Dante in Dannemora

"Everyone lies. I'm just here to write it down."
Clint Eastwood, *True Crime*

In the immediate neighborhood of a prison that bore witness to the mild and enlightened spirit of our times, dungeons existed that reminded one of the barbarism of the Middle Ages.
de Tocqueville, *Democracy in America*[1]

On 12 December 1917 Dr. Charles North, Superintendent at New York's Dannemora State Hospital, cried out and sunk to the floor in a pool of blood, chiseled through the back by a homicidal inmate.[2] In 1972 after years of controversy and conflict, this Adirondack last resort for the criminally insane shut its doors. But deep in the bowels of Clinton Correctional Facility (CCF), a vestigial state hospital maintains a fragile hold: one of 12 similar full service Office of Mental Health (OMH) *Satellite Units* in a larger network of 23 prison-patient clinics. Each unit is linked to the 210 bed maximum security mother ship, Central New York Psychiatric Center (CNYPC) in Marcy.[3]

It is now mid December 2003, and I have just subcontracted for 14 holiday-season work-days at CCF through a locum tenans agency servicing CNYPC to fill in for the vacationing unit psychiatrist. A pysch locums has three mission critical duties: (1) prescribe psychotropic medications; (2) evaluate and manage danger-risk; and (2) authorize transfers to other prisons and involuntary commitment to CNYPC. Despite Clinton's special OMH services, in the last three months three inmates have self-destructed.[4] The facility is on high alert.

My first impression is conditioned by Dannemora's early two foot snowfall and huge looming fortress walls. The maximum security Clinton Prison [5] was built in 1844 with the goal of

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[1] Alexis de Tocqueville, *Democracy in America*, Book I, Chapter 15. http://xroads.virginia.edu/~HYPER/DETOC/1_ch15.htm

[2] Thirteen years Superintendent at Dannemora, 48 yr-old neuropsychiatrst North was survived by his wife, judge Luella North, and 3 children. His killer was German-born furniture-maker Paul Reichert, sentenced to life for murder in 1908, found insane in 1909; subsequently described as a model prisoner and designated "trusty." The weapon was a keenly honed shop chisel with a 3-ft handle. Reichert testified he murdered North after his request for return to general prison population was denied by the doctor. "Memories of Hon. Luella R North" *Barnard Scrapebook*, vol.26:314, 13 December 1917 http://bigelowsociety.com/slic/danor3.htm

[3] Statewide the Satellite units cover psychiatric services to patients occupying 154 crisis beds, 534 Intermediate Care Program (ICP) beds, and about 7,500 clinic prisoner-patients. CNYPC is the sole recipient of committed patients from state prisons under NYS Corrections Law § 402. "Central New York Psychiatric Center," NYS OMH. http://www.omh.state.ny.us/omhweb/facilities/cnpc/facility.htm

[4] In October a prisoner hung himself, and in the two weeks preceding my arrival, two inmates died from self-inflicted wounds. Hughes B, "Elmsford man found dead in prison cell," *The Journal News*, 17 December 2003. http://www.thejournalnews.com [search author/title/date]

[5] Maximum security facilities contain inmates with lengthy records of assault, escape, in-prison violations, and gang membership. With long term incarceration, health service demands are increased by aging, terminally or

inmate reformation through isolation, hard work, and silent discipline. It garnered the name "Little Siberia" not just for its long winters with extreme arctic blasts, but for the all-season captive prison labor which broke through ice, granite, and chert to hand-shovel iron-laden ore which nurtured the19th Century industrial revolution.[6]

We had made
Wide circuit, ere a place we reach'd, where loud
The mariner cried vehement: "Go forth:
The entrance is here."[7]

My initial task is to show up on the job. But how to get in? A dark unmarked iron clad door is found at the turn of the southwest corner where the massive concrete surrounds define main street. The guard searches my person and briefcase, confiscating my cell phone and *Palm Pilot*.[8] Escorted through a half-mile long maze of tile and brick corridors, I pass two heavy oak chairs previously fitted for metallic searches, eerie reminders of an electrocuting big brother last in service here in 1914.[9] I proceed through seven locked iron gates, up multiple stairwells, following "hospital" arrows emblazoned at strategic turns. The final passage takes me past the hospital pharmacy and onto the locked *Satellite Unit.*

Description of Satellite Services

In virtue of the satellite's crisis and sub-acute mental health services, CCF is a designated "Level One" facility.[10] The Clinton OMH *satellite* is responsible for about 450 mental patients out

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chronically illness (e.g., diabetes, HIV, asthma), and mental disability.

[6] http://www.correctionhistory.org The promise of huge profit went unfulfilled, as the surface vein of ore was quickly exhausted. By the end of the 19th Century widespread protest against "unfair" competition and exploitation (the same forces that restrained child labor) brought a close to heavy congregate prison labor. Rothman, *The Discovery of the Asylum*, 246

[7] *The Divine Comedy of Dante Alighieri*, Hell, Canto VIII

[8] Dare I compare my *Palm Pilot* to a virtual *Virgil*, Dante's intrepid guide? Even though the *Palm* affords reliable access to the latest pharmacologic treatment warnings, doses, side-effects, and medication interactions; it cannot protect against ignorance, hypocrisy, or other malevolent practice demons.

[9] Electrocution was proposed in the Gay 1890's as a "humane" alternative to hanging. Lethal injection was then adamantly opposed by the medical profession, concerned that defamation would accompany physician directed death. Thomas A. Edison, an opponent of capital punishment and inventor/promoter of "safe" DC (direct current), attempted to kill his major competitor Westinghouse by promoting AC (alternating current) for death-row denizens. Instead Westinghouse gained new respect and market share. But convicts did not always perish in "the chair." In 1903 the current surge left Clinton convict Frederick Van Wormer still breathing and twitching on the autopsy table. Sing-Sing Prison took over all NYS electrocutions in 1914. In 1995 capital punishment reverted back to Clinton, this time by lethal injection. Bellis M "Death and Money: The History of the Electric Chair" Inventors. About.com. http://inventors.about.com/library/weekly/aa102497.htm

[10] Service Level One describes a correctional facility that provides (1) Residential Crisis Treatment (RCT); (2) Residential Day Treatment (ICP); (3) Psychiatric/nursing staff medication monitoring; and (4) Commitment to CNYPC for patients with "a major mental disorder" who need (or may need) "psychiatric treatment."

of some 3000 male prisoners under the supervision of the NYS Department of Correctional Services (DOCS). Patients are also admitted from other prisons, and on return from commitment at CNYPC.[11] The admission rate to the unit is roughly 60 patients/month. Refractory cases committed to CNYPC average about 10 patient-inmates per month. Psychiatric coverage is provided for at least one outside prison as well. About 350 patients are prescribed psychotropic medication.

The unit is staffed by 20 professional, mostly female mental health workers and 3 clerks under a unit chief. A psychiatrist, psychologist, and eight social workers work with a discharge coordinator, five RN's, and one nursing assistant to provide mental health services from 8 am to 4:30 pm Monday through Friday. Nursing services provide holiday and week-end coverage.

The acute in-patient Residential Crisis Treatment Program (RCTP) consists of a 7-bed dorm with small attached lounge, 3 solitary confinement observation cells (OBS-II), and 7 off-unit solitary cells (OBS-I) where mental patient-inmates are temporarily detained. Crisis patients include those with the worst "ticketed offenses" including self-mutilation, threats/suicidal behavior, and violence directed against prison staff or other convicts.[12]

A physically separate 60 bed Intermediate Care Program (ICP), maintained by DOCS and staffed on-site by an OMH psychologist and two social workers, provides day services to severely disturbed non-violent patients. In addition, the satellite clinic supervises services for patient-prisoners sequestered in the 24-cell Special Housing Protective Services Unit (SHU, "lock-down," "the box"),[13] where OMH staff reviews patients on a daily basis and the psychiatrist sees patients at least once per month.[14]

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[11] New York State prisons contain approximately 8,000 identified psychiatric inmates, 12% of the prison population. NYS Assembly, Bill Summary A08849 (Aubrey Bill). http://assembly.state.ny.us/leg/?bn=A08849

[12] Disciplinary lockdown is imposed for repeated rule infractions; possession of illicit drugs, arms or contraband; refusing orders; demonstrations; fighting; fire-setting; sex offenses; self-mutilations; and suicide threats or attempts. An estimated 23% of SHU (lockdown) inmates are on the mental health caseload, many with disciplinary punishment adding years to their original sentence. Two prisons (Attica and Five Points) have initiated a Special Treatment Program (STP) incorporating group and individual therapy with compliance-based reduction in SHU time. "Lockdown New York," The Correctional Association of NY, Oct. 2003, pp.15-18, 21-22, 45. http://www.corrassoc.org

[13] NY has 5355 disciplinary beds equally split between single and double-occupancy cells in free-standing disciplinary prisons at Southport and Upstate and at other maximum and medium security prisons which house gang members, discipline problems, and inmates in protective custody. Of the 5000 inmates on disciplinary status, 64% are placed in SHUs for 90 days or more. Goord GS (1) "Correctional Association ignores public safety, maligns staff to promote inmates' issues" DOCS news release, 27 June 2002. Http://www.docs.state.ny.us/PressRel/gangi.html; (2) "Prison chief criticizes overall bias, inaccuracies in Correctional Association report" DOCS news release, 21 October 2003. Http://www.docs.state.ny.us/PressRel/gangi2.html

[14] The SHU at Clinton originally housed 36 maximum security prisoners in 3 tiers of 12 cells each, with mental patients on the first floor. The top tier is now allocated to death-row inmates, the Unit for Condemned Prisoners (UCP). "Dying Twice: Conditions on New York's Death Row" ABCNY (Association of the Bar of the City of New York) Online, 2001. http://www.abcny.org/currentarticle/dying%20_twice2.html. The SHU is currently undergoing some physical alterations, but my one permitted brief visit revealed small walled cells (as in OBS) with the occasional addition of large external plexiglass protective shields which reduced the noise level from convict shouting but impeded conversation. Difficult brief cell-side interchange from the abutting narrow hall took place, but I was assured that confidential interviews could take place at the back of the cell.

My daily routine includes a 20 minute team meeting, a review of in-patient cases, and a 10am to 2pam call-out of out-patients (general prison/lockdown population) for renewal of medications, complaints, or other issues. On-site review of ICP patients takes place as needed, usually for medication renewal or change. On a typical morning 10-15 general population patients gather along two wall-side benches in a narrow clinic corridor facing a guard officer seated behind a desk. The rules of engagement permit patients to refuse mental health contact (unless acutely disturbed or disturbing) and psychotropic medication. My review involves four central elements: (1) the patient's understanding of need for contact, (2) charted information; (3) mental state examination; and (4) (as warranted) staff input. Common diagnoses include Undifferentiated and Paranoid Schizophrenia, Schizoaffective, Bipolar, Psychosis NOS, Depression NOS (Not Otherwise Specified), and Anti-Social Personality Disorder. Many charts reveal a history of drug and or alcohol abuse, sometimes cerebral trauma, mental retardation, and occasionally seizures.

I allocate a flexible 15-35 minutes to each case. Patients waiting to be seen in my office are silent and orderly. Some require interview with handcuffs, with a see-through door either open or shut as conditions warrant. Some patients ask after and request "the regular psychiatrist." Most readily accept medication recommendations; with occasional requests for enhancements or nocturnal sedation.[15] Non-compliance with medication orders is typically justified by reference to "allergy," adverse side-effects, or rejection of the enhanced scrutiny that accompanies parole or prison discharge for mental patients. Some request privileges (e.g., work, visits with relative, telephone calls to relatives), modification of psychiatric "level of care" that might enable transfer to a mid-level facility, and complex pleas for justice. Many clearly manifest the need to be heard by someone in authority. By two o'clock some remain unreviewed, others have left. For institutional convenience these latter are lumped together as having "refused service."

Daily rounds are attended by interruptions and inconvenience including multiple locked doors, guard shift changes, disruptive prison routines (cell counts, meals, recreation), and lack of office space.

Now am I come where many a plaining voice
Smite on mine ear. Into a place I came
Where light was silent all. Bellowing there groan'd
A noise, as of a sea in tempest torn[16]

On-unit lockdown OBS patients can be interviewed out of cell, but only if there are sufficient guards to secure the patient in transit and mount guard in the hall adjacent to the office. This has the practical effect of increasing cursory cell-side review. Off unit OBS-I and SHU patients are generally seen through a small sound-blocking plexiglass window in a locked metal door. Volatile ambient noise severely impedes two-way verbal communication, including intermittent banging on cell walls, repetitious demands and complaints, and voices raised in challenge and confrontation. Stooping down to speak through a small round, sometimes fecal-contaminated screen is a clear

[15] Sleep difficulties may be both early warning signs of psychiatric decompensation. Yet authority for sedation of all inmates has been turned over to the DOCS medical officers. To bypass this regulation, the use of the antidepressants trazadone (Desyrel) and mirtazepine (Remeron) in low doses is a common adjunctive practice.

