**Mental Health and the Carceral State**

by

Nixida Ansolone

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Sponsor: Emiliano Diaz

Second Reader: Connie Lobur

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**Abstract**

In effect, mental health is secondary. Mental health in prisons raises numerous concerns within medical, political, and social domains. With regard to mental illness, questions linger as to how the incarcerated are to be treated. This focus on punishing crimes obscures the actual treatment not only of the prisoner, but also for those living with mental illness. This project focuses on these factors that condition the inadequacy of mental health treatment options for prisoners. The scope of this project seeks to address the flagging care of inmates and their mental health that is endemic to the U.S.

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Mental health in prisons raises numerous concerns within medical, political, and social domains. With regard to mental illness, questions linger as to how the incarcerated are to be treated. It is commonplace knowledge that prisons are established to punish. This focus on punishing crimes obscures the actual treatment not only of the prisoner, but also for those living with mental illness. In effect, mental health is secondary. According to the Treatment Advocacy, "How Many Individuals with Serious Mental Illness Are in Jails and Prisons?" *Treatment Advocacy Center*, November 2014, approximately twenty percent of inmates in jails and fifteen percent of inmates in state prisons live with a severe mental illness. However, more than half of these individuals are not adequately treated--if treated at all. This blatant oversight leads to forms of self-harm and, in some cases, suicide. Factors regarding treatment plans within prisons vary from lack of political and cultural support for prisoners to the very funding and resources allocated to such plans. This project focuses on these factors that condition the inadequacy of mental health treatment options for prisoners. To that end, this project analyzes statutory and other legal instruments that aim to address mistreatment as well. It uses as case studies the notorious Rikers Island (New York) and ADX Florence (Colorado). It will examine current lawsuits brought against these institutions for constitutional and human rights violations as well as numerous personal accounts from inmates in both prisons. I will focus, in particular, on the appellate case *Cunningham v. Bureau of Prisons* (2015) and briefly on *Murns v. City of New York* (2001) in order to draw upon current conditions from the narratives of prisoners themselves and activists. The scope of this project seeks to address the flagging care of inmates and their mental health that is endemic to the U.S. criminal justice system.

As the scope of this project seeks to address the flagging care of inmates and their mental health that is endemic to the United States criminal justice system, sources such as first-hand accounts, court cases, and radical needs of reform within prison systems throughout the United States will depict the outcome of this case study.

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One source, Buser, Mary E. *Lockdown on Rikers: Shocking Stories of Abuse and Injustice at New York's Notorious Jail*. New York: St. Martin's Press, 2015, enhances the injustice, dehumanization, brutality, and abuse in Rikers Island through the author, Mary E. Buser, a former Rikers intern. Through Buser's first-hand accounts working in the mental health department at numerous jails, Rikers included, she was faced with black eyes, punched-out teeth, and statements of fear pertaining to inmates' treatments. While she recognized the immense danger, inmates were facing she felt the need to help while also maintaining to keep herself safe. It wasn't until she was assigned employment in the dreaded solitary confinement unit where she saw things she'd never want to see again. Similar encounters can be seen through the eyes of Jose Bautista and Andre Lane, both inmates at Rikers. Another source "Where Mental Illness Meets Brutality in Jail." *New York Times,* magnifies the extreme brutality these two inmates faced during their incarceration at Rikers. Jose Bautista was arrested on a misdemeanor charge following a family dispute which led to his attempted suicide at Rikers Island following with severe police brutality against him leaving Bautista with a perforated bowel. Andre Lane, another inmate at Rikers facing mental health issues, was locked in solitary confinement which led to an incident with correction officers handcuffing Lane to a gurney and proceeding to beat him. Examples such as the two above with Mr. Jose Bautista and Andrea Lane are only two of many that have and continue to occur against inmates, particularly those with mental health issues. Additional sources, such as "Rikers Island abuses mentally ill inmates." – *The Miscellany News* and "The Rikers Island Hot Spotters: Exploring the Needs of the Most Frequently Incarcerated." *Journal of health care for the poor and underserved* further discuss this mistreatment towards inmates with mental health issues through their desire for radical reform towards the incarcerated. In the first source, Barone, Nick. "The Miscellany News." Rikers Island abuses mentally ill inmates – The Miscellany News, September 9, 2015., observations regarding Rikers Island's desperate need of radical reform to address the needs and accommodations of the mentally ill as well as its right to defend their individual rights are discussed. Issues relating to previous incidents such as

Jose Bautista's leading to investigation at the prison are discussed in further detail as well. In addition, the second source Harocopos, Alex, Bennett Allen, Sarah Glowa-Kollisch, Homer Venters, Denise Paone, Ross Macdonald, and Alex Harocopos. "The Rikers Island Hot Spotters: Exploring the Needs of the Most Frequently Incarcerated." *Journal of health care for the poor and underserved* 28, no. 4 (January 1, 2017): 1436–1451 also elaborates on the issue for radical reform towards the incarcerated at Rikers Island. This form of radical reform in this particular source was found through a hot spotting analysis which then led to in-depth interviews conducted on inmates who had set foot in the jail system at least eighteen times within a six-year period at three Rikers Island Correctional Facilities. Findings from these interviews showed that life circumstances, chronic homelessness, mental illness, and substance use resulted in repeated institutionalization across multiple settings. These findings are then discussed in further depth throughout the article. Similar findings can be seen in another source, Teplin, L. Detecting disorder: the treatment of mental illness among jail detainees. *Journal of Consulting and Clinical Psychology*, *58* (2), 233–236 (1990) . The main argument in this text observes the detection of mental disorders in prison systems and the extent to which mentally ill inmates are treated in prison through interviews. These interviews were not only conducted on inmates during their incarceration but afterward as well. Detection of mental disorders in this research found that the prison system relies heavily on the type of mental disorder, crime, and previous treatment history.

