LOCKDOWN NEW YORK:
Disciplinary Confinement in New York State Prisons

A report by the Correctional Association of New York

EXECUTIVE SUMMARY

MAJOR FINDINGS

The findings from Correctional Association visits to nearly every disciplinary housing unit in New York – 49 visits to 26 lockdown units – reveal a disturbing picture characterized by emotional and physical distress, a reliance on warehousing instead of treatment, high rates of mental illness, suicide and self-mutilation, low staff moral and unsafe working conditions for prison guards and administrative staff.

New York prisons confine nearly 5,000 inmates, 7.6% of the total inmate population, in highly restrictive disciplinary lockdown units for 23 to 24 hours per day. Minimal human contact occurs inside lockdown facilities where there is little natural light and virtually nothing for inmates to do. The enforced idleness and reduced environmental stimulation can last for months or years and lead to severe psychological debilitation.

Some of the troubling realities of disciplinary lockdown are:

- By state estimate, nearly a quarter of the inmates in disciplinary lockdown system-wide are on the mental health caseload. In some units that we visited, over half of the inmates in solitary confinement were identified as seriously mentally ill.

- Between 1998 and 2001, over half of the system's 48 suicides occurred in 23-hour lockdown, although inmates in these units comprise less than 10% of the general population. Of the 258 inmates in our research sample, 44% reported previous suicide attempts while in prison and 20% had prior admissions to the psychiatric hospital.

- Department figures show that incidents of self-harm rose by 66% between 1995 and 2000. Of the 258 inmates we interviewed over one-third reported committing acts of self-mutilation while in prison. Unthinkable to outside observers, the Department issues misbehavior reports to inmates who attempt to kill or harm themselves.

- Although there are nearly 1,000 New York inmates with mental illness in disciplinary segregation, the prison system's sole psychiatric hospital, Central New York Psychiatric Center (CNYPC), has space for only about 200 inmate-patients. The CNYPC has not increased its capacity since it opened in 1980, although the prisoner population has tripled over that time.

- To punish inmates in lockdown who continue to violate rules, corrections officials utilize increasingly punitive "deprivation orders," most commonly time loss of recreation, loss of showers, and the use of mechanical restraints (handcuffs and waist chain) during recreation. The most severe punishment is the restricted diet, or "the loaf" where inmates are fed a dense, binding, unpalatable one-pound loaf of bread and a side portion of raw cabbage three times a day for seven days straight, followed by two days off.

- While the Department claims that deprivation orders are used infrequently and for only the most incorrigible inmates, nearly half (49%) of the inmates in our sample received "deprivation orders" for violating rules while in lockdown. Forty-one percent reported receiving four or more.

- Between 1997 and 2000, New York built ten high-tech, total lockdown facilities, representing the most dramatic expansion of high-security housing in state history. Construction costs alone ran to $238 million.

- If their prison sentence ends before their term in disciplinary confinement, prisoners are released, without any reorientation program, directly from the isolation of a disciplinary housing unit to the community.

- Disciplinary confinement often takes a heavy toll on correction officers. Officers in some units are stabbed, spat at, assaulted or "thrown at." Some officers use antidepressants to cope with the stressful and depressing nature of the job.

- New York's lockdown units provide few meaningful programs in which inmates can engage, no jobs to perform, or opportunities for socialization to determine their preparedness for release to general population or society.

The Department *has* demonstrated a capacity for responding positively to the grave problems plaguing NYS's lockdown units:

- Some disciplinary units, notably those at Greene, Shawangunk, Sing Sing, Sullivan, and Woodbourne Correctional Facilities, are markedly calm and quiet and commended by officers and inmates. Common to these cellblocks are the small number of inmates, an experienced and attentive correctional staff, regular rounds by mental health personnel, and sufficient coordination between correction officers and counselors.

- Some lockdown units offer a "behavior modification" system, known as Progressive Inmate Movement System (PIMS), that enables prisoners to earn time cuts in disciplinary confinement.

- Along with the Office of Mental Health, the Department has developed a small program for inmates with mental illness that provides them with mental health

services and enables them to earn their way out of lockdown. Known as STP for Special Treatment Program, the initiative was piloted at Attica, recently expanded to Five Points, and serves a total of 45 inmates.

