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THE CHALLENGES OF MENTALLY ILL FEMALE OFFENDERS IN PRISON

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An increasing number of women offenders arrive in prison with serious mental health problems. Such inmates tend to experience difficulties negotiating the prison environment. They create all sorts of predicaments for other prisoners and instigate crisis situations that present pressing challenges to members of the staff. One prevalent form of symptomatic behavior in women's prisons is that of self-injury, which carries the risk of death or serious impairment. Self-harm should not be the sort of behavior that invites disciplinary dispositions. Mentally ill women also become involved in disproportionate serious rule breaking, including assaultive acts, leading to inappropriate placement in segregation cells, where their difficulties are apt to become exacerbated. To address this problem, special settings can be created to accommodate some chronically disturbed women, but these serve to merely ameliorate a seemingly insoluble dilemma.

Keywords: female inmates; mentally disordered inmates; prison programs; segregation

On any given morning, the noise of cell doors opening as women are released from each of the 60 cells on a unit, 30 on each gallery, 360 cells altogether, resounds though the main housing block and over the hillside. On this particular morning, shortly before 6 a.m., the clanging and banging was interrupted by garbled screams from 114A gallery. All the solitary officer in the control bubble could hear was a repeated shout, "It's the devil. It's the devil. The devil's in her," followed by almost unintelligible pleas for help. As he rushed down the corridor, he heard again, "The devil's in her. It's the devil." However, before the officer could get to Cell A-7 near the middle of the gallery, three inmates who had been on their way to the showers rushed in through the open cell door. As the officer arrived, he could see Violet¹ sitting over Jane, straddling her prone form and choking her. She pounded Jane's head into the pillow. It took the three inmates to pull Violet off Jane. When the officer took control of Violet, she was still yelling about the devil; she continued to yell all the way to the mental health unit and for some time after. Jane, a teenager, was inconsolable, shaking and breathless, disturbed beyond measure and sobbing uncontrollably. It was clear that she had no idea what had happened. She had never met Violet, and it was the first night she had ever spent in a cell.

Violet struggled with demons long before she was incarcerated. She also had a history of not showering because she insisted that black bugs would come out of the showerhead and cover her body. Whenever Violet stopped showering, we knew that a referral for mental health services was in order. Sometimes another inmate made the referral before correctional staff because showering next to Violet usually led to the earliest clue.

Most women in prison know why they are there, accept that they have done something wrong, serve their sentences, and go about their business, making changes and doing what

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they need to do to move on. However, inmates with mental illness sometimes cannot even understand why they are in prison. For example, a woman named Jennifer would write to me periodically to say that the judge had framed her. She told me many times that she had not cooperated when he wanted to have sex with her, and so he had had her arrested, tried, and convicted of her serious crime.

Women like Violet who suffered with periodic delusional activity lived within the prison's population because there were too many of them to house in the prison's small specialized units for the mentally ill or because their symptoms could be controlled for periods of time. However, it was women such as Miriam, who suffered from severe behavioral problems, who created the greatest and most consistent dangers and challenges. Miriam accumulated one misbehavior report after another. Although many were for petty offenses, she was often involved in incidents that led to injury to herself, staff, or other inmates. On one occasion, she grabbed a baseball bat from a woman going up to bat in a game in the yard. She swung the bat wildly and menaced anyone who tried to take it away. She was finally backed by officers into an interior lobby adjacent to the yard, but only after breaking out every window within her reach. When the officers finally got control of the bat, Miriam was crying uncontrollably but could not explain what had caused her to act so dangerously.

On another occasion, Miriam took the fire hose out of its cabinet, whipped it around so fiercely that the brass nozzle made a whooshing sound, and threatened anyone who came within range, causing almost all normal activities to cease. These behaviors were not characteristic of what happened during an average prison day, but they are examples of an almost endless stream of violence-prone behavior from mentally ill women. It was very unlike the behavior of the majority of inmates, and it severely disrupted the ability of staff to perform their duties and inmates to serve their time. These incidents illustrate the challenges presented by mentally ill women within the prison environment.

In 1982, I was appointed deputy superintendent for programs at the Bedford Hills Correctional Facility, New York State's maximum security correctional facility for women and its reception center for all women entering the state correctional system. In 1984, I became superintendent, a position I held until my retirement in 2004. During these years, the female inmate population exploded, not only in New York but also across the United States. Embedded in this huge increase in the numbers of women in prison were growing numbers of mentally ill women. Because the most seriously mentally ill women remained at Bedford Hills, half of all inmates were on the mental health caseload, with one fourth of them considered seriously and persistently mentally ill. At times, to express my frustration, I would say that I was managing a mental institution, not a prison.