Alongside these personal encounters and trying needs for radical reform, numerous inhumane accounts against inmates with mental health issues have gone as far as legal action. One source Cote, Denise. "Murns v. City of New York." *Casetext*, (May 15, 2001) argues the mistreatment of the plaintiff's daughter, Susan Murns, who committed suicide while incarcerated at Rikers Island. The plaintiff's argument relied heavily on the fact that defendants were deliberately indifferent to the substantial risk that Murns would commit suicide after her multiple attempts as well as her past medical history. While Rikers is known for its inhumane treatment against its inmates, numerous other prisons treat their inmates similarly or even worse (reword), one being ADX Florence in Colorado.

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One source, Binelli, Mark. "'This Place Is Not Designed for Humanity'." *The New York Times Magazine*, (March 29, 2015) focuses on two inmates Michael Bacote and Rodney Jones and their experience in The United States Penitentiary Administrative Maximum Facility. The article then further discusses how Bacote and Jones both came together to file one of the largest lawsuits against the United States Bureau of Prisons, Cunningham v. BOP. This case, Cunningham v. BOP, is then further discussed in another source, Cunningham v. Federal Bureau of Prisons | Civil Rights Litigation Clearinghouse. (June 18, 2012) which argues that the defendants, Federal Bureau of Prisons, had violated the United States Bureau of Prisons policy as well as the Eighth Amendment by failing to properly diagnose and treat inmates at ADX Florence with significant mental illness. This case also seeks relief from the Federal Bureau of Prisons by requiring them to adhere to their policies regarding the treatment of inmates with severe mental health issues as well as their obligation to properly diagnose and treat inmates with severe mental health issues with the requirements of the Eighth Amendment. Similar encounters can be seen through the eyes of John Jay Powers, an inmate at ADX Florence. Another source Coffey, Emily. “Madness in the Hole: Solitary Confinement and Mental Health of Prison Inmates.” Lawcommon.edu, 2012., focuses on an inmate, John Jay Powers, who was sentenced to sixty months in solitary confinement at ADX Florence as punishment for escaping prison after testifying against the accused. Following his solitary confinement sentence Powers suffered from severe mental health issues which led him into amputating his own testicles, biting off two of his fingers, tattooing his entire body and repeatedly attempting to kill himself. While Powers drove himself insane, he did not suffer any mental health issues before his incarceration at ADX Florence, therefore showing the mistreatment of inmates at ADX leads to insanity, a topic further discussed in the article. Alongside personal accounts, high survey reports have also shown the horrific and inhumane treatment of inmates with mental health issues within the prison system. Another source, “USP Florence Administrative Maximum Security (ADX) Inspection Report and USP Florence-High Survey Report.” cic.dc.gov, October 31, 2018., focuses on findings found at The United States

Penitentiary Administrative Maximum Facility in an inspection report. These findings include the mistreatment of inmates, mental health care protocols, cell descriptions, safety and security, education and programming as well as daily living. While numerous of the above sources speak upon the inhumane and horrific treatment of inmates with mental health issues at both ADX Florence and Rikers Island through personal accounts and lawsuits a separate source highlights upon the U.S. Federal Bureau of Prison's response toward men and women with serious mental illness in the federal prison system. Another source, Golden, Deborah. “The Federal Bureau of Prisons: Willfully Ignorant or Maliciously Unlawful?” *Michigan Journal of Race & Law* 18, no. 2 (Spring 2013): 275–94. focuses on the U.S. Federal Bureau of Prison's response toward men and women with serious mental illness in the federal prison system. Topics such as the conditions in the supermax prisons and the case law that prevents those who suffer with mentally illness are also discussed. While numerous of the above sources speak upon the inhumane and horrific treatment of inmates with mental health issues at both ADX Florence and Rikers Island through personal accounts and lawsuits sources that advocate for change among all prisons will be discussed as well. One source that advocates for change in the prison system is Bender, Kenneth J. "Pending Legislation Addresses Mental Health Treatment in Prisons." *Psychiatric Times*, October 1, 2004. The main argument in this text observes The Mentally Ill Offender Treatment and Crime Reduction Act of 2003 which was made with the intent to increase public safety facilities by collaborating in the criminal and juvenile system, mental health treatment and substance abuse systems to intent to interrupt the revolving pattern of not providing a therapeutic environment for the mentally ill. Similar efforts can be seen in another source, Adams, Kenneth, and Joseph Ferrandino. “Managing Mentally Ill Inmates in Prisons.” *Criminal Justice and Behavior* 35, no. 8, 2008, observes how both the size of the population and the seriousness of mental illness is increasing in prisons. Given this information, the author mentions quick and up-to-date efforts that could better deal with mentally ill inmates in prison. The author also states an argument regarding further pressing approaches in dealing with mentally ill inmates such as extended therapeutic and evidence-based

treatment. Furthermore, two additional sources highlight the need to advocate for change among all prisons. Another source, O'Connor, Frederica W, David Lovell, and Linda Brown. "Implementing Residential Treatment for Prison Inmates with Mental Illness." *Archives of Psychiatric Nursing* 16, no. 5 (2002): 232–238. observes the collaboration between Washington State Department of Corrections and a consortium of the University of Washington faculty in conjunction to create a prison-based program to assist mentally ill offenders. The text further speaks upon the process of which it took to create this program highlighting the planning processes, implementation, and initial evaluation. The final source used in this project is Anonymous. "Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It." *American Journal of Public Health*. Washington: American Public Health Association, September 1, 1999. observes the mistreatment of the mentally ill in the prison system and how harsh conditions lead to their demise. This text also highlights the main issue regarding the madness in prison and the madness of prisons and how they both coincide with one another.