[16] *Divine Comedy*, Hell, Canto V

disincentive to exchange. Corrections Officers may hover nearby trying to facilitate, direct, or monitor the exchange. Representations by control officers of malingering prisoners and patient attacks on staff with body secretions are commonplace, and may be either legitimate warnings or attempts to discourage close scrutiny and interaction.

Most OBS patients are naked to secure safekeeping during crises. One man decorates his cell with ochral excreta, smeared expletives, snippets of thoughts and symbols. One hears "visions," sees "voices" and complains of frontal headaches.[17] In the next cell a man is vacantly seated on the toilet, unresponsive to all queries. Another quietly but firmly asserts that guards set a fire in his cell, ticketed him, and dumped him in OBS. Nearby a man lies supine on the floor, wrapped in a ragged mat. Most who speak request amenities, clothes, plastic spoons, more blankets. Some demand immediate return to general prison populations or the SHU.

Capping each patient visit is the necessity for summation in cogent and legible handwritten notes, discussion with staff of dispositions, and prescriptions or special treatment orders. Thick weighty charts overflowing with illegible notes and poorly bound pages fall apart at the turn of a page. Unsuccessful searches for appropriate blank forms, and repetitious hand transcription of names, diagnoses, and prison identification numbers consume time. Urgent requests by OMH staff for psychiatric review, and other rapid and unpredictable unfolding events take a toll. DOCS officers sporadically over-ride treatment directives, such as the provision of "amenities" (clothing, bedding, books, plastic dining utensils, etc.), which might in their opinion place patients or staff at risk.

The overload of patients and the crunch of time lends a surreal quality to the process and encourages the suspension of practice standards, especially as regards review, confidentiality, and treatment. A day at this pace in this place is rapid immersion, instant challenge, and practice torment. I am sensible of failure of adequate review, minimal therapeutic input, and an insidious system chasing and protecting its own tail. This institution is dedicated to custody, supervision and monitoring. But who monitors the monitors? *Sed quis custodiet ipsos custodes*?

[17] This patient's presentation prompted a useful staff discussion of synesthesia and a medical evaluation for migraine.

Part II. **The Problem: Incorrigible Corrections**

> "The Eight Amendment does not outlaw cruel and unusual "conditions"; it outlaws cruel and unusual "punishments."
>
> Hon. David Souter, *Farmer v. Brennan*, 1994[18]

Cruel and Unusual Punishment: The *Perri* Case

In early 1990 while a prisoner at the Clinton Correctional Facility, an agitated disruptive Anthony Perri was sent to crisis OBS after slashing his arms and putting a razor wire to his neck.. On three separate occasions for a total of 108 days he was confined to the 72 sq.ft. cell with its small in-facing window, sink, toilet, and 24 hour light. Held without blanket or clothes for two months, he slept naked on the floor, denied toothbrush, soap, writing materials, mail, exercise, recreation, programming, or group therapy. He was permitted a 5-minute shower twice weekly and occasional visits In May he smeared feces and urine on himself and the cell confines. He sometimes refused food. In June after severing an artery Perri was sent to CNYPC. Returning a month later, he was again placed in the observation cell. In September after destroying the cell sink and toilet during a two hour rampage, he was restrained and shackled. He then tried to hang himself. In October Perri was sent back to CNYPC in Utica, then discharged to Sing Sing where he eventually gained parole.

In his suit *Perri v. Coughlin and Surles* against the respective commissioners of DOCS and OMH, Anthony Perri charged cruel and unusual punishment and knowing and deliberate deprivation of necessary mental health services. In June 1999 the US District Court in Syracuse termed the Clinton Prison mental health services "smattering" and "exacerbating," and the official null response marked by "deliberate indifference" in violation of 8th Amendment rights applicable to the states through the 14th Amendment of the US Constitution. The Court ordered $50,000 damages to Perri, as well as court costs and legal fees against the DOC and OMH.[19] Deprivation of necessary service was again at issue at CCF in 2000 in *Brooks v. Berg, et. al.*[20]

In the *Perri* decision the Court outlined six conditions necessary to meet Constitutional safeguards during confinement: (1) systematic screening and evaluation of prison inmates for psychiatric care; (2) treatment that is more than isolation/close supervision; (3) sufficient professional mental health staff; (4) accurate, complete, and confidential mental health records; (5) psychotropic drugs administered with appropriate supervision and periodic supervision; and (6) a program to identify, treat, and supervise inmates at risk for suicide.

Perri criteria: A Re-evaluation

(1) **Systematic screening and evaluation. Test failed**

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[18] *Farmer v. Brennan* 114 S.Ct. 1970 (1994). http://supct.law.cornell.edu/supct/html/92-7247.ZS.html

[19] *Perri v. Coughlin (DOC) and Surles (OMH),* 1999 WL 395374 (N.D. N.Y., 6/1/99) [USDC, Northern District, Syracuse, Judge Neal P McCurn, 10 June 1999]. http://cl.bna.com/cl/19990707/1160.htm

[20] In 2000 Clinton convict Mark Brooks charged the *Satellite Unit* and a variety of CCF officials with denial of medical services. Brooks claimed to be suffering from a previously undiagnosed transsexual gender identity disorder. The federal court summarily granted his Eighth Amendment based due process claim to medical/mental health assessment. *Mark Brooks a/k/a Jessica M. Lewis v. Berg (CCF), et.al.*, Judge Kahn, Jul 2003, Albany NY, USDC (Northern District). http://www.nysd.uscourts.gov/courtweb/pdf/D02NYNC/03-06057.PDF

In significant areas screening and evaluation is neither systematic nor complete. I found no evidence of regular or updated psychiatric review of the general prison population for at-risk behaviors including suicide and violence. Instead, the psychiatrist focuses on after-the-fact crisis management and triage, and medication review/renewal of "call-outs" cases from the general prison population; while OMH clinic staff evaluate acute distress and threats of danger in the general prison population and the SHU.

(2) **Treatment more than isolation or close supervision. Test passed with reservations**

Psychotropics can effectively alleviate many symptoms of mental disability. But prisoners may lawfully refuse medications arbitrarily or for cause, including lack or failed response and unwanted side effects.[21] Under these circumstances treatment alternatives are rarely considered. Counseling is sporadic (under DOCS supervision) and many patients indicated it to be infrequent and inadequate. Some selected patients may be seen for therapy by satellite staff, but I was unable to adequately assess either the range or impact of these interventions. First impression suggests psychotherapy is generally instructive/supportive and proceeds with little direct psychiatrist supervision. An exception to therapeutic reliance on medication appeared in the supportive and rehabilitative interventions observable in the ICF..

(3) **Sufficient mental health staff. Test failed.**

The 24 person OMH staff is actually "part time" since there is regular coverage for only 8 hours per day, 40 hours per week. The four nurses rotate to cover nighttime, holidays, and weekends. The lone conscientious Hispanic female psychiatrist works 10 hrs/day four days a week and is apparently on emergency call 24/7. She is directly responsible in this catchment of some 3000 violent-recidivist felons for over 450 designated psychiatric patients. The key male case manager/coordinator sets team priorities through intense effort and acute memory for patient details. He arranges admissions and discharges to the crisis unit, advocates for patients, harmonizes OMH and DOCS conflicts, and minimizes bureaucratic entanglements. The treatment staff is professional, intelligent, motivated, and devoted. New unit management is attentive to detail, currently instituting useful organizational changes. All work remarkably well under conditions of acute demand and chronic overload during the allotted time. Despite the effort, such minimal staffing is not sufficient.

(4) **Accurate, complete, and confidential records. Test failed, limitations noted**

Are the records accurate and complete? At first impression the charts appear to be (1) poorly organized; (2) overstuffed with redundant information; (3) fragile, easily broken and hard to reassemble; (4) difficult to decipher with hand-written progress notes interspersed with nursing forms; (5) occasionally lacking important to-date lab values; and (6) often deficient in properly filed blank progress note and treatment forms. Denied access to the unit psychiatrist's desktop computer, I was unable to assess electronic contribution to this substandard process.[22] There is no chain-of-custody for the on-unit physical location of records in the course of the work day All CO's, OMH staff, and other prisoners can see who is a patient. Cell-side conversation, when it can be heard, can be overheard. Thus internal confidentiality is seriously compromised.

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[21] Although physicians routinely ascribe treatment failure to medication non-complaint patients, loss of neuroleptic efficacy may account for 60% of rehospitalization costs compared to 40% for noncompliance. Weiden PJ, Olfson M "Cost of relapse in schizophrenia" *Schizophrenia Bulletin* 1995 21:419-429. http://www.mentalhealth.com/mag1/scz/sb-cost.html

[22] See prior note on interdiction of *Palm* handheld computer.

Disclosure to outside sources appears constrained by the interdiction of computer and telecommunications, but no exit staff-search is part of the prison routine.

(5) **Periodic and supervised administration of psychotropics. Test failed.**

This legal mandate is somewhat unclear. The psychiatrist prescribes, the OMH nurses dispense, the patient may accept or refuse; all elements are charted. However, (1) the 3 month interval between medication prescription and review is inadequate upon consideration of psychotropic side-effects, drug interactions, and comorbid medical illness with potentially compromised organ function (e.g., high prison prevalence of Hepatitis B; preconfinement drug and alcohol abuse). (2) The amount of actual time/patient allocated to each patient for review is dangerously inadequate, given the ratio of patients to psychiatrists (i.e., 350/1). Moreover, (3) actual review may be delayed beyond the 3 months required, while (4) the intent of review may be frustrated by shoddy standards of practice, including difficulty in access to patients' mental health history and to patients themselves. In this latter regard I was initially asked to refill "routine" medication orders on patients I had not seen. This I refused to do.[23]

(6) **A program to identify, treat, and supervise inmates at risk for suicide. Test failed.**

Suicide prevention has a high priority for DOCS and OMH.[24] There is a significant DOCS attempt to identify and respond to suicide threats and gestures with rapid sequestration in acute unit observation cells (OBS). However, despite a well-developed professional literature on stratified risk management,[25] stereotypical institutional responses render the Clinton program superficial and dangerously counter-therapeutic.

(1) Marginal death-talk and manipulative scratches garner the same response as credible death threats and attempts. Exaggerated institutional response encourages suicide fraud by patients and prisoners who use threats of self-harm to relieve boredom or frustration and/or gain a change of cell venue. This "cry wolf" syndrome decreases vigilance on the part of care givers. It encourages control officers to punish difficult or non-compliant prisoners with OBS lockdown under the guise of suicide prevention.

(2) Isolation and medication impact cognitive process and can delay adaptive behavior. Countering isolation by trust-building and relational expedients such as peer group discussion and therapeutic conversation would likely have a more durable effect than sole reliance on

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[23] Prescriptions were restricted to two weeks beyond the conclusion of my services. Locum tenans doctors apply different standards in this respect.