When I first became superintendent, I would sometimes spend quiet evenings in the facility's special program units for the mentally ill reading to the women. At that time, I was trying in small ways to think about the kinds of programs that we could initiate for mentally ill women housed within the general population, given that there were never more than 50 beds available within our specialized mental health program units. However, as the population expanded quickly and we began construction of two new dormitory buildings to accommodate the influx, I could no longer spare the time for such endeavors. Within just a few years, the inmate population in Bedford Hills had doubled.

Mentally ill women can rarely negotiate prison environments long enough to get involved in the self-improvement programs that are available. For example, obtaining a GED is one of the most desirable goals that an inmate can pursue while in prison and one

closely tied to success on release. However, the mentally ill women fall asleep in classes as a result of their medication, or they attend for 3 days and miss the next 2, having been readmitted to acute psychiatric care. They write bizarre essays; they ask the teacher or tutor for help but they don't know the assignment, or they ruin their schoolbooks in a flood, having clogged the toilet in their cell with a blanket. They cut themselves with the smallest piece of glass, blood dripping on their just-completed schoolwork.

The mentally ill women are sometimes so out of touch with reality that they are incapable of distinguishing their thoughts from fantasy. Donna was near the fence surrounding the yard for the Intermediate Care Program (ICP) when she engaged me in a conversation. "Have you seen the spaceship?" she asked me. "It's going to land right here where you are standing. It's bringing me four cartons of cigarettes, but don't worry, I know that you always say there has to be enough for everyone, so they're bringing four cartons for everyone in Bedford. You'll tell me if you see the ship, won't you, Superintendent? You'll let them leave the cigarettes?" I responded that, as long as there were enough cigarettes for everyone, the spaceship was welcome.

Another woman would always ask if I had received her pardon from the U.S. president yet. She would then describe to me a gorgeous suit that she believed was now in the Package Room, having just arrived from Paris from her parents. As seasons and presidents came and went, she was still awaiting the pardon, ready with the latest fashion. If you are not prepared for such conversations with inmates, then you are not prepared to work in a prison today.

THE NEW MENTAL HEALTH HOSPITALS

It is the seriously and persistently mentally ill who are truly prison's untouchables. In our prisons, just as in our society, the mentally ill are looked on as people it is best to keep at a distance. In prisons, they remain stigmatized, isolated, and misunderstood. The numbers of mentally ill women in prison have grown significantly during the past 20 to 30 years, and they are at the absolute bottom of the hierarchy of a women's prison. As with other mentally ill persons, the closure of most residential mental institutions in this country led to the release of many women who had been in the back wards of our mental institutions. This change was driven by the development of a whole range of new medications that addressed various symptoms, making institutionalization unnecessary for many women. However, community mental health opportunities did not keep pace with need, and funding for alternatives to the larger hospitals was not always adequate. Mentally ill women, who had once been disproportionately represented among the ranks of the institutionalized mentally ill, found themselves in shelters or among the homeless. They joined the ranks of the self-medicating and as a result involved themselves in the illegal drug world. Some of these women became victims of the get-tough policies toward crime, the war on drugs, and the ever more rigid sentencing policies of the past few decades, and now they populate our jails and prisons in ever-increasing numbers. The range of community alternatives is increasing but still remains underfunded or unavailable to many poor women.

Human Rights Watch announced in 2006 that there were three times as many men and women with mental illness in U.S. prisons as in our mental health hospitals (Human Rights Watch, 2006). To put it another way, prisons have become our new mental institutions.

In mid-2005, a U.S. Department of Justice (DOJ) study estimated that nearly 75% of the female inmates in prisons and jails had mental health problems (James & Graze, 2006, p. 1). The DOJ research found that 12% of female inmates self-reported symptoms of mental health disorders, with 10% reporting symptoms of major depression, 2% reporting symptoms of manic disorders, and 3% reporting symptoms of psychotic disorders (p. 3). Of these female inmates, 23% reported that they had been diagnosed by a mental health professional with a mental disorder in the past 12 months, and 9% had stayed overnight in a mental health facility (p. 4). Although figures were not calculated by gender, inmates with mental health problems were more likely to have been homeless, were more likely to have current or past violent offenses and more prior incarcerations or probations, had a higher rate of substance abuse or dependency, were more likely to have used drugs in the month before their arrest, and had histories of past physical or sexual abuse. A larger percentage of female inmates who had a mental health problem had been injured in a fight since admission to a state prison than those without a mental problem, 10.3% to 3.8% (p. 10).

