large would benefit as young doctors returned from their prison residencies with firsthand knowledge of what is really happening inside prisons.

Third, treatment can be improved by decentralizing its provision; prisoners are less likely to fall through the cracks if they do not have to be transferred from prison to prison. California concentrates mental health treatment in a few facilities, such as the California Medical Facility in Vacaville (42.3% of inmates are in twenty-four-hour psychiatric care, receive therapy/counseling

and take psychotropic medications) and the California Institution for Women (46.1% of inmates in therapy/counseling, 30.7% on psychotropic medications). Decentralization of treatment may yield better results: local treatment facilities capable of handling mental illness might provide greater flexibility to prison administrators and less disruption to mentally ill inmates, although decentralization might simply strain already scarce resources.

Fourth, health care providers should enlist corrections officers (COs) to be the first line of treatment for mentally ill prisoners. COs should receive more support and training for dealing with mentally ill prisoners, including training on mental health symptomology and pharmaceutical treatment. Jurisdictions outside California have experimented with different ways of imposing discipline on mentally ill prisoners to positive effect: behavior modification techniques engender order without as much confrontation as traditional techniques and seem to work better with mentally ill inmates, whose impulse control is not well established.

3. Tailor Programs to the Mentally Ill Population.

Programming must be expanded for mentally ill prisoners, and alternatives to standard policies, where appropriate, should be developed. This includes the possibility of separate housing for the mentally ill, separate disciplinary procedures, and an expansion of tailored post-release programs. Furthermore, individual sub-populations of mentally ill prisoners, particularly female prisoners with mental illness, need programming tailored to their particular needs.

Existing programs for the general population that are particularly effective for the mentally ill must be identified and mentally ill prisoners should be placed in them. At the same time, programming that is designed specifically for the mentally ill needs to be developed and

implemented. These programs must address not only post-release needs (self-care, job skills, information about federal and state post-release programs) but deeper psychological needs as well. Prisoners with co-occurring drug and alcohol abuse must be specifically targeted, since their rate of recidivism is much higher than that of either the mentally ill or the general prison populations. Moreover, many mentally ill prisoners have suffered from emotional, physical, and sexual abuse; counseling to address the legacy of abuse and help prisoners avoid becoming abusers themselves should also be developed and implemented.

Safety, discipline, and housing also need to be modified to reflect the reality of mentally ill prisoners. First, mentally ill prisoners are more likely to be victimized by other inmates and also more likely to violate prison rules. The result in both cases is often solitary confinement—either as punishment or protective custody. Given the harsh, decompensating effects of solitary confinement, alternatives to solitary confinement must be developed. Second, on a more general level, housing of the mentally ill should be done with their needs in mind. Some inmates should not be housed with the general population, both for their safety and for the safety of those around them. They might benefit from a regime in which somewhat less traditional disciplinary rules prevail—this would avoid the cycle of violations and solitary confinement without sacrificing officer safety. Women prisoners with mental illness should be provided with programs and training that focuses on the particular needs of women prisoners in the penal context.

4. Transform the Culture of Failure.

All parties with any involvement in the corrections system need to acknowledge openly that these problems have existed for many years, and that the system needs a major overhaul.

Every few years, new reports document the lack of record keeping, the inadequacy of mental health care, and the needless duplication of effort and expense that goes into the wasteful system, and yet year after year, nothing seems to change except the dates on the latest atrocious review of policies. Over ten years ago, Coleman (1995) described the prison mental health system in words that could apply with equal force today: “Defendants have been confronted repeatedly with plain evidence of real suffering caused by systemic deficiencies of a constitutional magnitude. Their responses have frequently occurred only under the pressure of this and other litigation” (1995:912). Litigation of these issues is expensive and removes any discretion from corrections officials. While this is a better alternative than keeping control in the hands of incompetent officials, it would be better still to address the problems proactively.

While these and other recommendations have been made by others, what is lacking is the administrative skill and political will to implement them. The citizens of every state—not merely its mentally ill prisoners—certainly deserve no less.

5. Re-Entry Planning Should Begin Upon Entry To Prison.

An often-overlooked aspect of incarceration is the “backdoor” of prisons, the re-entry of poorly prepared prisoners into the community. Nationally, over 600,000 prisoners are released to society every year. In New York, approximately 28,000 state inmates are released annually, some 3,000 or 11% of whom suffer from mental illness. Prospective neighbors and communities have a stake in prison mental health care, because the treatment inmates receive on the inside will affect their experiences and relationships on the outside.

Many former inmates will lack the resources to obtain treatment when released from prison. Upon re-entry, many former inmates will not have access to mental healthcare and will

not be able to afford the psychotropic medications provided in prison. These individuals will have to suddenly adapt to an outside world without the assistance of psychotropic medications. An abrupt cessation of psychotropic medications carries many undesired consequences. Pharmaceutical industry companies generally recommend tapering medications under the supervision of a physician, and specifically warn against an immediate termination.