[24] Clinton prisoner Felix Jorge (George) had a considerable record of self-cutting, fire-setting, and fecal smearing, at one point predicting (on videotape) that he would be killed by his captors. Admitted to CNYPC and returned to Clinton, his discharge treatment plan advised twice weekly visits and medication re-evaluation. In 1994 Jorge died by suffocation (toilet paper stuffed in his nose and mouth) "suicide" in a psychiatric OBS cell. Six years later, in July 2000, NY State paid substantial damages to his family where neglect of this CNYPC plan highlighted OMH satellite deficiencies in risk assessment, treatment, and supervision. Matter of Felix George [Jorge], NYS Commission of Corrections report, NYS DOCS, April 17, 1996. www.docs.state.ny.us ; " Ill Equipped: US Prisons and Offenders with Mental Illness," *Human Rights Watch* , October 2003, XIII, "Felix Jorge, New York." http://www.hrw.org/reports/2003/usa1003/23.htm. See also, Purdy M "Prison's Violent Culture Enveloping Its Guards," *New York Times* (12/19/95), p.A1-B8

[25] Dolan M, Doyle M "Violence risk prediction: Clinical and actuarial measures and the role of the Psychopathy Checklist" *British Journal of Psychiatry* (2000) 177:303-311. http://bjp.rcpsych.org [search]

psychotropic remediation.[26]

(3) High risk sub-populations (e.g. patients confined to lockdown) deserve lethality evaluation at first contact. Optimal estimates of risk combine several methods of inquiry: historical, actuarial, contextual, and clinical.[27]

(4) Non-patient lethality also deserves scrutiny. A significant institutional dilemma is represented by prisoners who show few or minimal signs of psychiatric disturbance, yet are susceptible to peer or control officer intimidation, unresolved familial distress, or the stress of isolation itself. Actuarial assessment without reference to mental illness might serve as early warning, discriminate non-mental patient subgroups at risk, and pinpoint corrosive prison policies and conditions which contribute to or facilitate self-destruction.[28]

Who is Responsible?: The Baxstrom Case

Court decisions, orders, and consent decrees mark persistent attempts to redress prison grievances and conditions.[29] In 1966 CCF patient-prisoner Harold Baxstrom entered suit to gain his release from Clinton Prison's adjunct Dannemora State Hospital after serving full sentencing time. The U.S. Supreme Court ruled that his continued post-sentence incarceration for mental illness without the opportunity for a judicial hearing or jury trial was a deprivation of Constitutionally guaranteed equal protection of the law.[30] Baxstrom was then "released" from

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[26] Suicide is the ninth leading cause of death in the US and the second for persons under 35, but even in the violence-prone prison population it is a relatively rare event, roughly identical to that in the general population. In year 2000 there were 179 suicides in state prisons out of 2855 deaths. In contrast 2142 deaths were by medical-natural causes (excluding AIDS), 280 by "other" (including accidents, drug overdose, and executions), and 275 due to AIDS. However suicide outstripped the 51 in-prison homicides by 3.5 times. Stephan JJ, Karberg JC "Census of State and Federal Correctional Facilities, 2000" US Dept. of Justice, *Bureau of Justice Statistics* (revised 10/15/03), p.8. http://www.ojp.usdoj.gov/bjs/prisons.htm. In the non-prison population most successful suicides occur in persons with no prior psychiatric diagnosis. Despite the fact that suicide is not illegal in most jurisdictions, a broad social consensus encourages police intervention and psychiatric commitment in serious attempts. Professional management is then (paradoxically) based upon interpersonal "trust building," pharmacotherapy for severe recurrent psychiatric disorders (psychosis, Bipolar disorders, major depression, and anxiety), and structured post-discharge social affiliation.

[27] Suicide is a complex behavior characterized by intention mediated by a variety of internal meanings and contextual factors. Douglas cautions regarding reliance upon official statistics for theory construction and causal analysis. Douglas JD, *The Social Meanings of Suicide* (Princeton U Press 1967). Risk assessment of low frequency events remains highly problematic. Szmukler G, "Violence risk prediction in practice," *British Journal of Psychiatry* (2001) 178: 84-85. http://bjp.rcpsych.org [search]

[28] Kennedy HG "Therapeutic uses of security: mapping forensic mental health services by stratifying risk," *Advances in Psychiatric Treatment* (2002) 8:433-443. http://apt.rcpsych.org/ [search]. For a discerning critique of both clinical and actuarial risk assessment see Pate K "The Risky Business of Risk Assessment," CAFES (Canadian Association of Elizabeth Fry Societies), 2003. http://www.elizabethfry.ca/risky/Contents.htm

[29] Stephan JJ, Karberg JC "Census of State and Federal Correctional Facilities, 2000" US Dept. of Justice, *Bureau of Justice Statistics* (revised 10/15/03), p.9. http://www.ojp.usdoj.gov/bjs/pub/pdf/csfcf00.pdf

[30] *Baxstrom v. Herold*, NY 1966, 383 US 107, US Supreme Court. http://caselaw.lp.findlaw.com [search]. After serving two years (on a 3-year max sentence for assault) Clinton prisoner Baxstrom was certified by a DOCS physician as mentally ill and transferred to the adjoining DOCS Dannemora State Hospital for the care and

prison and reincarcerated under civil commitment to an Department of Mental Health facility. The court order led to the subsequent release of 967 "dangerously insane" prisoners first to civil hospitals and then to the community. A four year followup of these patient-ex-prisoners confirmed the predictive exaggeration by psychiatrists of the likelihood of continued violent misconduct after release from confinement.[31]

Following that decision "dangerous predator" confinement laws first chipped at, then swept away substantial Constitutional protections.[32] Current prison regulations mandate civil commitment for "evaluation" of risk in known previously violent patient-inmates at the end of their prison term, even absent findings of acute psychosis or imminent danger. A pro-forma examination is conducted by the OMH psychiatrist and the opinion routinely co-signed by a complicit DOCS physician.

It is now thirty-eight years post *Baxstrom* and five years after *Perri*. The huge 30-ft. high Clinton Prison walls have proved impregnable to significant attempts at correction. The Correctional Association of New York, charged by law with visiting and assessing prison services, has just instituted suit to gain access.[33] DOCS disputes their credibility.[34] Because all CCF satellite housing is supervised by Department of Corrections, the Joint Commission on Healthcare

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confinement of the criminally insane. Prior to the end of his sentence he was certified by two DOCS physicians for civil commitment as mentally ill and in need of hospital and institutional care. Refused admission by DMH (Dept. of Mental Hygiene, now OMH) to a civil facility, Baxstrom was detained in the prison hospital and denied jury trial or judicial hearing, rights available to challenge civil commitment. In 1962 Baxstrom's writ of habeas corpus was dismissed after an "independent" court-ordered psychiatrist testified that Baxstrom was still mentally ill. A subsequent 1963 writ sought either his release (if sane) or transfer to a civil hospital (if insane). His request was again dismissed because he was failed (by virtue of indigence and incarceration) to produce psychiatric testimony challenging the previous finding of insanity. The Supreme Court found the absence of civil procedural rights after full time served contrary to Due Process, compelling his release from the prison psychiatric hospital to a non-prison psychiatric hospital.

[31] Cocozza J, Steadman Y "The failure of psychiatric predictors of dangerousness: Clear and convincing evidence" *Rutgers Law Review* (1976) 29:1084-1101

[32] *Kansas v. Hendricks*, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997). 337. http://supct.law.cornell.edu/supct/html/95-1649.ZO.html Hendricks, a self-admitted recidivist "irresistible-impulse" pedophile challenged his civil commitment order just prior to the completion of his prison sentence. In a close 5 to 4 decision, the US Supreme Court broadened permissible precommitment criteria to include any mental abnormality or personality disorder linked to a finding of danger to self or others; and ruled that civil involuntary confinement is not "punishment" where the legislative intent is neither retribution nor deterrence, and thereby could not amount to impermissible double jeopardy (citing *Baxstrom*). Four dissenting judges affirmed Hendrick's Constitutional challenge, rating the punitive intent of the civil commitment law primary and treatment incidental.

[33] The Correctional Association of NY, authorized in 1846 to inspect and oversee prisons, recently requested injunctive relief against DOCS "retaliatory measures" restricting access to prisons. News release, "Correctional Association of NY announces Lawsuit against Department of Correctional Services" (18 March 2004), The Correctional Association of NY Correctional Association of New York, March 2004. http://www.correctionalassociation.org

[34] Goord GS, APrison chief criticizes overall bias, inaccuracies in Correctional Association report@ NYS DOCS, 10/21/2003. http://www.docs.state.ny.us/PressRel/gangi2.htm

Accreditation (JCAHO) has never reviewed Clinton Satellite Unit operations.[35] The courts have broadly exempted state officials and employees from liability under the doctrine of qualified immunity.[36] Even when found culpable by "deliberate indifference," the respective DOCS and OMH Commissioners are merely slapped with modest damages paid by the state.[37] Nor has the Governor ever been held accountable.[38] New York's crusading attorney-general Elliot Spitzer supervised the government's denial of accountability in the Clinton prisoner claims of *Perri v. Coughlin* and *Brooks v. Berg*.[39]

Protection of psychiatrists from accountability is an incentive for relatively low-status but secure employment in the state penal system. Few instances appear in the last decade where OMH staff at Clinton Prison or other satellites received public censure or rebuke.[40] (1) In the 1994 "suicide" death of Felix Jorge (George), a prior treatment plan developed at CNYPC was lost or

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[35] Under a revised OMH/DOCS agreement, The JCAHO is slated to perform its first on-site *Satellite* review sometime in 2004.

[36] *Brooks a/k/a Lewis v. Berg, Senkowski, et.al.* Judge Kahn, July 2003, USDC Northern District of New York. http://www.nysd.uscourts.gov/courtweb/pdf/D02NYNC/03-06057.PDF

[37] Personal involvement in deprivation of services may be established by (1) direct participation; (2) failure to correct a known occurrence; (3) creating a policy or custom which permits the deprivation; (4) gross negligence in managing culpable subordinates; and (5) neglect of a clearly established law. *Perri v. Coughlin and Surles*, 1999 WL 395374 (NDNY 6/11/99). The Federal standard of official culpability permits evidence that the "substantial risk of serious harm" was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past" and that the official being sued "had been exposed to information concerning the risk." *Farmer v. Brennan*, 114 Supreme Court 1970 (1994). http://supct.law.cornell.edu/supct [search]. Biologic male Dee Farmer was a non-violent diagnosed transsexual subject to homosexual rape by placement with male convicts. Articulating the Eight Amendment standard of "reckless disregard" the court remanded the case to the lower court.

[38] A challenge to mental health disparity with medical services in adult-homes takes the highest state officials to task. *Disability Advocates, Inc.,Plaintiff v. George Pataki, In His Official Capacity As Governor Of The State Of New York, Antonia C. Novello, In Her Official Capacity As Commissioner Of The New York State Department Of Health, James Stone, In His Official Capacity As Commissioner Of The New York State Office Of Mental Health, The New York State Department Of Health, And The New York State Office Of Mental Health, Defendants.* http://www.bazelon.org/issues/disabilityrights/nycomplaint (1 July 2003)

[39] *Brooks a/k/a Lewis v. Berg, Senkowski, et.al.* Judge Kahn, July 2003, USDC Northern District of New York. See Caher J "Jailed Killer to Get Sex Change Treatment" *New York Law Journal* (posted 07/16/2003). http://209.157.64.200/focus/f-news/947127/posts. Attorney-General Spitzer's supervisory role in his agency's defense of state agencies and functionaries is mandatory under DR-1-104, NY Code of Professional Responsibility (22 NYCRR§1200.5). But persistent defense of a government policy repeatedly adjudicated to violate constitutional due process raises important issues of ethical conflict where the attorney general is also an officer of the court charged with implementing court directives. See also Ronald Shansky, "Court Monitoring and Quality Assurance: A Happy Marriage or a Required Divorce?" (Summer 2003), *Correct Care*, National Commission on Correctional Health Care. http://www.ncchc.org/pubs/CC/courtmonitor.html.

[40] Some reports may find psychiatrists at fault, but then advocate increased mental health services, implying the fundamental problem can be resolved by expansion. Pfeiffer MB "Mental care faulted in 6 prison deaths. Psychiatric hospitals proposed." (3/10/2002), *Poughkeepsie* Journal, June 28, 2003. http://www.poughkeepsiejournal.com/projects/suicide/
Hedgedus N "We're not protected" [1/11/04], *Times Herald-Record* (recordonline.com). http://www.recordonline.com/archive/2004/01/11/index.html

ignored. The psychologist and psychiatrist were subject to intensive questioning on review.[41] (2) In the 1999 suffocation of a SHU inmate during a take-down by Franklin CF guards, the Clinton *satellite* psychiatrist who discharged him three days prior to his death was cited for "discipline."[42]

In practice social and political condition mute public outcry. (1) The closure of large state mental hospitals has virtually terminated revelation of psychiatric abuse.[43] (2) Prisons, not hospitals, have been chosen to warehouse criminals with interwoven drug and alcohol related infractions, acute intermittent and chronic mental disorders, and violent offenders. Such criminals are generally considered as less deserving of protection. (3) Society has embraced coercive psychotropic pacification beyond prison walls, most obvious in methadone maintenance of drug addicts, ritalin treatment of attention-deficit/hyperactivity in schoolchildren, and antipsychotics to quell the disturbing urban homeless..