A PRISON IS NOT A MENTAL HOSPITAL

Placing mentally ill women in prison means that they must acclimate themselves to the regimentation and unquestioning obedience that keep prisons running smoothly. However, the behaviors required are simply beyond the abilities of most seriously mentally ill women. They do not set out to be recalcitrant or to involve themselves in serial self-harm or serial violence; in fact, in most cases, these patterns formed long before they entered prison. In her National Institute of Justice–funded research in a female maximum-security prison, Janet Warren (2003), a clinical associate professor of psychiatric medicine at the University of Virginia, studied a sample of 802 women in one prison's general population and found very high levels of psychological distress. She described the women inmates in her sample as more similar to women who were receiving inpatient or outpatient mental health treatment than to women in the community. Symptoms of personality disorders among the women inmates fell in two major clusters of diagnoses that included tumultuous relationships, impulsivity, recklessness, susceptibility to substance abuse, and abuse in one cluster and suspiciousness, social awkwardness, and overly dependent attitudes and behaviors in another. Warren stated that these behaviors preceded incarceration and inevitably contributed to the behavior or the series of behaviors that led to incarceration.

As the population exploded at Bedford Hills, we tried our best to be responsive to the needs of mentally ill women who lived in cells or dormitories in the general population. In the case of a young woman who banged and yelled throughout the night, we discovered that she had been kept in a closet as a young child whenever she refused to consent to her uncle's sexual demands. We installed a nightlight in her cell (there were no dormitories at the time), and the unit became more peaceful. When we added bunk beds in our new dormitories, we asked for railings to prevent falls by women who were heavily medicated. Denied these, we created a system to review bed placements with mental health staff, a time-consuming process. Mental health and correctional staff continued to fill the gaps and address these seemingly small needs, but within the context of a prison, individualized needs are neither small nor simple. There is always an overlay of security concerns to be reckoned with, always a concern that other inmates might demand similar treatment but for dangerous reasons.

SELF-HARM ACTIVITIES

Some mentally ill women self-harm exclusively, and some vacillate between self-harm and violence. They do all sorts of damage to themselves with whatever lies in reach. If one woman self-harmed, others often followed because the nature of relationships between women cued much of their behavior, both positive and negative. Women use broken pieces of light bulbs; screws that they pulled out of objects; broken pieces of floor tile; pieces of plastic, including pieces from medicine cups; the sharp edges of little foil packets that contained skin cream; paper clips; staples taken out of books; pencils; knitting needles; a small, sharp stone; a thousand different things. It is impossible in a prison to remove every item that can be used for self-harm. Prisons do not have rubber rooms. They do have observation cells overseen by mental health professionals, but inmates remain in them for only a few days until they are calm or are transferred to the secure psychiatric hospital.

Self-harm activities often began long before a woman arrived in prison. Most began to cut or swallow when they were young teenagers, often in juvenile facilities, on observing another girl cut or self-harm. Many women arrive with scars over much of their body; some arrive with eating disorders, a less visible self-harming behavior. One woman had to be taken to the outside hospital each time she inserted an item into her abdomen, sometimes in the unhealed scar. After each of these incidents, she ended up in an observation cell but was then released and self-harmed again. At times, she used a pencil stub, at another, magic markers that bled their colors all over her intestines causing severe infection. She was denied the stick pens issued to all inmates because she inserted so many into her abdomen. Finally, she was given only nontoxic, washable crayons, but they, too, found their way into her abdomen.

In prison, women are not in a position to make many choices: They cannot choose the neighborhood in which they live or their neighbors but rather are assigned to a cell and a unit; they cannot choose the place where they work but rather are assigned according to security or facility need; they cannot choose where they spend their leisure hours but rather recreate in large, open outside yards; they cannot choose with whom to share a classroom or the visiting room; in many prisons, they cannot hold or physically touch their children; they cannot choose where they go to worship, or where to get their hair cut, or a thousand other decisions that we take for granted each day. Therefore, to reside in the cell next a woman who may at any moment borrow some small item and insert it into her abdomen, swallow it, or cut herself with it so badly that the blood runs in rivulets down her arm, or use it to assault someone else, is not conducive to serving out a sentence.