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**Introduction Chapter**

Each year thousands of mentally ill prisoners are mistreated within the prison system due to their mental illness. Such illnesses include major depression, anxiety, bipolar disorder, schizophrenia, mania, and post-traumatic stress disorder, all of which have one thing in common, their ability to impair one's thoughts, actions, mood, and behavior. Major depression is a mood disorder that causes one to feel persistent feelings of sadness, despair and loss of interest in day-to-day activity leading to an interference in daily function. Symptoms of major depression include changes in sleep, energy levels, appetite, concentration, self-esteem, and daily behavior. Anxiety is a mental disorder characterized by feelings of anxiety, worry or fear leading to an interference in daily function. Symptoms of anxiety include increased heart rate, sweating, trembling, rapid breathing, and feelings of restlessness and nervousness. Schizophrenia is a long-term mental disorder that causes one's ability to think, feel and behave clearly to become altered. Symptoms of schizophrenia include delusions, hallucinations, disorganized speech and difficulty in concentration. Mania is an extremely excitable and elevated mood disorder typically in association with bipolar disorder. Symptoms of mania include disconnected thoughts, increased sexual desire, inappropriate irritability, social behavior and elation. Post-traumatic stress disorder is a psychiatric disorder that occurs after an individual experiences a traumatic event such as a natural disaster, terrorist attack, war, rape or serious accident. Symptoms of post-traumatic stress disorder include unwanted memories of their trauma, nightmares, anxiety, depression and heightened reactions to triggers. According to the Ill-Equipped: U.S. Prisons and Offenders with Mental Illness Report, "On any given day, between 2.3 and 3.9 percent of inmates in state prisons are estimated to have schizophrenia or other psychotic disorder, between 13.1 and 18.6 percent major depression, between 2.1 and 4.3 percent bipolar disorder, between 22.0 and 30.1 percent with an anxiety disorder, and between 6.2 and 11.7 percent with post-traumatic stress disorder." (Human Rights Watch, 2003) Those diagnosed with a mental disorder from above are often processed to a prison rather than to an institutionalized mental facility. This process began due to

deinstitutionalization in 1960, which came from states closing and decreasing their mental health facilities. Surprisingly, deinstitutionalization first began to improve the lives of mentally ill patients while also cutting government funds.

During the initial deinstitutionalization process, thousands of mentally ill men and women were freed from uninviting institutions with the hope of living freely and independently in the community while attending community mental health programs, which were aided by the passage of federal legislation. Unfortunately, deinstitutionalization was too good to be true and came to an end after the federal government cut funds for their neighborhood mental health programs. This absence of government funds and inadequate mental health facilities left many individuals diagnosed with mental disorders: homeless, poor, neglected, and incarcerated. Due to their neglect and poor living conditions, many will find themselves committing crimes they would not have had the system adequately funded. Now, as the Ill-Equipped: U.S. Prisons and Offenders with Mental Illness Report states, "Jails and prisons have become, in effect, the country's front-line mental health providers." (Human Rights Watch 2003) Although prisons are now considered the "country's front-line mental health providers," it does not make them adequately suited for mentally ill individuals.

In many cases, those convicted of crimes, most likely resulting from their mental illness, are treated as criminals rather than incompetent adults in need of professional medical attention. This abuse continues to occur since more bodies equal more money for the prison system, and the longer inmates are imprisoned, the longer they will keep "fueling the fire." Therefore, numerous individuals do not receive the required or prescribed treatment they deserve, which continues to force them into the prison system. Prisons rely on mental disorders to thrive; without them, they would not receive the funding they are currently receiving off of the mistreatment they place on the mentally ill. Often, those sent to prison do not understand why they are there due to their illness's intensity, resulting in exaggerated psychotic behavior. This behavior results from the harsh conditions the mentally incarcerated cope with every day, only to worsen when prison personnel get tired of dealing with

mentally ill inmates. Some examples of the harsh physical conditions mentally ill inmates endure include solitary confinement, absence of privacy, dirty, overcrowded, poorly ventilated, and dirty facilities, and more. According to psychology professor Hans Toch of the State University of New York, Albany, "Prisons are not set up for people who have to cope competence as limited as it is for some of these folks. They are tense and overcrowded places in which all prisoners struggle to maintain their self-respect and emotional equilibrium despite omnipresent violence, exploitation, and extortion; prisoners with mental illness must survive as best they can infrequently brutal and brutalizing environments that they may be particularly ill-equipped to navigate" (Human Rights Watch 2003) On the contrary, alongside such brutal conditions and mistreatment, we must realize that our system is outlined not to include the mistreatment of incarcerated individuals. Instead, our system is created to think of incarcerated individuals as "bad" and do not deserve fair and just treatment during their imprisonment. Instead, our system is created to punish rather than teach and help those learn from their past mistakes, whether through community rehabilitation, medications, or group support.