However pressure for penal system change appears to be building. In May 2002 *Disability Advocates* entered suit against OMH, DOCS and 13 OMH Satellite Mental health Unit Chiefs in a Federal Court challenge to persistent and deliberate system-wide neglect of prisoners with serious mental illness. The action specifically targets "harsh and punitive conditions of disciplinary isolated confinement."[44] Now two years later, the action appears mired in "discovery" with no apparent time-line for resolution.[45] But newly proposed segregation of SHU mental patients, expansion of in-house psychiatric beds at two state prisons, and an increased budget for prison (forensic) mental health services appears designed to assuage some critics of the present system.[46]

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[41] Issues provoked by Jorge's SHU suicide included continuity of care, medication refusal, and control officer physical abuse and neglect. The unit psychologist was unaware of the CNYPC recommendations, and the psychiatrist allegedly found no mental illness related problems prior to Jorge's SHU placement. Commissioner Thomas Goldrick "Final Report into the death of Felix George," *NYS Commission of Correction*, NYS DOCS, April 17, 1996, Findings 10 and 14, reported in "Ill Equipped," Human Rights Watch, Oct. 2003. http://hrw.org

[42] "Special Housing Units," National Alliance for the Mentally Ill (NAMI) [undated]. http://www.naminys.org/leg_shu.htm

[43] The most recent budget proposal calls for closing Middletown Psych Center (savings $6.9 million), while cutting $7.7 million from community mental health services. Precious T "Cuts put aid for mentally ill at risk" (3/21/2004) *Buffalo News*. *http://www.buffalonews.com/editorial/20040321/1047493.asp*

[44] *Disability Advocates v. NYS OMH, Stone, et.al.* USDC Southern District., 28 May 2002. http://www.hrw.org/english/docs/2003/10/22/usdom7148_txt.htm. [go to NY]. See also Kerr S, Esq., "Testimony on Mental Health Care in NYS Correctional Facilities," Prisoners' Rights Project (PRP) of Legal Aid Society , November 18, 2003. http://www.legal-aid.org/SupportDocumentIndex.htm?docid=11

[45]"Prison chief criticizes overall bias, inaccuracies in Correctional Association report" DOCS news release, 21 October 2003. Http://www.docs.state.ny.us/PressRel/gangi2.html. Telephone contact, Attorney Nina Loewenstein, Disability Advocates, Albany NY, 19 March 2004

[46] NYS plans two new psych prison units with a total of 102 beds, and an additional $13 million to hire 66 new nurses and psychiatrists starting 4/01/2004. Ertelt P "Prisons to get new units for mentally ill inmates" Middletown *Times Herald Record* (2/5/04.). http://www.recordonline.com/archive/2004/02/05/onssull.htm.; Silverberg M, "NAMI-NY Statement at the NYS Budget Hearing on Mental Health Services" 4 February 2004. http://www.naminys.org/2004BudgetTestimonyA.pdf

Part III. **Thirty-Nine Stripes**[47]

Ah! what caution must men use
With those who look not at the deed alone,
But spy into the thoughts with subtle skill.[48]

Psychiatrists share with all physicians the need to uncover malingering.[49] The psychiatrist must distinguish who is faking, who is legitimate among populations noteworthy for deceit and disinformation. Mistaken attribution of malingering as the result of cursory, incomplete, erroneous or obreptitious professional assessments may potentiate morbid or mortal consequence.[50] Conversely, mistaken attribution of disability or disease may result in inflated medical costs, unnecessary treatment or surgery, huge insurance payoffs, and heightened malpractice premiums.

This determination is big business. In 1973 there were 93,000 mental patients in NY State mental hospitals and 12,500 inmates in jails and prisons.[51] Today there are roughly 4000 state hospital mental patients and 8000 penal mental patients (out of over 65,000 inmates). State detention facilities thus contain twice as many "seriously" mentally ill as the once mighty state hospitals.[52] Beyond prison walls, community management and psychotropic success have

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[47] From ancient times whipping was a proximate timely severe non-lethal punishment-of-choice by parents, schools, military, magistrates, and governments. *The Body of Liberties of 1641*, the first articulated colonial code of restraint upon government punishment, ruled out *cruelty* and set the limit at 40 stripes for offenses against *some expresse law of the Country waranting the same, established by a generall Court and sufficiently published.* The actual number administered was 39, faithfully following Hebraic practice as recorded by the Apostle Paul. Whipping was abolished in Massachusetts in 1826. Edwin Powers, *Crime and Punishment in Early Massachusetts 1620-1692*, 163-167, 193

[48] *The Divine Comedy*, Hell, Canto XVI

[49] "Malingering or Real Illness? Prison Staff Learn Difference" *Psychiatric News* 20 October 2000. http://www.psych.org/pnews/00-10-20/malingering.html

[50] In two tales of lethal neglect, Dr. Michael Paurini described an inmate, ".trying to create documentation for a mental health disability case" who strangled himself to death while observed hanging for 15 minutes by security officers convinced that he was "just faking." He also presents a patient with "embellished" complaints of numbness and gait disability where initial medical dismissal of symptoms is followed by a delayed diagnosis of untreatable spinal malignancy followed by death in 3 months. Paurini M "Malingering - a Label or a Lying Patient," *CorrDocs. Newsletter Society Correctional Physicians*, Winter 2003, 7(1), pp.1,4. http://www.corrdocs.org/resources/7-1CorrDocs.pdf. Paurini neglects to mention professional fraud, well known in the insurance and managed care industry, as a significant contributory factor. In circumstances of mental health short-staffing the "diagnosis" of malingering may be an attempt to reduce active patient loads and stress by dismissing annoying provocative claimants to service, or even protect the inmate from the stigmatizing effect of a psychiatric diagnosis. The attribution of malingering may also be used by corrections officers to inflict punishment without fear of psychiatric interference in the decision making process.

[51] Wagner P "Incarceration is not a solution to mental illness" Prison Policy Initiative, *Mass Dissent*, April 2000. http://www.prisonpolicy.org/articles/massdissent040100.shtml

[52] "Notice of Joint Public Hearing," NY State Assembly Committees on Correction and Mental Health, Retardation and Developmental Disabilities, October 2003; NYS Assembly, Bill Summary A08849 (Aubrey Bill). http://assembly.state.ny.us/leg/?bn=A08849

rendered obsolete most long-term civil in-patient services and marginalized the mystic of psychiatry based upon interpersonal influence cast as "psychotherapy." With the exception of some private facilities and practice, psychiatrists are drug-prescribing agents for governments, managed care corporations, insurance companies, and private contractors.

Psychiatrists deprived of leading institutional and interpersonal roles continue none the less indispensable. The guild carefully guards treasured prerogatives, some held in common with other medical professionals, some distinct and separate. The state medical license permits all physicians to make (1) psychiatric diagnoses; (2) prescribe psychotropic medication, and (3) authorize certain forms of civil commitment. In addition psychiatrists must gain (4) government job certification, met by a medical degree and post-degree psychiatric education, training, and testing leading to Board Certification.[53] Other components for procuring a job generally include current recommendation from at least two other active physicians, malpractice insurance, and a (relatively) clean practice record.[54]

With all this training and credentialing psychiatrists must perform a special expert service. They must distinguish real from fake. But in stark contrast to other medical specialties, psychiatry resolves the issue of the "real patient" not by examination of the bodily state, but by assessment of the mental state.[55] For psychiatrists this complex skill demands systematic observation and inquiry, combined with intuition and pattern recognition. One example serves well. Malingering itself may be mild or severe, simple or "comorbid," i.e., entwined and intermeshed with conditions both medical, psychological and social. The differential diagnosis of falsification includes exaggeration, intentional lying, pathological (compulsive) lying; factitious (self-induced) and context-dependent disorders (e.g., Ganser's "prison" psychosis); dissociative identity, multiple personality, borderline personality, and post-traumatic stress disorders; organic fabrications (e.g., Korsokoff's syndrome); seizure states (pseudo-seizures, reflex epilepsy, temporal lobe-psychomotor epilepsy); delusional disorders; and a variety of psychoses. This initial "mental inspectometry" is the crux of management; determining who, what, when, where, to be dismissed; observed, admonished, referred, educated, or subject to psychotherapy, behavioral therapy, medication, and/or risk management.

The "stigma" of "mental illness" is the bugaboo-whipping boy of psychiatry. Rarely acknowledged is the protective function of such diagnoses. The attribution of malingering destroys the shield that protects the mentally ill from accountability. While the appellation of medical fraud in open society is a profound disqualification; in prison it may be a badge of honor, a brave assault upon the system. Psychiatrists in open practice tend to over-diagnose mental illness, especially borderline personality. This not only lessens risk, but is good for business. In the prison context, as in the insurance-claim investigation, the burden of proof is reversed. The criminal is considered malingering until proven otherwise. This is especially useful to corrections

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[53] At various times NY State has choose to waive certain requirements, for example permitting foreign licensed psychiatrists, or those eligible but not board certified to practice in certain institutional settings.

[54] Stringent professional job requirements inflate costs and increase pressures to undermine the monopoly, for example granting prescription privileges psychologists, physician's assistants, and certified nurse practitioners.

[55] Equally important in this diagnostic process is attention to "history," but over-reliance here amplifies subjective assessment error. In psychiatric practice, although diagnostic categories are frequently altered, remission is rarely noted due to wary professional regard for fluctuating symptoms and the risks attendant upon "false-negative" assessment, i.e. the ascription of a clean bill of mental health to a potential patient.

officers as it permits the punitive process full sway.

What is Treatment?: Medication and "Other"

Patient management characteristically revolves around medication adjustment and changes in prison status and placement.[56] Given a prison population with a high percentage of drug pushers and dealers, both heightened demand and considerable scepticism regarding authorized psychotropics is to be expected. Patients can be demanding and knowledgeable consumers. A older schizophrenic cohort may prefer time-tested haloperidol (Haldol) or other first generation antipsychotic meds. Some "depressed" patients advocate for amitriptyline (Elavil). But potent neuropathic side effects, potential long-term dyskinesias, and comorbid insomnia, depression, agitation, aggression and apathy commend newer "atypical" antipsychotics and less dangerous (in terms of overdose) SSRI antidepressants.[57] And although treatment for insomnia at Clinton is the province of the general medical officer, the off-label use of antidepressants with sedative side effects continues to be common practice.[58]

Alternative treatments have little currency in the crisis setting other than to mitigate some of the harsh punitive conditions facing patients in OBS keeplock. Parenthetically, I was unable to offer or order any Hispanic language book (other than the Bible) to a willing patient faced with a weekend of naked isolation.[59] Despite dominion over diagnosis and drugs, prison psychiatrists have relinquished roles that in other settings assured professional hegemony: (1) authority over admissions; (2) control of cell conditions; (3) psychotherapeutic expertise; and (4) active supervision of subordinates. But diagnosis, medication, assessment for risk, and commitment remain within their well-protected domain.

As elsewhere, a small percentage of prisoner-patients consume a significant percentage of acute mental health services.[60] Most general population prison mental patients are not at

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[56] In state correctional facilities with primary confinement mental health units, roughly half of all patients receive therapy/counseling, slightly higher than rates for medication. Although conceptually distinct, counseling is lumped with treatment statistically. Beck AJ, Manuschak LM "Mental Health and Treatment in State Prisons, 2000" *Bureau of Justice Statistics*, July 2001, NCJ 188216, p4. http://www.ojp.usdoj.gov/bjs/pub/ascii/mhtsp00.txt. At Clinton, DOCS provides separate counseling services, considered inadequate by a number of mental health patients interviewed.

[57] Kapur S, Remington G, Editorial "Atypical antipsychotics" *British Medical Journal* 2 Dec 2000; 321:1360-1361. http://bmj.bmjjournals.com/cgi/content/full/321/7273/1360. New generation antipsychotics are one of the fastest growing categories of drugs. "Atypical" because they treat anergy, apathy, and depression as well as overt psychosis with little or no EPS (extra-pyramidal syndrome). These include risperidone (Risperdal), olanzepine (Zyprexa), ziprasidone (Geodan), quetiapine (Seroquel), and aripiprazol (Abilify). Symbyax, the first FDA approved combined medication for bipolar depression, mixes olanzepine and the SSRI fluoxetine (Prozac). Several SSRI's (selective serotonin reuptake inhibitors) introduced for depression, namely paroxetine (Paxil) and escitalopram (Lexapro) are now approved for anxiety.

[58] As previously noted, several antidepressant are commonly prescribed at CCF for sedation. From the psychiatric perspective, insomnia represents a recurrent early warning sign of decompensation, and hence commends treatment, but renders a charted diagnosis of "depression" problematic.

[59] The prison psychiatrist apparently filled this gaping service need from her own personal collection.

[60] With respect to HMOs it is sometimes suggested that 8% of patients consume over 70% of services. Published aggregate data for psychiatric over-consumers is sparse. In general psychiatric practice, two specific psychiatric

significantly greater risk of violence or suicide than the general population. SHU mental patients are at much higher risk.[61] Other than facilitated admission to OBS, there appears to be no proactive effort to target and treat those patients. In the event of continuing high risk, management defaults to commitment to CNYPC. For committed patients a finding of continued severe mental illness and significant current danger to self or others is required. A DOCS physician is necessary to corroborate the psychiatrist's evaluation for the two physician certification (2 PC) which authorizes transfer of prisoners to the forensic psychiatric facility.