PRINCIPAL RECOMMENDATIONS

There is great potential for misuse of authority, violation of policies, and abuse of both inmates and staff in lockdown facilities. Lacking extraordinarily careful measures to mitigate against these factors, these units can become breeding grounds for cruel behavior and callous indifference to human suffering. The Governor and other state policymakers should take bold action to address the grave deficiencies that characterize conditions inside these prisons within New York's prison system.

- **Create a permanent, independent oversight board with the authority to monitor conditions in 23-hour lockdown units.** The review board should conduct monitoring visits, make unannounced inspections, investigate complaints, evaluate compliance with directives and report findings and recommendations annually to the governor, the legislature and the public.

- **Regularly review the inmate death reports published by the New York State Commission of Correction and implement its recommendations.** These carefully considered recommendations often go unheeded, because no entity requires their implementation. The Governor's Director of Criminal Justice should review the Commission's reports and hold prison and mental health officials accountable for making necessary reforms.

- **Provide appropriate housing for mentally ill prisoners** by enacting the bill introduced by Assemblymember Jeffrion Aubry (D-Queens), Chair of the Corrections Committee, that prohibits confining inmates with serious mental illness in 23-hour lockdown units and provides the resources for creating correctional psychiatric facilities.

- **Institute a suicide prevention program in every 23-hour lockdown unit, including keeplock.** A properly administered suicide prevention program could mean the difference between life and death for inmates in 23-hour lockdown.

- **End practices of mechanically restraining inmates during recreation, of punishing inmates with a restricted diet of bread and raw cabbage, and of penalizing inmates for acts of self-harm.**

- **Provide meaningful programs to inmates in lockdown.** The state can increase public and prison safety by requiring inmates to participate in group activity prior to their release. No inmate should be released directly from lockdown to general population or society before participating in congregate activities that help prepare them, and determine their readiness, for release.

- **Restrict the use of disciplinary lockdown to inmates who commit serious offenses.** The National Institute of Corrections of the U.S. Department of Justice asserts that lockdown facilities are inappropriate for the "nuisance inmate." DOCS should limit the use of long-term disciplinary lockdown to the most serious disciplinary cases.

- **Avoid double-celling of lockdown inmates to the extent practicable**, including using cell-blocks in the new high-tech prisons for drug treatment programs or other purposes, and take all necessary steps to ensure that inmates with a capacity for violent behavior are not double-celled.

- **Allocate the resources needed to expand the capacity of CNYPC** so that the prison system can better accommodate the treatment needs of severely mentally ill inmates.

- **Increase funding for the Special Treatment Program that provides therapeutic services for mentally ill inmates in lockdown units.** The 45-bed capacity of this well-regarded program is clearly insufficient to meet the needs of the nearly 1,000 inmates in disciplinary lockdown on the mental health caseload.

- **Appoint a task force of seasoned correction officers to identify ways to improve the safety, morale and training of security staff** in 23-hour lockdown units. The recommendations of this task force should be reported to the governor and legislature and translated into programs and policies.

Because of the severe impact of disciplinary housing on inmates, we have prepared an addition to the executive summary, drawn from our report, on some of the terrible human consequences of this policy.

LOCKDOWN'S EFFECTS: THE WRECKED LIVES OF PRISONERS

On nearly every site visit, Correctional Association representatives encountered individuals in extreme desperation: men weeping in their cells; men who had smeared feces on their bodies or lit their cells on fire; prisoners who cut their own flesh in a form of self-directed violence; inmates who rambled incoherently or expressed paranoid and delusional thoughts – "the COs are poisoning my food," or "The prison psychologist is drugging me." Other comments include the following:

- "Objects talk to me," said a 26-year-old man at Five Points Correctional Facility. The inmate had been in solitary confinement for 18months and had another 18 months to serve. "Sometimes the radiator comes alive and tries to attack me. At

night I get lonely and the door and the radiator and the shadows come alive and try to get me."

- "I think I see people spying on me at night," said a 33-year-old man at Southport, serving eight years in disciplinary lockdown.