While one reads through this project, I strongly advise these points to remain in the back of their mind with no prior judgment on the topic and an open mind to realize the unjust and inhumane abuse that continues to occur against the mentally incarcerated today

## Chapter 2: Rikers

Rikers Island, also known as "The Notorious Rikers Island," is a correctional facility located in the heart of New York City between Queens and the Bronx. The island was purchased from the Riker's Family roughly around 1884, only to sit silently until the city decided otherwise in 1920. In the year 1920, Rikers Island was then transformed into a jail with the hopes of replacing Blackwell's Island Penitentiary at the time. With that said, the Notorious Island is still up and running and serving New York City since - but is it rightfully serving its inmates? Outside of Rikers Island's long, detailed and fascinating history, it has been known to hold a bad reputation that stemmed from multiple accounts of discrimination, excessive and unjustifiable abuse, and multiple judicial action cases against the facility. This chapter will detail multiple accounts of abuse against inmates, specifically those diagnosed with mental disorders, through numerous firsthand accounts and the legal case: Murns v. City of New York. Murns v. City of New York is a legal case brought by a Rikers Island inmate's immediate family after their daughter Susan's death. On November 22nd, 1999, the plaintiff, Susan K. Murns, was found deceased after committing suicide in her cell due to prolonged strangulation resulting from hanging herself from a light fixture in her cell. This tragic incident occurred during her imprisonment at the Rikers Island Correctional Facility. Prior to Susan's death, she had already attempted suicide four other times within the last two years, one attempt being at Rikers before her death in late August of 1999. Now, the question we must ask ourselves is: who is responsible for the care of the incarcerated with mental illness at Rikers, how could Susan's death have been prevented, and what caused it?

New York City Health and Hospitals Corporation is the municipally operated corporation responsible for all procedures, policies, and medical and mental health facilities at Rikers Island. These responsibilities were further achieved through a subdivision known as the HHC Office of Correctional Health Services, with Luis R. Marcos, M.D, obtaining the President's title at the time. At the time, St.

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Barnabas was also responsible for on-site care of inmates at Rikers Island through its contract with New York City. Under its contract with the City of New York, Barnabas was paid three hundred and forty-two million dollars within three years and was permitted to hold onto any funds not used during their contract. With that being said, St. Barnabas did everything they could during that time to increase the amount of funds they received during their contract with the City of New York. To increase profits, St. Barnabas decided to drastically reduce their level of funding and staffing at Rikers compared to when Montefiore Hospital Corporation was the current contractor. It also decided to narrow down the number of access inmates were given to medical services. Some examples of change that St. Barnabas placed on Rikers Island medical services includes a staff reduction from two hundred people when under Montefiore to now fifty under St. Barnabas, a fifty-seven percent referral reduction to hospitals off-island, as well as substitutions from experienced physicians to either physician assistants or recently trained physicians. St. Barnabas received an increase in profits between fourteen to eighteen percent, while the average profit in prison health care is roughly between six to ten percent. Due to these cuts, their actions continued to reduce the quality of care towards Rikers Island inmates. After these cuts were placed, the average suicide rate of Rikers Island inmates increased by fifty percent within only the first two years of their contract with St. Barnabas. With that being said, Rikers Island staff were aware of Susan's medical history. They knew she was a high suicide risk that would have one believe they would take the necessary precautions and protocols to ensure Susan's safety and well-being. Instead, Rikers Island staff did the exact opposite, which led to her death. In Susan's case, the Rikers Island staff should have followed the Mental Health Policy and Procedures manual of CHS. This manual state that "medical and correctional personnel at Rikers Island place inmates known to be at risk of suicide under preventive supervision. The Mental Health Manual also requires that medical and mental health personnel at Rikers Island provide psychological counseling and medical treatment to inmates who exhibit symptoms such as those that Murns exhibited" (United States District Court, 2001) With that in mind, the plaintiff, Susan's family, then alleged Susan's death occurred due to lack

of psychological counseling, medical treatment and Riker's persistent need to increase funds by decreasing the quality of care towards inmates at Rikers Island. Unfortunately, the court and defendants thought otherwise when presented with Susan's case. It was concluded that the plaintiff's claims were dismissed since the court believed there was an inadequate amount of facts to support their claim.

To draw upon the ongoing issue regarding the mistreatment of inmates with diagnosed mental disorders at Rikers Island, other encounters must be discussed to draw upon the similarities within one another. Similar or worse encounters have also been reported at Rikers Island, such as those of Mr. Bautista, Mr. Lane and others described in the article *"Where Mental Illness Meets Brutality in Jail"* (Winerip and Schwirtz 2014.) Jose Bautista was imprisoned at Rikers Island after he was arrested for a misdemeanor and unable to pay his two-hundred-and-fifty-dollar bail. The main question we should keep in mind here is: why was Mr. Bautista imprisoned at Rikers Island, a correction facility, due to him being unable to pay his bail? To answer that question Mary E. Buser states in her book "*Lockdown on Rikers*" that "Unlike prisons, which house those convicted of crimes, jailhouse "detainees," those who may well be innocent of their charges but cannot afford bail as they await trial. Since money is the sole factor in determining whether or not bail is attainable, by default Rikers houses the poor. In most cases, the bail amount is less than $1,000." (Buser, Mary. 2015. Lockdown on Rikers. Chapter 1. Page 8) A few days after Mr. Bautista's arrest and transfer to Rikers he was found hanging from his cell's highest metal bar with his torn underwear wrapped around his neck. How would Mr. Bautista have gone from a man unable to pay his bail to a man now attempting suicide at Rikers just a few days later? Shortly after Mr. Bautista was found in his cell, four of the correctional officers rushed to get him down while handcuffing him to the floor forcing him to lie face down as they continually began punching him. This incident was so severe that Mr. Bautista suffered from a perforated bowel which needed emergency surgery. With that being said it should be questioned as to why Mr. Bautista was not immediately put into observation since he was a high suicide risk. According to Mary E. Buser, a