In this latter regard I was asked to examine for commitment a patient-prisoner for no other reason than his prison sentence was nearing completion. A brief OBS cell-side visit revealed no acute severe mental distress nor imminent risk of harm to himself or others. The certifying OMH satellite psychiatrist and the unit staff coordinator maintained the procedure was necessary and "a part of the job" although the state had not provided "the right form."[62] Upon my refusal to co-sign, the 2-PC papers were passed on to a DOCS physician.

Such pro-forma certification renders the commitment "examination" a sham, casting doubt upon the integrity of the process and the physician alike. What if the prisoner is suicidal but not mentally ill? Or a psychiatric patient but not dangerous? Indeed the knowing misuse of the 2PC appears to me to be both medical fraud and a clear deprivation of prisoner civil rights. Such is the power of a virtually autonomous institution abetted by collaborative courts to undermine a bulwark of justice now reduced to indeterminate punishment by confinement.[63]

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diagnoses, "Munchausen's disorder" and "Munchausen-by-proxy," are infrequently diagnosed. In the general hospital/acute psychiatric unit setting demanding frequent returnees are often informally identified as "borderline," "drug-seeking," "psychopathic" or "needy." At Clinton frequent crisis readmissions with clear but fluctuating psychotic symptoms may be informally construed as "malingering."

[61] In July of 2002 DOCS Commissioner Goord stated that the 20 year prison suicide rate was 16/100,000 inmates, compared to an age-adjusted rate of 15/100,000 across the whole US. Out of the total 79 inmate suicides since 1995, 25 or 32% occurred in solitary confinement disciplinary housing units. Goord GS (1) "Correctional Association ignores public safety, maligns staff to promote inmate's issues" DOCS news release, 27 June 2002. Http://www.docs.state.ny.us/PressRel/gangi.html

[62] Is this not a variation on the "Nuremberg Defense," i.e claimed non-culpability for carrying out orders of superior officers? This flawed process lays bare the conflict-of-interest manifest in which an OMH employee (psychiatrist) and a DOCS employee (physician) ordering commitment to another OMH facility for the administrative convenience of the same DOCS facility in which both are is employed.

[63] In 2002 the NY State Court of Appeals adopted a broad definition of "dangerousness" in the incarceration of defendants found not guilty by reason of insanity. In *Matter of David B.*, 2No.5, and *Matter of Richard S.*, 2No. 6 two male acquittees sued for release after confinement for over 20 years. The court ruled that an assessment for danger might be based not only recent acts of violence and proximate risk of harm "occasioned by release from confinement," but prior conduct, likelihood of relapse, history of drug or alcohol abuse, effect of medication and noncompliance, duration of confinement and treatment, time since last criminal acts, and "any other relevant factors" of the "psychological profile." Caher J "Standard for Confinement is Set" *New York Law Journal*, February 14, 2002. [Google]. See also http://www.legalcasedocs.com/120/251/816.html

Part IV. **Securing Treatment**

What is the principal object of punishment in relation to him who suffers it? It is to give him the habits of society, and first to teach him to obey.

De Tocqueville, *The Penitentiary System in America*, 1833

In 1995, then CO union president Curt Bowman defined the necessary attributes of a guard: "Go to work. Come out alive."[64] Many control officers experience chronic stress-related syndromes, and both health and longevity may be compromised by employment.[65] The guards at Clinton are mostly white middle-aged rural men, with considerable pride in their uniforms and work, projecting an opaque congeniality towards their superiors, and a brusque antagonism towards prisoners.[66] Guard depredations are a common feature of inmate complaints, validated in numerous court suits and on-site inspections.

In dynamic tension with "the Man" (prison authority) are two enclaves; one African-American, one Hispanic.[67] Prison gangs subjugate through distribution of privileges including congregate recreation, contraband drugs and weapons; and terror tactics including abuse, assault, and targeted murder.

Among corrections officer and inmates a "code of silence" strongly interdicts revelations of misbehavior across group lines. Cardinal rules of in-group survival include "don't snitch, mind your own business, don't lose control."[68] Breaking the code may provoke morbid or lethal consequences wrought by peers.[69]

The code functions most strongly among the most durable and permanent prison denizens. Control Officers and convict gangs thus manifest common elements of dominance, territoriality,

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[64] Harassment, racial slurs, mental abuse, and physical brutality by Clinton guards is a chronic recurrent disorder. From 1990-1995 inmates at CCF won 17 cases of excessive force by guards, 7 adjudicated, 10 settled without court intervention. Purdy M "Prison's Violent Culture Enveloping Its Guards," *New York Times* (12/19/95), p.A1-B8

[65] Miller L "Law Enforcement Traumatic Stress: Clinical Syndromes and Intervention Strategies" *The American Academy of Experts in Traumatic Stress*, 1999. http://www.aaets.org/arts/art73.htm. This article draws attention to the protective "cop culture," chronic mistrust, and other mechanisms which mask aggression, suicidal tendencies, and vulnerability to PTSD (Post Traumatic Stress Disorder) among law enforcement officers.

[66] There is also a significant presence represented by non-guard DOCS support staff (e.g. food service) whose effect on prison culture has received little notice.

[67] The persistent influence of gangs at Clinton was reported to me, but I did not directly observe this activity.

[68] http://www.prisonzone.com/prisonphoto/gallery14.html. See also Penn Pete, "Inside Prison Rules" Ottawa Innercity Ministries. http://www.ottawainnercityministries.ca/newsArticlesStats. This compilation of 20 commandments for survival supports prison homophobia. Despite a slew of recent peer-reviewed journal articles, data regarding sex and forced sex in prison remains elusive. In prison spread of AIDs and STDs gives the lie to the official DOCS no-sex policy while there are specific indications of deficient medical care and confidentiality violataions at Clinton and other correctional facilities. "No Time To Lose: HIV/AIDS and Hepatitis C in New York State Prisons" *Act Up NY*. (NYC: April, 2004). http://www.actupny.org/reports/prisons.html. See also SPR, " Stop Prison Rape" website. http://www.spr.org

[69] "Ill-Equipped: U.S. Prisons and Offenders with Mental Illness," Human Rights Watch, October 2003, pp.109-113. http://hrw.org

and nurturance which can sustain and protect individual members; or induce stress and extrude unreliable or disloyal members from the group. Such cultures enforce authority through comradery and fear of sanctions.[70] Prime targets are those who threaten existing pecking orders and prerogatives many informal; or among prisoners, gang members of opposing racial subcultures, imprisoned ex-cops; hostile inmates; snitches, pedophiles,.and mental patients.[71]

Opposing the "code of silence" are official rules, and unofficial access to personal advantage and privilege through interwoven complicity with guards and betrayal of other prisoners. The informer "rat" within prison walls is as much a fact of prison life as the snitch without. Intergroup ties, intragroup hostility, situational emergencies, rewards by control officers, and promised rewards by prisoners can all work to facilitate code breakdown.

The mentally disabled exhibit failed "self-control," manifest as downward social drift. They migrate towards the bottom of the order in terms of influence and friendships. They are distinguished by a lack of social competence and reversion to purely individual modes of self-protection and sustenance.[72] Although singled out for management because they suffer, they are in context, uncontrollable and "insufferable."[73] They challenge peers and authority by ignoring rules and rituals, break out in spontaneous non-sense or prolonged silence, sporadic violence, self mutilations, and fitful aggression. They are by turn moody, noisy, demanding, angry, threatening, and isolative. Some assault cell-mates sexually, some are vulnerable to assault. Severely disordered individuals spit, masturbate, urinate, and defecate on self and cell; occasionally launching excreta at cell-mates or captors. Both manipulative and unpredictable, they appear intransigent and unresponsive to DOCS schemes of reward and punishment, including the

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[70] Psychosocial control is rooted in spiritual traditions, e.g., fear of *God's wrath*; leveraged by legal threat of punishment extending to death. Pain is ameliorated by *hope*, an uncertain promise of relief, e.g., in religion by *predestination*, in law by *justice with mercy*, in culture by kinship, chance acquaintance, welfare, and the *lottery*. For "rational" persons painful experience elicits the avoidance of pain by deference to authority. But this feedback--regulation is diminished in many instances of drug induced states and illness, both physical and mental. In "going over the edge" such persons may also inflict unpredictable anguish upon family, neighbors, peers, or strangers. Those who consistently ignore, suppress, or surmount fear may become terrorists *in their own right*, e.g., suicide bombers or new leaders, sometimes of gangs, sometimes nations. [see also note on "state-dependent learning"]

[71] The complex interplay of guards and sacrificial scapegoats is documented in the crushing strangulation of ex-priest John Geoghan by a pedophobe killer in a maximum secure Massachusetts facility. Psychiatric revelation of "confidential" records was instrumental in Geoghan's 10 year conviction for fondling a young man's buttock. Farragher T, Murphy S "John Geoghan. Abuser, Inmate, Victim" *The Boston Globe*, 8/25/03, 11/30-12/1-12/2 2003 (three part series). http://www.boston.com/news/specials/geoghan/

[72] Identification of "severe mental disability" in prison typically excludes solitary severe psychopathy or personality disorders which are broadly considered untreatable. Haddock A W, Snowden P R, Dolan M, Parker J, Rees H "Managing dangerous people with severe personality disorder: a survey of forensic psychiatrists' opinions" *Psychiatric Bulletin* (2001) 25:293-296. http://intl-pb.rcpsych.org/cgi/content/full/25/8/293. At Clinton there is a tendency to diagnose "anti-social personality" in some patients prescribed psychotropics. This may represent expanded off-label confidence in the new "atypicals" and SSRI's. Or it may amount to psychiatric rationalization for medication refusals where "non-compliance" is imputed to "underlying" mental disorder, e.g.. "paranoia" or "psychopathy."

[73] In this they have much in common with drunks, addicts, religious enthusiasts, artists, and lovers.

imposition of immense amounts of added sentence time.[74] These different and difficult behaviors are often first reported by fellow prisoners.[75] Guards and other non-professional staff may also direct referrals to mental health staff.

Security for prisoners at times required isolation and material deprivation. But the prison system breeds a special form of mental torment. Segregated prisoners are specially vulnerable to derision and guard harassment in the isolation of the SHU or the *satellite* OBS cells.[76] On the psych unit I observed sporadic manhandling by guards of patient-prisoners amenable to less antagonistic intervention. A bully-guard mentality is tolerated if not encouraged, and may facilitate cover-up of substantial abuse extending to high officials.[77]

Persistent isolation may itself induce severe behavioral deterioration.[78] In Clinton Prison episodic hints of self-harm or uncontrolled violence in a previously identified mental patient typically results in a minimum of several days of naked OBS "crisis intervention," punctuated by brief (week-day) clinical staff visits, and occasional psychiatric contact. Lack of further threat triggers a move to the clinic dorm or return to prior custodial setting. Regression leads to commitment to Central NYPC for further psychiatric intervention.