Changing the serious and chronic medical and behavioral conditions with which inmates struggle requires intensive and long term change strategies which should be implemented from the beginning of incarceration until release. Preparation for reentry should begin early in a prison sentence using the time for education, skill building, behavior assessment and change, and medical treatment and interventions. Providing these resources reduces the risk that prisoners will commit crimes leading to re-incarceration and increases the safety, health and stability of the families and communities to which they return. Inmates have multiple needs which are significantly correlated with their criminal history, and mental health and medical problems. These needs include poor educational levels, lack of employment-related skills, mental illness, substance abuse, medical conditions, housing resources and family problems. When inmates are released without adequately addressing these needs through assessment, training and treatment, recidivism rates are high and the quality of community health and safety is negatively influenced. Furthermore, inmates returning to their communities frequently lack the skills or knowledge to seek services or have difficulty gaining access to the services they need. Thus, long term behavior change programs connected to re-entry services that begin pre release and offer a continuum of community-based services are essential if incarcerated clients are to effectively transition to the programs and services to which they are referred at release. It is

also imperative that a system be developed and fully implemented that ensures that prisoners be eligible to access Medicaid and other public benefits immediately upon release to ensure continuity of treatment and community stability.

Conclusion

Our correctional facilities have become inadequate and ill-prepared psychiatric wards-the largest purveyors of mental health services in the United States today. An unprecedented number of prisoners enter the system already in need of psychiatric attention, and countless others suffer emotional breakdowns inside as a result of the brutal, cruel, and inhumane treatment experienced behind bars. In prison, these women are subjected to ridicule, abuse, and punitive policies that worsen their psychiatric disorders and exacerbate an already explosive situation. Without adequate treatment, many wind up in punitive solitary confinement or subjecting themselves to a self-imposed isolation in their own cells-where their condition deteriorates. The result is a major hazard, not only to the prison population and their caretakers, but once released, these brutalized and broken individuals constitute a real and documented threat to our communities.

Eventually, a majority of mentally ill inmates are released back into the community, generally with a limited amount of medication, little preparation, and sometimes no family or support structure. "We release people with two weeks' worth of medication. Yet it appears that it's taking three months for people to actually get an appointment in the community to continue their services and if they don't have the energy and/or the insight to do that, they're going to fall through the cracks and end up back in some kind of criminal activity," warns Debbie

Nixon-Hughes, chief of the mental health bureau of the Ohio Department of Corrections.

As echoed in a 1999 Amnesty International report on the human rights of women prisoners, just because a woman has been deprived of her liberty does not mean she should be humiliated, abused, or treated inhumanely. While prisoners should have just as much right as everyone else to be treated humanely, in the United States, women are often the victims of prison regimes whose practices flout human dignity and international human rights standards.

The immeasurable human suffering caused by the mass incarceration of the mentally ill is not only inhumane, it is unnecessary. While some dangerous offenders must be confined to protect society, there are many low-level, nonviolent offenders with mental illness who could be safely diverted into community-based mental health treatment programs. By reducing the overall number of mentally ill prisoners, such programs would also free up prison resources that could be used to remedy the generally low quality of prison mental health care.

Numerous changes in prison policy, programs and procedures are necessary if mental health care in prisons is to improve. Many of these changes must occur within the prison institution to strengthen prisoner access to quality physical and mental health care (urgent care, preventive care, chronic care, specialty care) and health education materials. Other institutional changes must address the issues of assuring patient confidentiality, facilitating prisoners in taking partnership in their health care decisions and providing continuity of follow-up care, especially when an outside physician is consulted. Unfortunately, these types of changes may rely on transforming the prison culture. The mission of prisons may need to be redefined, correctional staff members retrained and the health care budget reevaluated.

Changes within the institution, however, cannot be isolated from changes in the

community at large. For example, to insure continuity of care for those released from prison, changes in prison mental health care must be accompanied by improvements in access to mental health care services in the greater community. Furthermore, the general public, in the form of oversight committees or accreditation organizations, must be more involved in reviewing the standards of care within prisons. In short, the general public and public mental health care systems may need to reevaluate how incarceration affects public mental health and redefine their own mission of building and maintaining healthy communities.

While the changes needed to improve prison mental health care may seem unattainable, there are ways that mental health care providers working with prisoners can impact the system and the mental health care of prisoners. The first step is developing knowledge about the institutional barriers that exist in providing quality mental health care in prisons. Defining the obstacles, however, must be combined with an understanding about the prisoner's background and the way that prison life fosters a milieu of fear and distrust. Evaluating and measuring these two factors, will set the foundation for successfully advocating for the mental health of a prisoner patient. Furthermore, it will establish the groundwork for effectively designing and implementing programs that have the potential to mitigate and remove the barriers to providing quality mental health care in prison.

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