former chief assistant in the mental health unit at Rikers, “Most of the jails on the island have a Mental Observation Unit, or ‘MO’ as we call it. It’s where each jail houses its mentally ill inmates, those with schizophrenia, bipolar disorder, dementia. It’s also where we place inmates at risk for suicide.” (Buser, Mary. 2015. Lockdown on Rikers. Chapter 2. Page 18) If Rikers did indeed have a mental observation unit, as Mary E. Buser stated, why wasn’t Mr. Bautista immediately transferred into it? The officers did the complete opposite of Rikers Island Protocol and why could that be? Could it be that the correctional officers didn’t want to deal with him and felt they could get away with it due to lack of security cameras or did they simply just not care about the wellbeing of its inmates. In this case the same can be said for Ms. Susan Burns who was a high suicide risk at Rikers as well. A similar event occurred just a few weeks prior to Mr. Bautista’s incident to another Rikers Island inmate: Andre Lane. Andre Lane was a Rikers Island inmate who showed evident signs of mental illness. Mr. Lane spent his time at Rikers licked in solitary confinement. Solitary confinement at Rikers was used to house those with mental illness who became violent or unstable. In Mr. Lane's case he was sentenced to solitary confinement after becoming angry at the correction officers for not giving him his dinner which led to him splashing the guards with his own urine. Instead of offering Mr. Lane medical attention or even medication to ease his nerves, the correctional officers handcuffed him, transported him to an examination room outside the reach of any security cameras and began to beat him. The following day witnesses stated that the walls and cabinets were stained with Mr. Lane's blood. As you can see there are similarities in both Mr. Bautista’s and Mr. Lane’s attacks. According to The New York Times “Brutal attacks by correction officers on inmates -- particularly those with mental health issues -- are common occurrences inside Rikers, the country's second-largest jail, a four-month investigation by The New York Times found” (Winerip 2014) However, this four-month long investigational report was never published and has been concealed to the public. With that being said one can only imagine the horrific activities that were found within Rikers - such horrific incidents that needed to be made unknown to the public. Nonetheless, within this four-month investigation it was

stated that the New York Times was able to “uncover details on scores of assaults through interviews with current and former inmates, correction officers and mental health clinicians at the jail, and by reviewing hundreds of pages of legal, investigative and jail records.” (Winerip 2014) Among such documents that were obtained by the New York Times was a confidential internal study completed by the city's Department of Health and Mental Hygiene which the health department refused to release under the state's Freedom of Information Law. The Department of Health and Mental Hygiene is responsible for medical care at Rikers specifically on violence by correctional officers. With the little information given to the public, the study found that over an eleven-month period one hundred and twenty-nine inmates suffered from 'serious injuries' that were unable to be treated by prison doctors. These serious injuries included fractures, wounds requiring stitches and head injuries. Among those injured with such serious injuries it was reported that seventy seven percent had received a mental illness diagnosis. The study also hinted at efforts to cover up assaults within the prison after more than half of the inmates within the study reported facing intimidation or interference from correction officers after an altercation. Five out of the reported one hundred and twenty-nine cases resulted in suicide attempts after such altercations. Daniel Selling, the jail's previous director of mental health services stated, “there’s lots of brutality, horrible brutality.” (Winerip 2014)

## Chapter 3: ADX

ADX Florence, also known as "the most secure prison in the United States," was built in November of 1944 in Florence, Colorado, by the Bureau of Prisons. The prison was designed to model The United States Penitentiary at Marion, a prison built in 1963 to replace Alcatraz and to contain "problem prisoners" with "high-security ratings," the Bureau of Prisons claims. In comparison, ADX Florence was built to follow Marion's models; its repressive techniques of sensory deprivation and isolation were intens`1ified. At ADX Florence, prisoners are forced to sleep, eat, and defecate in their cells while only being allowed out of their cells for limited amounts of time. Those part of the "general population" at ADX are limited to a total of nine hours of out-of-cell time per week. One can only imagine how many hours of the out-of-cell time those outside of the "general population" receives each week. Alongside limited out-of-cell times, prisoners endure limited sunlight due to the three-inch-wide and three-foot-long slit in their cells and lack of communication between prisoners due to the two layers of steel and cement doors and furniture in their cells. Prisoners also have limited contact with prison officials, being that ADX was designed so that one correctional officer could control the movements of multiple prisoners with the use of electronic doors, cameras, and audio equipment. The technology at ADX Florence has been perfected sources, say, with strip searches, metal detectors, and constant video surveillance, which serve only as intimidation techniques against its prisoners. Russ Martin, the project manager for ADX, stated, "these guys will never be out of their cells, much less in the yard or anywhere around here." (people.umass.edu, n.d.) The prison is also notorious for using its severe isolation techniques on its prisoners. Puerto Rican Prisoner of War Oscar Lopez Rivera stated, "isolation is perfected here, both in the structure of the cell and in the minimal communication. People do not realize the value of human intercourse until it is denied." (people.umass.edu, n.d) With that

being said, the psychological side effects of isolation are incredibly harmful on its prisoners, with prisoners at Marion reporting signs of increased anger, rage, and less self-control. These effects have been observed by the United States government as early as the year 1890 when the United States Supreme Court ruled that solitary confinement in prisons was known as infamous punishment that can cause severe mental illness. Further on in the year 1985, the United States Congress then addressed their concerns regarding solitary confinement in prisons and the number of time prisoners were required to spend in their cells.