Lockdown, whether to DOCS SHU or DOCS/OMH OBS serves institutional risk-management needs by isolating manipulative, malingering, and/or distressed patients. Despite the debilitating context, some prisoners prefer the SHU to general population confinement, and some SHU inmates prefer the psychiatric version of solitary confinement (OMH Back Cell/OBS). The latter, with heightened scrutiny and staff interaction, may provide some relief from boredom or facilitate transfer to another prison setting or hospital facility. Nor should it be ignored that OBS

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[74] In a small cohort of 43 diagnosed offenders and 24 controls from 2 high-security forensic hospitals, Psychopaths (but not those with Borderline Personality) displayed deficits in affective stimulus processing and a marked failure to respond to aversive events. Herpertz SC, Werth U, Lukas G, et.al. "Emotion in Criminal Offenders with Psychopathy and Borderline Personality Disorder" *Archives of General Psychiatry* August 2001:58(8):737-745. http://archpsyc.ama-assn.org [search author/date. Abstract also available on medline]

[75] Fobbins IP "Does Scary Cellmate Warrant Transfer" *The Forensic Echo* 2(4) 1 March 1998. http://echo.forensicpanel.com/1998/3/1/doesscary.html

[76] The State has an affirmative duty to protect inmates from foreseeable risks of harm (*Colon v. State of New York*, 209AD2d842, 843). Former corrections officer/inmate Smith served 3 yrs in the Clinton SHU of a 25-to-life sentence for murder. Three years after transfer to Sullivan CF, he was robbed and stabbed in his general population cell. Smith's legal action was dismissed based upon his failure to prove negligence in the State's failure to intervene in the instant attack, assessment of his continued vulnerability to harm, and assailants' dangerous propensities. *Smith v. State of New York*, 728NYS2d530 (NYS 3rd Dept. Appellate Division 2001).See "Duty of state to protect inmates from other inmates" *Correction Law Report* (Winter 2001) 7(4):5-6. http://www.scoc.state.ny.us/pdfdocs/clr01-4.pdf

[77] Special Master John Hagar's 71 page preliminary report for US District Judge Thelton Henderson slams California DCS director Edward Almeida's action to quash perjury charges against prison guards. The report details "code of silence" protections for so-called "rogue" guards, retaliation against control officers who blow the whistle, and the corrupting influence of a prison union whose gold vein taps deep into to the State capital The prisons crisis "California's corrections system is a corrupt shambles, and state leaders don't appear capable of fixing it." February 2, 2004. *FresnoBee.com*. http://www.fresnobee.com/opinion/story/8076004p-8934965c.html

[78] Grassian S "Report on Attica Site Visit" in *Eng. v. Goord*, pp.1-74. http://hrw.org/english/docs/2003/10/22/usdom7148.htm

provides convicts an opportunity to protest prison regulation and conditions via food refusal, nakedness, fecal smearing, self-mutilations or other infractions. In any event, OMH staff must remain alert to patient denials of intent to self-harm which may be post-hoc rationalizations of impulsive dyscontrol, dissociative states, or disowned psychotic behavior. In this high-risk context, a dismissive attribution of "malingering," may have lethal consequence. But the chance of correctly predicting a statistically rare event for any individual, or devising interventions that substantially alter risk beyond the intensified "suicide watch" is remarkably small.[79]

Treatment Recommendations

With the exception of psychotropic medication, there is little consensus on the provision of crisis treatment, much less effective[80] or cost-effective treatment.[81] The *Satellite* Residential Crisis Treatment program (RCTP) conforms to a traditional risk-management penal model which emphasizes custody, pharmaceuticals, and triage. This presents a marked contrast with the Intermediate Care Facility (ICP), a day care segregated-housing unit where supportive mileau, rehabilitative, and interactional services are implemented for a relatively stable, non-violent group of identified patients.[82]

As discussed above, the acute unit fails to provide adequate assessment and treatment due to (a) devaluation of treatments other than medication, (b) inadequate mental health staff and resources, (c) deference to DOCS risk management; and (d) oversight failure of OMH, DOCS, and the State of NY. Alternative brief treatment models appropriate to crisis prevention might arguably include Cognitive Retraining and Interpersonal Therapy.[83] But the lack of well-trained

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[79] Although less than 10% of the general convict population, SHU prisoners account for over half of NY prison suicides. "Lockdown New York: Disciplinary Confinement in New York State Prisons," The Correctional Association of NY, Oct. 2003, p 51.http://www.corrassoc.org . From 1998-2001, 48 NY prisoners killed themselves, 25 in disciplinary housing. Gonnerman J, "Suicide in the Box" *Village Voice*, p.2 of 8, 17-23 December 2003. http://www.villagevoice.com/issues/0351/gonnerman.php. See also Pfeiffer MB "Suicides high in prison 'Box'" *Poughkeepsie Journal*, 16 December 2001. http://www.poughkeepsiejournal.com/projects/suicide/

[80] To qualify as effective treatment, the value of a given intervention in its real world context must be established. Streiner D "Research Methods in Psychiatry: Few evidence based studies of psychotherapy effectiveness have been conducted. The 2 "Es" of Research: Efficacy and Effectiveness Trials" *Canadian Journal of Psychiatry*, Aug 2002;47:552-556. http://www.cpa-apc.org/Publications/Archives/CJP/2002/August/researchMethods2.asp [paste to browser]

[81] For-profit prison service contractors may turn to "treatment" as an important value-added profit center. Elliott AR, "Cornell Corrections. Houston, Texas: Locking up more business a cell at a time," *Investor's Business Daily*, 31 December 2001. http://www.capp.50megs.com/popupfrppage17.html

[82] "Ill Equipped" *Human Rights Watch*, Oct. 2003. Ch. X. "Insufficient Provision of Specialized Facilities for Seriously Ill Prisoners," Subsection "Specialized Intermediate Care Units". Http://hrw.org/reports/2003/usa1003/15.htm

[83] Interpersonal psychotherapy (IPT) and cognitive-behavioral therapy (CBT) are two structured methods considered effective in the treatment of depression and anxiety. These interventions take longer to work than medication, and require considerable training and practice. Weissman MM, Markowitz JC "The future of psychotherapies for mood disorders, *World Psychiatry*, Feb. 2003, 2 (1):10. http://194.90.2.156/mentalnet/doctors/wpa-journal/wpa%20feb%202003.pdf [paste to browser]

and competent mental health staff with clinical direction and skills beyond pharmaceutical manipulation severely restricts alternatives. Conditions in OBS mimic those in SHU, but are more reprehensible insofar as they are under direct OMH scrutiny.

To minimize adverse emotional and context-dependent effects, a voluntary non-punitive time-out to solitary cell might be provided for both general population prisoners and prisoner-patients. Education for isolation could incorporate training in practical and therapeutic expedients such as t'ai chi chuan, isometrics, yoga, meditation and prayer which alter perception of time's passage and each person's singular place in time. Intellectual and sensory-motor stimulation to alleviate boredom could encompass piped-in music, color, aroma, books, and computer terminals.[84] Correction officers could benefit from training in therapeutic approach, listening, mediation, and respectful disengagement.

No rationale further than good health and minimizing conflict is needed to authorize clean cells, stabilize cell temperatures, and induce exercise of mental faculties.. Why not paint cells? And install sound proofing to dampen clamor, technology to facilitate private communications, and infra-red cameras to permit lighting change for both tranquility and observation during day or night.[85] Why not provide books written in the native language of the culture (Black-street, Hispanic)? Why misidentify as "treatment" decent conditions *for all prisoners* and render thoughtful interventions the exclusive prerogative of psychiatrists and *satellite* commanders whose primary task is not correction, but the taming of feral human behaviors.

Who gets what?

Dredging for social dysfunction brings to surface many marginal adaptors dually disabled by condition and diagnosis. For many "mentally ill," jails and prisons now serve as a substitute for civil commitment. This is especially true where both criminality and the prison system have expanded in response to heightened social apprehension and scrutiny. The crack-down on drug-related crime, strict enforcement, and mandated maximum sentencing helped encourage federal funding for costly state prison building. The lack of community alternatives has consigned urban drug-offenders and job-less home-less to rural brown-field dumps.[86] The US Bureau of Justice reports an overall mental disability rate of 16% in US prisons.[87] The OMH satellite unit at Clinton

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[84] Beaumont and de Tocqueville firmly rejected such "eutopian" schemes:

> "Thus Bentham wishes in his *panoptic* prison the continual sound of music, in order to soften the passions of the prisons. Mr. Livingston asks for...a system of instruction almost as complete as that established in any of the academies"

Beaumont and de Tocqueville, *The Penitentiary System*, 87

[85] Taking the spotlight off a frightened human can alleviate fear, and subdued lighting can induce calm. Why call in a psychiatrist for common sense?

[86] NYS locks up latinos and blacks at respective rates five and ten times that of whites, with persons of color comprising over 80% of the total 100,000 person in NY prisons and jails. "Race and Incarceration in the United States," Human Rights Watch press Backgrounder, 2/22/2002. http://hrw.org/press/2002/02/race0227.htm

[87] !0% of inmates get psychotropics, 13% therapy/counseling. Almost 50% of its prisons (31 of 69) screen inmates at intake and 52/69 are able to conduct psychiatric assessment. The report uncritically asserts that 66 of 69 facilities provide "24-hour mental health care." "Mental Health Treatment in State Prisons" *Bureau of Justice Statistics* 2000, pp.1-8. http://www.ojp.usdoj.gov/bjs/abstract/mhtsp00.htm. This claim of "24-hr. services" is clearly inapplicable to CCF.

supervises 450 patient-prisoners, roughly 15% of inmates.[88]

One 2002 review of 12 western nations found in-prison psychosis (4%) and depression (10%) disability rates two to four times higher than outside; and ten times higher for personality disorders (65%, 47% anti-social type).[89] Identified mental disability at NY maximum security facilities under-reports both the prevalence and severity of mental disorder.[90] Partly this is due to under-diagnosis of severe personality disorder. But consider also that an estimated 50% of NY state prisoners can't read.[91] In fact prisoner learning-disability rates (by self report) equal those of other mental disabilities. Cognitive impairments are glossed in mental disability rates due to statistical presentation as a "medical problem."[92]

Calls for increased mental health services are a persistent feature of prison critiques, but fail to recognize deeply embedded psychiatric abuse carried out in the name of necessary intervention and treatment. Additional mental health services also carry a huge up-front cost. While proposals for increased personnel, psychotherapy, and social rehabilitation command attention, current demands for more effective, less adverse, yet more costly psychotropics are increasing.[93] Special justification and delayed authorization for newer medications continues to restrain their specific application.[94] Cost containment by rationalization of substandard antipsychotics is a predictable institutional response.[95]

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[88] "OMH Site Visit: Clinton Correctional Facility, Dannemora, NY" 9/25/2003. [no diagnostic breakdown]

[89] Caveats: (1) Substance abuse/drug addiction was not included due to survey "reporting and ascertainment biases;" (2) personality disorder diagnosis was based on "life-long behavior" and excluded clinical (rather than validated instrument) diagnosis. Fazel S, Danesh J "Serious mental disorder in 23000 prisoners; a systematic review of 62 surveys" *Lancet* 2002; 349:545-550; Singleton, N, Meltzer, H "Mental disorders in prisoners." *Lancet* 2002; 360:572. http://www.thelancet.com [search authors]

[90] "Ill-Equipped: U.S. Prisons and Offenders with Mental Illness," Human Rights Watch, October 2003, 17-18. http://hrw.org

[91] "Offender Education" CURE-NY (Citizens United for the Rehabilitation of Errants). http://xroads.virginia.edu/~HYPER/DETOC/1_ch15.htm

[92] "Medical problems of Inmates, 1997" *Bureau of Justice Statistics*, Jan. 2001 (NCJ 181644). http://www.ojp.usdoj.gov/bjs/abstract/mpi97.htm

[93] Estimated $3120 annual drug cost for moderate symptoms treated with aripiprazol (Abilify, 15mg/day) contrasts with $570 for haloperidol (Haldol, 10mg/day). Pollack M, Kanavos P, Link C "Variations in the Prescribing Pattern of Atypical Antipsychotics," working paper No. 2002-05, pp.6-7, Dept. Economics, University of Delaware (Dec. 2002). http://www.be.udel.edu/economics/WorkingPapers/papers/paper2002-05.pdf [paste to browser]. Hamer A "Two new mental health drug options reviewed" DUR Newsletter (May 2003), College of Pharmacy, Oregon State University. http://pharmacy.oregonstate.edu/drug_policy/news/5_5/5_5.html

[94] While the psychiatric consensus favors "atypical" antipsychotics, the debate has now shifted to which new atypical is best. In several prisoners a trial on aripiprazole appeared indicated. Although eventually authorized, the delay in availability was up to 5 days.

[95] Markus A, "Superiority of New Schizophrenia Drug Challenged," *HealthDayNews, HealthCentral*, 25 November 2003. http://www.healthcentral.com/news/NewsFullText.cfm?id=516210. This Veterans Administration study downplayed observable cognitive decrement, akathisia, and EPS (extra-pyramidal syndrome) as the result of treatment with haloperidol in favor of it clear cost advantage.

Several factors may constrain budget bloom.[96] The concentration of aged, recidivist, addicted and violent convicts, now well over 56% of all NY prisoners, increases demand for all medical services, not just mental health. Staffing and other medical costs can be countered by consolidation of specialist services; limiting access by managed care with preauthorization and second opinion requirements; contract services; medical furloughs; co-pay by inmates; telemedicine (remote diagnosis and prescription); and computerized administration, pharmaceutical, and medical care monitoring.[97]

Federally funded prison construction and the expanded prison population has saddled the state and DOCS with enlarged maintenance and operating costs. Under severe budgetary constraint, states have adopted cost-saving schemes in several elements of the penal process to reduce penal incarceration. These include *Kendra's Law*, compulsory "assisted outpatient treatment" (AOT); diversion programs fronted by distinct drug-offender and mental health courts linked to completion rehabilitation programs; and post-sentencing housing, counseling, and rehabilitation efforts.