- "From the corner of my eye, I see things…. people moving," a skittish Elmira inmate, aged 37, said to us though the feed-up slot in the metal door of his cell. Sentenced to 31/2 years in solitary confinement, he described himself as "a suicidal loner."

The Inevitable Neglect

The thick metal doors that separate inmates from staff and the location of lockdown units in the most isolated areas of the prison create the very conditions that encourage neglect.

- During an August 2002 visit to Upstate, Correctional Association representatives met a disabled prisoner who had recently been transferred from the wheelchair unit at Green Haven. When he arrived at Upstate, his wheelchair was confiscated "for security reasons," according to a deputy superintendent. Through a window in the cell door, we saw the inmate sprawled on the floor. He had pulled the mattress onto the floor and placed his belongings on the bed frame so that he could reach them. He was in extreme distress and said that he could barely hoist himself onto the toilet. Because of his disability, he had trouble moving his hands and could not write a grievance to medical staff. He had spent several weeks at Upstate living on the floor.

- In the long-term keeplock unit at Clinton, which Correctional Association representatives visited in August 2002, a correction officer directed us to a foreign-born inmate who had been housed in keeplock for over a year for refusing a TB test. He was lying in bed, stock-still and staring into space. He appeared catatonic. A correction officer reported that the inmate had not spoken to anyone, neither inmates nor staff, in almost a year. He refused recreation and showers and occasionally bathed in his cell. Because he was not a disciplinary problem and refused to speak with mental health staff, he was simply left in this condition.

- Also on Clinton's long-term keep-lock unit, Correctional Association representatives came upon a man with full-blown AIDS. He was so ill that he could barely lift his head off of the pillow. He said that he was extreme pain and "starving" and asked us repeatedly to contact a nurse. He was disoriented but aware that he was dying in the darkest, dankest cellblock in the prison.

Deaths in Lockdown

Sometimes neglect or missteps in policy or practice led to the deaths of prisoners in disciplinary confinement.

- In May 2001, Elmira inmate Shane Maxwell, aged 27 died of "decreased food and water" intake five months after announcing that he was going on a hunger strike. Maxwell had a long history of mental illness and was housed in disciplinary lockdown. The official death report noted that staff repeatedly failed to record the inmate's vital signs or monitor his condition. It criticized his discharge from a mental health unit to disciplinary housing, calling such restrictive confinement "inappropriate…given Maxwell's medical and mental health history."

- In November 2001 inmate Harry Figueroa, aged 45, died of "decreased intake of food and water" at Auburn Correctional Facility following a hunger strike. Figueroa had a history of mental illness and was being held in an observation cell on suicide watch at the time of his death. The official death report stated that correctional and mental health staff should be disciplined "for service inadequacies," noting that "no vital signs or weights were ever taken," and that "the entire process clearly violates accepted standards of practice.

- Pedro Molina, a Spanish-dominate inmate at Upstate with a history of mental illness, wrote a request for counseling one month before he killed himself. The note, which was written in Spanish and never translated, was given to a newly hired part-time social worker, who had 40 outstanding referrals when he started work at the prison – three weeks after Molina sought counseling. "I don't want to suffer," he wrote before he took his own life. The State Commission of Correction report cited an "inexplicable lapse" in care.

- In the SHU at Five Points Correctional Facility, Demario Parks, aged 35, hung himself in a recreation cage attached to his cell. A videotape later showed Parks "climbing the rec pen and attaching the bed sheet to the pen and fashioning a ligature around his neck," the Commission of Correction report stated. After his first failed attempt, he tried again and succeeded. The report noted that the facility had no policy for monitoring the video cameras that are trained on inmate recreation pens.

- Seventeen years old at the time of his death in November 2001, Jessie McCann hung himself with a bed sheet at Downstate Correctional Facility after being put in disciplinary lockdown. "Isolated confinement is horrible and stressful for anyone," said Bryce McCann, the teen's uncle, to a reporter at the *Poughkeepsie Journal*. Jesse McCann was placed in disciplinary confinement for infractions that his family said were related to his mental illness. A Commission of Correction investigation of his death noted that McCann reported anxiety attacks when he was locked in his cell. The use of disciplinary confinement "is appalling for someone his age who is struggling with anxiety and depression," Bryce McCann stated.