This chapter will detail multiple accounts of abuse against inmates, specifically those diagnosed with mental illness, through numerous firsthand accounts and the legal case: *Cunningham v. Federal Bureau of Prisons*. *Cunningham v. Federal Bureau of Prisons* was a legal case brought by multiple prisoners diagnosed with mental illness at ADX Florence regarding their mistreatment during their incarceration. The case sought to seek injunctive and declaratory relief from the Federal Bureau of Prisons while trying to have them comply with their policies regarding the treatment of prisoners at ADX with mental illness. The case also sought the Federal Bureau of Prisons to provide adequate mental health diagnoses and treatment within the requirement of the eighth amendment. The eighth amendment of the United States Constitution guarantees all prisoners at ADX Florence adequate mental health care and other necessary care to its prisoners; however, one can see that these policies are yet to be obeyed, leading to a violation of one's own constitutional rights. To satisfy the eighth amendment requirements, ADX must provide consistent care aided with contemporary community standards towards its prisoners, the case stated. Whether it be in a community or a prison, each system composed of mental health services provides different levels of care. These levels of care include crisis intervention services, inpatient services, residential services, outpatient services, and psychiatric services. Crisis level care at ADX is meant to help prisoners who have attempted suicide or inflicted acts of self-harm. With that in mind, ADX is required by the constitution to provide timely provisional mental health services to those prisoners with such services requiring short-term infirmary settings for

diagnostics and a length of stay for up to ten days or less. Inpatient level care at ADX is meant to help prisoners with severe mental illnesses to prevent them from attempting suicide in the future. The United States Constitution requires ADX to provide this treatment when necessary, in a timely manner, whether it be at ADX itself or at another suitable facility. Residential level care at ADX is also meant to help those struggling with mental illness through supportive housing and psychosocial rehabilitation treatment approaches. The United States Constitution requires ADX to provide this treatment towards its mentally ill prisoners in a residential health treatment unit, whether at ADX itself or at another suitable facility. Outpatient level care at ADX is the last mental health service provided to its prisoners. Community standards within outpatient level treatment require such patients to have access to appropriate ongoing assessment and diagnostic services to ensure medications and services are being properly adjusted, necessary medically scheduled and unscheduled recreation opportunities, necessary medically scheduled and unscheduled confidential mental health counseling, and adequate mental health crisis intervention. Outpatient level care at ADX is also required under the United States Constitution. Prisoners are also required under the United States Constitution a thorough psychological evaluation either before their transfer to ADX or immediately after their arrival and periodic psychological evaluations during their imprisonment. This process is supposed to help prison staff identify symptoms and signs of worsening or developing mental illness in order to provide its prisoners with adequate mental health care properly. Upon filing the lawsuit, the BOP's policies initially stated that those with serious mental illness should not be imprisoned at ADX. Those same policies also reflected the BOP's recognition pertaining to extended isolation confinement and the institution's disciplinary actions' harmful effects on its inmates diagnosed with a mental illness prior to such inhumane conditions. Despite the BOP's policies, prior to the filing of this lawsuit, dozens of individuals with serious mental illness were imprisoned at ADX due to the BOP's disregard of their prior mental health evaluations of prisoners. At the same time, the BOP also failed to adequately monitor ADX prisoners for mental health issues before their imprisonment while also failing to

provide those already diagnosed with a mental illness adequate mental health care. This disregard from the BOP then resulted in numerous prisoners harming themselves. Prisoners would scream, wail, and bang on the walls of their cells, cut themselves with razors, shards of glass, writing utensils or chicken bones, swallow nail clippers, razor blades, broken glass, and other dangerous objects, carry on delusional conversations with themselves, spread their feces on the wall and at officers or sadly commit suicide.

Such abuse is seen through first-hand accounts mentioned by the numerous plaintiffs in this case - prisoners imprisoned at ADX diagnosed with a mental illness. To draw upon the ongoing issue regarding the mistreatment of inmates with diagnosed mental illness at ADX Florence due to the disregard from the BOP, other encounters must be discussed to draw upon the similarities among one another. Harold Cunningham is one victim that draws upon his mistreatment while imprisoned at ADX within this case study. Prior to Cunningham's incarceration, he lived in Washington, D.C, where he was previously diagnosed with multiple mental illness disorders such as paranoid schizophrenia, antisocial personality disorder, borderline intellectual functioning, psychotic disorder, conduct disorder, major depression, drug and alcohol abuse, and attention deficit disorder with hyperactivity. The reason for Mr. Cunningham's previous diagnosis before his imprisonment arose from his attempt to plead an insanity defense during his trial on July 15, 1996 - the trial that would land him in prison for the rest of his life. Cunningham was on trial for committing multiple crimes with two other men in Washington, D.C, and Maryland immediately after his release from prison due to cocaine possession. While he chose to represent himself and refused counsel, Cunningham attacked and stabbed a witness with a homemade knife he had constructed as she was leaving the witness stand in front of both the judge and jury. Cunningham was then indicted for attempted murder due to the courtroom stabbing and was examined by Dr. Carol Kleinman - a board-certified member of the American Board of Psychiatry and Neurology, who opined that Mr. Cunningham was not fit to stand trial. However, in early 1999 Kleinman revised her diagnosis at Cunningham's hearing which led to the court finding him competent