Closure of minimum and intermediate facilities also reduces acute operating costs. In early 2004 Governor Pataki proposed closure of three rural NY low-security facilities and housing cuts in six medium security prisons due to a decline in non-violent prisoners with savings estimated at $18 million Meanwhile the more expensive prison population continues to increase in state maximum-security prisons where violent felons occupy 56% of prison cells, up from 52 percent in 1994.[98] Prison privatization continues to provoke powerful prison union opposition, inciting queries into failures of private control manifest in escapes and violence, and the insidious effect of private corporate contributions to gain political influence.[99] In this regard the Governor remains on the fence and NY remains on the sidelines, content to watch private action in other states.[100]

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[96] NYC's Rikers Island 10 jails hold close to 14,000 prisoners, 80% with drug problems, 30% homeless, and 15% with significant mental illness. As such it is NY's largest penal-psychiatric facility with over 2000 mental patient-prisoners, and costs amounting to $60,000/yr per prisoner. Adame J, "After Rikers" *Gothom.com*, December 2003. http://gothamgazette.com/article/20031205/4/791. [Precise CCF patient-prisoner costs not located]

[97] "Prison Medical Care: Special Needs Populations and Cost Control" *Prison Medical Care*, Sept. 1997 (US Dept. Of Justice, National Institute of Correction Information Center, Longmont, Colorado). Http://nicic.org/pubs/1997/013964.pdf

[98] "County not on prison closure list" *The Citizen. Auburn NY.*, (AP) 11 April 2004. http://www.auburnpub.com/articles/2004/01/23/news/news03.txt

[99] Hallinan JT "Federal Government Saves Private Prisons As State Convict Population Levels Off" *Wall Street Journal*, 6 November 2001. http://www.commondreams.org/headlines01/1106-05.htm

[100] Although NY Governor Pataki continues to veto laws prohibiting private prisons, he has yet to authorize their entry into the state. Stashenko J "Pataki vetoes prison legislation," AP (NY), Nov. 27, 2003. http://www.afscme.org/private/prisons/ppw2003.htm

Part IV. **Final Analysis**

> ***In the ancient prison of Auburn, isolation without labor has been tried, and those prisoners who have not become insane or did not die of despair have turned to society only to commit new crimes.***
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> De Tocqueville, *The Penitentiary System*, 1833

Professional railing against the "stigma" of mental illness conceals a profound hypocrisy. Stigma is in fact a primary mechanism of social disempowerment which facilitates psychiatric intrusion. Emotional problems or learning disorderx are grave enough. But diagnosis of mental illness compounds social disability, even when individual treatment may provide surcease from discomfort. Mental illness is both public revelation of personal weakness and a definitive social incapacitation. Once designated as "mental," such "patients" can be more readily "managed" by isolation, compulsory medication, and prolonged if not indefinate commitment.

The iatrogenic contribution to mental disturbance is well understood by prisoner-patients. Guards and peers follow-up on professional diagnosis by taunting, harassing, and threatening "bug-nuts" to induce rules violations and provoke violence, thus enabling lawful vengeance. Official retribution too often leads to increased sentencing, with time in segregated lockdown accompanied by "deprivation" orders which include the loss of clothes, bedding, eating utensils, etc. Not surprisingly psychiatric keeplock - OBS, which foreshortens but otherwise imitates the brutality of the SHU, may be misidentified as a therapeutic intervention, rather than institutionally protective risk management.[101] In fact, OMH, DOCS, and professionals within the system routinely respond to periodic revelations of systemic abuse with cover-up and concealment, defensive attacks on whistle blowers, and prolonged defensive litigation,.[102]

Although stigma and some harmful side-effects of psychiatric treatment (e.g., addictions, neuromotor disorders, and cognitive interference) are broadly acknowledged,[103] others are not. Penology is replete with sporadic attempts to control prisoners through mutilations including castration and sex-inhibiting drugs. Nine states currently mandate "chemical castration" of certain repeat sex offenders.[104] But commonly applied antidepressants and neuroleptics are also effective

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[101] Kennedy HG "Therapeutic uses of security: mapping forensic mental health service by stratifying risk" *Advances in Psychiatric Treatment* (2002) 8:433-443. Http://apt.rcpsych.org/cgi/content/full/8/6/433

[102] In 1846 The Correctional Association was authorized to inspect NY prisons and report to the legislature its findings. The Association now requests injunctive relief against DOCS which it claims restricts legitimate access. "Correctional Association of NY announces Lawsuit against Department of Correctional Services" (18 March 2004). http://www.correctionalassociation.org

[103] "Lockdown New York: Disciplinary Confinement in New York State Prisons," The Correctional Association of NY, Oct. 2003, pp. 1-58. http://www.corrassoc.org

[104] No firm evidencr supports the use of saltpeter (KNO_3) to desexualize military recruits and convicts. Anti-androgens such as medroxyprogesterone acetate (Provera) and leuprolide acetate (Lupron) reduce sexual drive in most males. Copulatory capacity may be retained. Levenson M, "Is Drugging Molesters the Answer?" *Tech Live*, 12 August 2002. http://www.techtv.com/news/culture/story/0,24195,3395488,00.htm

sex suppressants.[105] Secondary and spin-off effects of singular reliance on psychotropic medications are no less debilitating. Medications condition learning in ways not generally recognized. While medication may stabilize behavior and emotions, it may also rob the patient of precious insight, self-recognition, and self-regulation lost in the non-medicated state.[106] Otherwise intelligent and motivated therapeutic staff are deprived of useful roles. Beyond cognitive interference, coerced psychotropification is social cleansing pogrom conducted in the name of science[107] against distressed, disempowered, and professionally branded peoples.[108]

In the 19th Century "Willard's Law" sanitized New York city streets, almshouses, jails, and rural backwater communities. The "chronic pauper insane" were swept into Willard State Hospital, the largest homeless detention "treatment" center of its time.[109] In 1999 Assisted Outpatient Treatment or "Kendra's Law " was drafted by New York State Attorney-General Spitzer. It authorized the psychotropic pacification of the wandering homeless.[110] It nay strike some as doubly ironic that in the State's leading maximum security prison for violent recidivists, the most fractious aggressive, and recidivist prisoners may refuse medications except in the most extreme, acute, and lethal circumstance.

There was a time in American penal history when silent labor secured by the anticipation of the whip was not just compulsory anodyne but reformative experience.[111] While stripes are history,

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[105] Although the anti-testosterone drug (depot) Lupron is theHaloperidol (Haldol) and most centrally active dopamine blockers antagonize the pro-erection drug apomorphine. Some newer atypical antipsychotics may be absent this effect. The SSRI antidepressants are frequently rejected by patients due to sexual inhibition.

[106] "State dependent learning" is learning acquired while in a specific state that disappears when that state is no longer present. Besides medication, context, stress, therapy and other psychological influences may also create a similar dissociation. The "learn drunk, forget sober" (and vice versa) phenomenon is encountered with many drugs including alcohol, caffeine, nicotine, cannabis, phenobarbital, morphine, benzodiazepines, anticholinergics, amphetamines, methylphenidate (Ritalin), SSRIs, etc.

[107] For a powerful advocate of coercive treatment, see psychiatrist Torrey EF, "Reinventing Mental Health Care," *City Journal*, Autumn 1999, 6pp. http://www.city-journal.org/html/9_4_a5.html

[108] Robert N Proctor, *Racial Hygiene. Medicine Under the Nazis* (Cambridge, MA: Harvard U Press, 1988)

[109] The Willard Act of 1865. Albert Deutsch, *The Mentally Ill in America* (Garden City NY: Doubleday, Doran & Co., 1937), 236-237

[110] NYS Mental Hygiene Law §9.60, *Kendra's Law,* provides for court-ordered assisted outpatient treatment (AOT) of relapse-prone mental patients presenting a serious risk to themselves or others. The law features the threat of incarceration (first 72 hours, then by other civil commitment process up to 6 months) to coerce medication compliance and case management services. In 2002 *K.L.* initiated a due process challenge to AOT based upon its failure to (1) authorize judicial review to challenge a physician's certification of non-compliance; and (2) require a finding of incapacitation prior to deprivation of liberties. The challenge was dismissed in succession by a NY Supreme Court, the Appellate Division, and the NY Court of Appeals. *In re K.L.*, 2004 N.Y. Int. 0014 (Feb. 17, 2004). http://www.law.cornell.edu/ny/ctap/I04_0014.htm. In deferring to a physician's "reasonable belief", the courts claimed that "forced medical treatment" was not authorized by the legislature, but that a patient has a limited right to control their own medical treatment condition upon the state's police powers to provide public safety and *parens patriae* authority to care for citizens unable to care for themselves. Doublespeak anyone?

[111] Francis Lieber, introduction to Beaumont and de Tocqueville, 1833, *The Penitentiary System in America,* ix

New York state currently employs some 2500 inmates in industry and service [112] Although forced labor and solitary confinement are heavily critiqued in the politically charged prison context,[113] a non-descript "psychotherapy" gains lip-service, despite historic ineffectuality in severe mental disorders including schizophrenia and bi-polar disturbance, and characterologic states of impulse-dyscontrol, oppositional-defiance, disruptive behavior, and other conduct disorders. Buoyed by robust and intelligent psychopharmacologic bullets, the psychiatric establishment presses for medical parity, which in the prison terms translates to new psychiatric prison hospitals and services.[114] New York now proposes in a new 64-bed mental health unit at Sullivan maximum security prison in Fallsburg and a 38-bed unit in Washington County.[115]

The ancient partition between therapy and punishment in the prison setting is now functionally obsolete. There is little justification for withholding "treatment" when acute disturbance may be prevented or contained with minimal side-effects by Risperdal, Zyprexa or Abilify; and where chronic conditions including depression and multiform anxiety, PMS, etc., are susceptible to Prozac, Paxil or one their brethren.[116]

Indeed, with a proviso for appropriate legislation and public notice, there is little protection from "liberty interests" to prevent punishing all hyper-aggressive or suicidal prisoners with psychotropic intervention.[117] This should appeal to white middle-class society, which heavily subsidizes such racial concentration camps. It is also but a short schuss for the medical profession which advocates lethal injection for capital punishment.

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[112] "Corcraft" is the trade name for DOCS industry. Wages range from 16-45 cents/hr with a 7 hr/day 5day shift typical. By law, goods and services cannot be sold to private organizations or individuals. "Who We Are - Corcrcraft Products" NYS Correctional Services. http://www.corcraft.org/01_what.html

[113] Browne J "The Labor of Doing Time" (1995) published in *Criminal Injustice: Confronting the Prison Crisis*, Prison Activist Resource Center. http://www.prisonactivist.org/crisis/labor-of-doing-time.html. Contrary to Browne's view, forced prison labor exemplified in both the Auburn and Philadelphia prison systems long antedated the Civil War and the abolition of slavery. More credible is her argument that the penitentiary system evolved from abhorrence of public corporal punishment and an appetite for prison labor which filled public coffers. Relying upon a call for prison abolition, Browne fails to consider the reformative value of labor, and address the perception of relative security which supports extended incarceration..

[114] NY State Assembly Bill A08849 would establish "Psychiatric Correctional Facilities" jointly operated by OMH and DOCS. http://assembly.state.ny.us/leg/?bn=A08849

[115] Ertelt P "Prisons to get new units for mentally ill inmates" Middletown Times Herald-Record (Record Online) 2/5/04. http://www.geocities.com/MotorCity/Downs/3548/newsarticles65.html#section1119 [paste into browser]

[116] Most studies find substantial remission on psychotropics in about 20% of schizophrenia patients, with some relief for 66%, but high relapse rates even for those continuing meds. Javitt D, Coyle J "Decoding Schizophrenia" *Scientific American*, 15 January 2004: 1-4. http://www.sciam.com/issue.cfm?issueDate=Jan-04. "Atypical" antipsychotics promise to (1) reduce both "type I" positive symptoms (agitation, hostility, delusions, hallucinations, thought disorganization) and "type II" negative symptoms (apathy, empty-ambivalent feelings, repetitive thoughts, social isolation); (2) decrease relapse; and (3) reduce nasty parkinson-type side-effects causing non-compliance.

[117] See "The Tranquilized Body: Contemporary Specularization and Symbolization of the Body of the Prisoner" Chapter 11, in Hyde A, *Bodies of Law* (Princeton U. Press, 1997). This analysis of the leading Supreme Court case defining "liberty interests" *Washington v. Harper*, 494 US 210 (1990) makes explicit the transitory boundary between society and individual, public and private, differentially vested in property, liberty, and empathic interests.

A modest backlash might emanate from fearful ex-patients and concerned ethicists who sympathize with the liberty of convicts over that available to denizens of the street. Or jurists who challenge extension to Clinton Prison of remote orders to "medicate over objection" issued at CNYPC.[118] But do not anticipate protest from psychiatrists who have long claimed singular expertise in reading minds, predicting risk, and dispensing prescriptions for a variety of social ills.[119] In this age of encompassing civil addictions psychiatry has much to gain by leveraging its supervisory and civil incarceration monopolies with the addition of forced prison medication.