to stand trial. A few months later, Cunningham's charges were dismissed by the government without explanation. Following the dismissal of his charges, he was then sent to USP Marion, where he was placed in long-term isolation. Despite Cunningham's long-term isolation, adequate mental health treatment was still provided during his incarceration. Such examples of the adequate mental health treatment that Cunningham received included: monthly psychological counseling with psychiatric treatment to identify what might modify or aggravate symptoms and mental status examinations to prescribe medications. Upon these examinations, multiple doctors such as Dr. Urbanik, chief psychologist at USP Marion, concluded that Cunningham's current mental status, emotional expression, and behavior suggest Cunningham possesses significant mental health issues and that he was a potential risk to himself and others. Mr. Cunningham was then transferred to ADX in December 2001. Upon his arrival, Cunningham received multiple unproductive contacts among the mental health staff with his initial psychological assessment stating he was "a very antisocial individual who is probably prone to misinterpret the actions and motivations of staff members and that mental illness can certainly not be conclusively ruled out at this point." (Cunningham v. Federal Bureau of Prisons ) Cunningham was then under the primary care of Dr. Morrison. Upon his arrival, Dr. Morrison suggested that Cunningham try and go without his previously prescribed medications Risperdal and Prozac from Dr. Urbanik at USP Marion. This switch was done intentionally by Dr. Morrison in order to place Mr. Cunningham in the ADX control unit, a unit where policy prohibits the administration of such medications. Dr. Morrison then dropped Mr. Cunningham as a patient, which led to him being denied any form of psychiatric medication for his mental illness from December 2001 to 2013. Due to Mr. Cunningham's lack of medication, his behavior predictably worsened over the next several years. Cunningham then began to refuse to leave his cell, refusing to submit to restraints, possession of weapons, and assault on corrections officers, all due to the blind eye from many at ADX. Cunningham was also held in his isolation cell within the ADX control unit from 2002 to 2007, where he would endure assault from the correctional officers and was frequently shackled to his bed for days or weeks

at a time. On March 23, 2004, Mr. Cunningham filed a remedy appeal for a request for psychiatric treatment to the central office of administration. Upon filing his appeal, a tele psychiatric examination was conducted, which indicated no mental illness. On August 10, 2004, Mr. Cunningham then filed another appeal to the Central Office of Administration for being denied mental health treatment again. Cunningham specifically stated he wished for an investigation to take place into why he was taken off his medications: Risperdal and Prozac. Cunningham stated, "I am in pain. Everything that makes me act out in uncontrollable ways… Records show that when I am taking my medication, I can function without pain or suffering or incident." (Colorado District Court, 2015) In response to Mr. Cunningham's statement, the BOP denied his second appeal stating that "it was evident you have received prompt, professional medical care consistent with reasonable community standards and Bureau of Prisons' policies." However, one can see that Mr. Cunningham has not received prompt, professional medical care during his imprisonment at ADX. The extent of Mr. Cunningham's treatment while at ADX during his first eleven years only consisted of therapy classes from an educational channel on television and two workbooks: "Cage Your Rage" and "Breaking Barriers." Mr. Cunningham then remained at ADX until the spring of 2014, when the BOP transferred him to USP Hazelton in West Virginia. Until Mr. Cunningham's transfer to USP Hazelton in West Virginia, he was continued to be denied psychological evaluations and access to a psychiatrist and his medications. As a result, Mr. Cunningham continues to live with serious mental illness, which continues to remain untreated.

## Chapter 4: Conclusion & Summary

Upon examining the inhuman, brutal, and unconstitutional treatment mentally ill offenders endured at Rikers Island and ADX Florence in both case studies: Cunningham v. BOP and Murns v. City of New York, one can see the significant similarities between each case. Apparent similarities between each case regarding the mistreatment against its mentally ill prisoners included: lack of funding and staff, abuse, ignorant and unsympathetic behavior from prison personnel, and the systems blind eye at acknowledging their clear inhumane, brutal, and unconstitutional policies - policies in which they believe present no issues among their mentally ill offenders. We must ask ourselves, how can these problems be solved, and if so, when will they be solved? Can the brutality and unconstitutional treatment be stopped, or will it continue to go unnoticed as it did for Mr. Cunningham, Ms. Murns and the other silenced mentally ill offenders now and in the future to come? An exploration of current and past legislation and its effects on mentally ill offenders will be discussed to answer these questions. Other sources touching upon residential treatment for mentally ill offenders will be discussed as well.

One form of legislation to aid mentally ill offenders was the Mentally Ill Offender Treatment and Crime Reduction Act. The Mentally Ill Offender Treatment and Crime Reduction Act was signed into law by George W. Bush on October 30th, 2004, to amend the Omnibus Crime Control and Safe Streets Act of 1968 and interrupt the revolving pattern around the system's poor efforts in reducing crime. Before the act passing it was first introduced into the Senate by Senator Mike DeWine. He argued that "the reality of our criminal justice system is that jails and prisons do not provide a therapeutic environment for the mentally ill and are unlikely to do so anytime soon. Although these problems tend to manifest themselves primarily within the prison system, the root cause of our current

situation is found in the mental health system and its failure to provide sufficient community-based treatment solutions." (Bender, 2004) The act then enabled the attorney general the power to award grants to eligible local and state governments and organizations to begin the implementation of treatments towards their mentally ill offenders. Such entities included "mental health courts that incorporate treatment components into sentencing; training programs for mental health and criminal justice personnel to improve recognition and responsiveness to mental illness in offenders; and programs that facilitate transition from incarceration to community and increase access to community-based mental health care" (Bender, 2004) This grant enabled such entities to implement programs that help: "(1) promote public safety by ensuring access to mental health and other treatment services for mentally ill adults or juveniles; and (2) are overseen cooperatively by a criminal justice agency, juvenile justice agency, or mental health court and a mental health agency (collaboration programs)" (govtrack, n.d.) These programs are also meant to specifically target nonviolent adults or juveniles who "(1) have been diagnosed as having a mental illness or co-occurring mental illness and substance abuse disorders or who manifest obvious signs of such an illness or disorder during arrest or confinement or before any court; and (2) face criminal charges and are deemed eligible on the ground that the commission of the offense is the product of the person's mental illness." (GovTrack, n.d.)

With that in mind, one must come to think: if former President George W. Bush signed this act in an effort to help mentally ill offenders in prison, why does unconstitutional treatment against such offenders continue to occur? For this legal action to work to perform and function appropriately within the prison system, numerous changes need to be made. First, and most importantly, mental health training must become a requirement for all present and incoming correctional officers. It is both dangerous and counterproductive for a new hire to be put into a mental health unit with little to no training regarding their future work environment and those amongst it. Such practical training for new hires and present officers should include: the education behind the side effects of common medications and the types of treatments used for those who have a mental illness, the proper and effective

interaction towards their mentally ill offenders, the recognition of potential signs of suicide and self-harm, the proper and effective physical and mechanical restraints and the refusal of escalated situations amongst such offenders.

Moreover, outside of this training, current and new hires must also be required to take exams with minimum cut-off scores. While one can say they understand the material, proper knowledge will only be shown through examinations and will give instructors a clear understanding of a student's strengths and weaknesses. Once the student's strengths and weaknesses are analyzed, measures can be taken depending on each instructor whether or not such students need to retake courses and examinations. Furthermore, officers should also be required to participate in externships after such training. Such externships will aid in the learning process. They will also give future and current officers first-hand experience and insight on the day-to-day work activities and responsibilities they will be required to handle in the future. In addition, following such training, exams, and externships, current and future officers should also be required to pass one crucial examination that determines one's ability to practice in a prison setting with mentally ill offenders, which will aid in establishing continuity of care protocols. Outside of such training, further recommendations can also be proposed.

First and foremost, the number of incarcerations amongst mentally ill individuals should be significantly reduced. Both chapter three and chapter four of this paper evidently and undeniably show that such individuals as Ms. Burns, Mr. Cunningham’s, and others are not fit to handle the prison system due to their diagnosed mental illnesses. The prison system is meant to punish; however, it is not meant to punish those who are mentally incapable of making sound and rational decisions. Therefore, the government needs to halt the incarceration rate amongst mentally ill offenders and instead send them to designate mental health facilities that are equipped and able to handle such offenders and provide them the proper care needed according to each individual's needs. Secondly, the prison system needs to improve the conditions of their confinement units. Both chapter three and chapter four make it undeniably evident that both Rikers and ADX Florence exhibit such inhuman and revolting

environments that aid in the destruction of one's mental status. Thirdly, the prison system need only be allowed and required to hire qualified and competent mental health staff with experience among mentally ill offenders within the prison system. Determination of such staff can be calculated through an assessment, one's experience, references, and required credentials. In most cases, many unqualified, inexperienced, and unlicensed professionals are hired amongst the prison system leading to the diminished quality of care towards their mentally ill offenders.

While the Mentally Ill Offender Treatment and Crime Reduction Act was signed into Congress to help mentally ill offenders, other acts have also been constructed to do quite the opposite. One act that does such is the Prison Litigation Reform Act which Congress passed in 1995. The act intended to place various restrictions on a prisoner's ability "to file lawsuits based on the conditions of their confinement, reduce frivolous litigations, allow correctional officials the ability to remedy problems before litigation, and lighten the caseload for courts handling prisoner litigation." (FindLaw, 2019) One of the most critical aspects of the Prison Litigation Reform Act is its strict exhaustion requirement which states, "No action shall be brought with respect to prison conditions [. . .] by a prisoner confined in any jail, prison, or other correctional facilities until such administrative remedies as are available are exhausted." (FindLaw, 2019) With that being said, before a prisoner is able to file a lawsuit, their claims must be reviewed and then exhausted through administration before a suit can begin. Failure of such claims not being exhausted can result in the dismissal of a case. The Prison Litigation Reform Act also requires prisoners to pay their court fees in full. However, in most cases, courts will prisoners the ability to pay their fees over a set period if they are filing in forma pauperis.

Nevertheless, under the Prison Litigation Reform Act, prisoners can be stipend from their forma pauperis and be forced to pay their filing fee up front. According to the Human Rights Watch, the Prison Litigation Reform Act needs to be amended or repealed and urges Congress to "1) modify the excessively stringent exhaustion requirement in the PLRA that requires prisoners to comply with all internal prison grievance procedures and appeals before being allowed to bring a federal lawsuit

which frustrates the prosecution of many meritorious prisoner lawsuits; 2) repeal the requirement that judicially enforceable consent decrees contain findings of federal law violations; 3) repeal the requirement that all judicial orders automatically terminate two years after they are issued, and 4) restore special masters' and attorneys' fees to reasonable levels." (Human Rights Watch, 2003)

As one can see, the prison system inarguably and evidently shows various signs of abuse, disregard of one's constitutional rights, and unsympathetic regard towards its mentally ill offenders. Apparent similarities between Rikers Island and ADX regarding the mistreatment against its mentally ill prisoners were made evident with such similarities, including lack of funding and staff, abuse, ignorant and unsympathetic behavior from prison personnel, and the systems blind eye at acknowledging their clear inhumane, brutal and unconstitutional policies. This abuse has and continues to occur within the prison system to this day. While evidence was shown through Ms. Burns, Mr. Cunningham’s, and others case studies, many stories of abuse among other mentally ill offenders remain and continue to rest silently. Without proper adjustment amongst the prison system, these forms of abuse will continue to occur in years to come.