In military ranks, gymnasiums, schools, streets, and parking lots, mood, sex, and performance-enhancing drugs with new converts at ever earlier ages provide a fertile ground for social acceptance. The Afghan trade in illicit opium - supporting global heroin addiction and funding international terrorism - has expanded ten-fold since America tamed the Taliban.[120] Global illicit drugs sales are now larger than the annual take of the world-wide pharmaceutical industry.[121] Cheap heroin floods American streets and lifts American youth to new highs in ever growing numbers.[122] Fighting illicit with licit addictive drugs is a model well established in government-run methadone "maintenance" centers. Even more common is the treatment of alcohol and nicotine addictions with substitute pharmaceuticals.[123] Specially trained physicians are now being recruited

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[118] *Rivers v. Katz*, 67 NY 2d 485, 504 NYS 2d 74 (1986). The jurist argument is that medication over objection in prison "isolates prisoners with serious mental illness from access to legal representation and judicial oversight." "Mental Health Care in NYS Correctional Facilities," Prisoners' Rights Project. The Legal Aid Society, 18 Nov 2000, pp. 6-7 of 9. http://www.legal-aid.org/SupportDocumentIndex.htm?docid=11 [NB: web title error "NYC" for "NYS"]

[119] Consider the therapeutic arrogance of phrenologists, psychoanalysts and suicidologists in the past century, groups defrocked by methods of statistical and scientific inference.

[120] "Free trade" is the rallying cry of the impoverished Afghan farmer. Seper J, "US set to target Afghan opium" *The Washington Times*, 22 January 2004. http://www.washtimes.com/national/20040121-101235-9084r.htm. [Outlawry makes this market international and a font of funds for international terrorism. Only global legalization will undermine it.]

[121] Sales of illicit drug (the world's second largest industry) are estimated to top out at $500 billion annually, compared to $300 billion in legal pharmaceuticals. In the US in 1998 marijuana was the fourth most lucrative crop, trumped only by corn, soybeans, and hay. "Illegal Drug Harvests Remain High," *WorldWatch Institute*, July 24, 2003. http://www.worldwatch.org/topics/vsow/2003/07/23/

[122] Factoids: "In 2003 Massachusetts admitted 36,000 persons into heroin treatment programs..The average addict is a white, middle-class teenager....New treatment regimen uses prescription drugs and can be obtained in participating doctor's offices....particularly useful for young users, before their addiction causes bigger problems." "Heroin in America," NPR (National Public Radio), 2/23/04. http://www.npr.org/features/feature.php?wfId=1688762

[123] A recent UN report claims that psychoactive substances embodied in tobacco and alcohol contribute 8.1% to the global burden of disease, while illicit drugs contribute 0.8%. WHO news release, "Substance dependence treatable, says neuroscience expert report" *World Health Organization*, (18 March 2004). http://www.who.int/mediacentre/releases/2004/pr18/en/. The news release fails to address (1) the value of alcohol and tobacco as self-medication for pleasure and a variety of ailments (e.g., depression, pain); or (2) the disability and costs attributable to prescription medications used to mitigate addiction. For a perspective on costs of legal drug consider that in the US death attributable to adverse pharmaceutical reactions average around 32,000/yr, roughly equal to those due to suicide. "Matter of Scale: Threats to Security" *WorldWatch Institute*.

for a massive experiment with buprenorphine, yet another opiod/opiate detox swap.[124]

The drug-for-drug war will not end with *Kendra*-style street sweeps and *Willard*-model shock incarceration.[125] With punishment by certain anticipation of immediate physical pain and durable aggregate heavy labor blocked by social consensus,[126] a great remedial experiment hovers in the wings.[127] A multi-faceted drug explosion already shapes politics, finance, and medical practice. Some 80% of inmates in federal and state correctional facilities are involved in drug related crimes."[128] The imposition of psychotropic medication upon violent prisoners, not as treatment but as punishment, beckons with its promise of squaring the circle, resolving the issue of "humane" intervention.[129] Since nearly 30,000 NY prisoners are released each year, this portends a shift from illegal to legal pharmaceuticals and expanded consumer social control.[130] Almost, but not quite, a final solution.

Summary

Crisis mental health services at the Clinton Correctional Facility are examined in the light of relevant judicial inquiries into systemic Department of Correction disregard of patient-prisoner rights to access treatment free from cruel and unusual punishment. Continued professional, institutional, and government complicity; and failures of accountability contributing to marked defects in humane conditions and service delivery are noted. Some reasons for these degrading and knowingly abusive conditions are examined in an historic light and current reliance upon psychiatric examinations and psychotropics to mask failed and flawed penal managment. Some suggestions for change are made.

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http://www.worldwatch.org/pubs/mag/2002/156/mos/

[124] "Facts about addiction" International Center for Advancement of Addiction Treatment. http://www.drugaddictionrx.info [search buprenorphine]. "Facts" taken with grain of salt.

[125] After 126 years of operation Willard State Hospital formally closed its doors in 1995. It re-emerged the same year as a "Drug Treatment Campus" (DTC) under DOCS in collaboration with the Division of Parole and Office of Alcohol and Substance Abuse Services (OASAS). A prison diversion program for non-violent drug offenders and parole violators, the mileau program consists of 3 months "boot camp." This "shock incarceration" combines military discipline, physical workout, education, labor, and substance abuse therapy, followed by a supervised month of out-patient community-based treatment."Willard Drug Treatment Campus" NYS Division of Parole. http://parole.state.ny.us/willardcampus.html. See also Gonnerman J "What they Left Behind" *The Village Voice* (Jan28-Feb 3 2004). http://www.villagevoice.com/issues/0404/gonnerman.php

[126] "NYS Workforce Development Program" draft, 2 February 2002, CURE-NY (Citizens United for the Rehabilitation of Errants). http://users.bestweb.net/~cureny/work.htm

[127] Welner M, "Anxiety Draws Water Guns in Prison: Psychotropic Drugs May help the Overwhelmed Prisoner, *Forensic Echo* 5 (10): 1-2, 17 May 2002. http://echo.forensicpanel.com/2001/10/12/anxietydraws.html

[128] "More than 3/4 of prisoners had abused drugs in the past" US Dept. of Justice, 5 January 1999. http://www.ojp.usdoj.gov/bjs/pub/press/satsfp97.pr

[129] Whitaker R "Forced medication is inhumane" *Boston Globe*, E8, 6/9/2002 http://thefreedomcenter.blogeye.com/whitaker_force.pdf

[130] Lyon D "From Big Brother to Electronic Panopticon" *The Electronic Eye: The Rise of Surveillance Society*, ch4, pp 57-80. http://www.rochester.edu/College/FS/Publications/Lyon.html

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Appendix: Prison Reorganization Project

I. Inside Prison

A. Reorganization and Oversight
- 1. OMH under Department of Health (DOH), subdivision Public Health
- 2. Oversight of prison medical care to DOH

B. Psychotropic Medication
- 1. All prescription by DOCS docs, physician assistants, advanced practice nurses
- 2. Anti-aggression drug punishment/prevention for all adjudicated violent prisoners

C. Constitutional Liberty Interests
- 1. End commitment to mental health facilities at end of prison term
- 2. Full medical/mental evaluation to all consenting prisoners
- 3. Active treatment with non-pharmaceutical alternatives at patient discretion

D. Non-violent Prisoners' Rights
- 1. Miranda warning: "anything you say, or do (don't) may be held against you"
- 2. No treatment without consent unless lawfully incapacitated
  - a. Incapacitation determined by jury with right of judicial appeal
  - b. Guardians *ad litem* appointed for incapacitated patient-prisoners
- 3. Judicial protection orders against unwanted medical-psychiatric intervention[132]

E. Evaluation-Assessment of Danger to Self or Others
- 1. actuarial risk assessment for everyone on entry, updated regularly and on crisis

F. Non-medication interventions: Shock Incarceration plus planned exercise
- 1. Daily scheduled aerobic workouts: music and dance
- 2. Daily training in isometrics and progressive relaxation
- 3. Peer-bonding games, virtual intramural sports

G. Education
- 1. Free tuition community college guarantee for prisoners who complete GED
- 2. One way incoming Internet touch terminals in every cell: parental lock-out

H. Economy
- 1. Token positive reinforcement economy
- 2. Prison scrip - "jail bucks, prison pence"

I. DOCS
- 1. Label changes
  - a. "civil commitment" to "civil jail"
  - b. "correctional facilities" to "prisons"
  - c. "inmates" to "convicts"
  - d. "housing units" to "cells"
  - e. OMH "Satellite Units" to "Spirit Rovers"

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[132] Szasz T. "The psychiatric protection order for the 'battered mental patient.'" *British Medical Journal* 327:1449-1451 20 December 2003. Full text at "Szasz: Cybercenter for Liberty and Responsibility" http://www.szasz.com/bmj12202003.html. For more than four decades Szasz had argued for the legal curtailment of psychiatric authority in order to preserve significant liberty interests of citizens of legal age. Thomas S Szasz, *Law, Liberty, and Psychiatry*, 142-146, 185-186, *et passim.* However, the protection needs to be extended to all physicians or physician surrogates.

2. Close solitary housing unit (SHU). Replace with voluntary isolation[133]
3. Governance: peer mediation, moot courts. (captive rogue state model)[134]
4. Grievance: Guard-Prisoner and Prisoner-Patient Committees (PACS)
5. Conflict resolution: mutual criticism and peer co-counseling
6 Privacy for masturbation

II. Outside Prison

A. Legal
1. Separate violent crimes from status crimes, e.g., "statutory rape"
2. Decriminalize non-violent consenting-adult crimes, i.e., "crimes absent victims"
2. End civil commitment except for incapacitation
3. Depsychiatrize suicide
a. make commitment for self-mutilation and suicide a professional crime
b. refer suicide attempters to friends, peers, and ethicists

B. Political
1. Exconvict Prisoners Union (EXPU)[135]

C. Economic
1. Low interest loans to ex-cons with small business start up: FINCA model[136]

D. Drugs
1. Legalize all drugs (with appropriate warnings)
2. Control access to dangerous drugs (as with automobiles and weapons)
2. Hold drug makers strictly liable for harm (like cigarette companies)

E. Emergency
1. Peer shelter and counseling network
2. Breakdown Insurance: Triple Ex and Triple Ex plus: 24/7 service
a. immediate aid for locked-in, locked-out syndromes
b. emergency lift to home, school, job, hospital, etc.

III. New Programs

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[133] Consider the difference between the old Central Park Zoo and the Bronx Zoo. If you must isolate dangerous creatures, do so in a habitat that encourages civil human behavior.

[134] In 1860 convicts at the Detroit House of Corrections practced self government. Two NY prisons had inmate "republics" by 1914. A "guard-free" honors camp and inmate-guard recovery of escaped inmates were instituted at Norfolk Colony in 1929. Prison communities evolved to provide inmate counseling, suicide and crisis management. Toch H, *Police, Prisons, and the Problem of Violence* (NIMH 1977), 85-89

[135] Prisoners and ex-cons account for 2.7% of the US adult population, some 5 6 million persons . Anderson, AP News, "American Indicators. Civil Liberties, Crime & Drugs" *Progressive Review*, 2003. http://prorev.com/statscl.htm. The potential clout of penal alumni deserves representation by an organization of the highest integrity, before international drug cartels do the job.

[136] FINCA site at http://www.villagebanking.org/

1. **Center for Mental Contagion**[137]

a. epidemiology of persona-born disability (host, vectors, target)
b. mechanisms of negative influence (aggression, shame, intimidation, hate)[138]
c. conditions of disenpowerment (poverty, disruption, unpredictability)
d. diagnoses (folie a deux; Munchausen by proxy; hysteria; Ganser's syndrome)

2. **Prisoner Empowerment Project**

a. Exconvict Prisoners Union Site Inspections, Grievance review, Accreditation
c. Prisoner Exchange Program: military; overseas; private dangerous duty
d. Prisoner Investment Program: stock options in private prison corporations
e Prisoner Owned Prison Management Corporation

3. **Psychiatric Alternative Service**

a. prison work for CME (continuing medical education) credit

[137] Isaac Ray in1863 issued a warning to relatives and friends of patients regarding vulnerability induced by continued close contact with the mentally disturbed. He advocated incarceration "not more for their own (patient) welfare than the safety of those immediately surrounding them." Rothman, *Discovery of the Asylum*, 286

[138] Nelson L, "I feel your pain" *Nature science update*, 20 February 2004. http://www.nature.com/nsu/040216/040216-19.html

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