Women in prison want to go to school, go to their job, participate in drug treatment or domestic violence group or violence preventions programs, and then spend their evenings washing their clothes, cleaning their room, taking a shower, watching TV, making a cup of tea, calling or writing home, playing cards—not much different from most of us. When the population includes the severely mentally ill, however, these activities are often interrupted by some medical or security emergency surrounding a mentally ill woman. Sometimes, it is a woman who has saved up her pills and has taken an overdose; at others, it is someone cutting herself. When someone is howling like a dog, quacking like a duck, or otherwise disturbing sleep, it is difficult to even get up in the morning, much less endure the daily routine of prison.

Although some prisons punish self-harm, most prisons punish the behaviors associated with self-harm. However, there is nothing to be gained by stigmatizing these women still more or sanctioning them. In fact, cell confinement seems to result in yet more self-harm.

Women who self-harm are expressing such deep pain that punishment seems absurd and inappropriate. Too often, both correctional and mental health staff are concerned that women will self-harm again if not punished, that they would feel able to manipulate the prison system and rules. This is faulty thinking that needs to be eradicated. Punitiveness and feelings of guilt are what often led to this behavior, and more punitiveness by the prison is not going to reverse it or establish a climate to address the dynamics and pain that self-harm is indicating. In fact, the entire chain of events that surrounds self-harm behaviors needs to be looked at flexibly and as a whole unit of behaviors related to the initial self-harming act.

RULE BREAKING

There are few mechanisms to create conformity in prison other than institutional rules and punishment for not following them. Although many mentally ill inmates serve their time quietly and almost invisibly, routinely attending what therapeutic appointments the overtaxed staff can provide and taking their medications regularly, even one incident involving a mentally ill woman can create stigma against all others. These women, especially those with severe borderline personalities, startle staff and other inmates with their quick changes of demeanor and outbursts of anger aimed at anything or anyone. A few inmates suffer serious psychosis and exhibit odd mannerisms that signal a serious loss of touch with reality. Both inmates and staff see such women as potentially dangerous, as “earth disturbers,” resulting in the belief that their unpredictability makes them inappropriate candidates for sharing living quarters or work areas within prison, even in the less dangerous and somewhat less violent atmosphere of most women’s prisons.

This is not a surprise to anyone trying to manage a woman’s prison or to anyone who has been involved in corrections during the past few decades. At Bedford, about 80% of all unusual incidents involved inmates who were on mental health caseloads. (Unusual incidents are those deemed serious enough to be reported to the central office of the Department of Correctional Services, which monitors serious incidents in all facilities. They include only incidents that present a serious threat to the safety and security of a facility.) Many of these incidents actually involved self-mutilation or disruptive behavior. These disturbances sometimes involved attacks on others, but often the violence was random, involving such out-of-control behavior that it spilled over to result in some level of harm to a staff person or another inmate. It has become clear that mentally ill women contribute more than their share to chaotic situations arising amid the normal routine of prison.

Warren (2003) suggested that “suspiciousness and odd beliefs are highly relevant to risk assessment for violence among women, superseding the reckless and tumultuous behavior more commonly associated with personality disorders among female inmates” (p. 23). These findings, Warren wrote, indicate that women in prison

suffer from more extensive types of psychopathology than is suggested by studies that focus only on the acute forms of mental illness. It also highlights the societal cost that accrues from our current impasse regarding effective ways of either minimizing the development of these less obvious forms of psychiatric impairment or treating them once they have crystallized into long-term forms of maladaptive functioning. (pp. 23-24)

Warren found that in addition to the forms of mental disorder that are associated with specific symptoms and discrete episodes of disturbance, such as depression or substance abuse disorder, incarcerated women frequently are diagnosed with varying forms of character pathology. This type of dysregulation, usually termed personality disorder, refers to stable, long-standing dysfunctional interpersonal behavior that results in impairment throughout most spheres of adult functioning (p. 37). Prison, therefore, becomes just one more in a series of environments that create difficulties in adaptation for mentally ill women.

Martin and Hesselbrock (2001) created a typology of women to examine the relationship of risk, resilience, and vulnerability. They labeled the group with the highest rates of mental illness as "Troubled" and found that these women were the most likely to be incarcerated for violent offenses or public order offenses. They were described as having the highest rates of posttraumatic stress disorder, antisocial personality disorder, and depression; as being least likely to be substance abusers; as having experienced trauma as children; as having the highest rates of family criminal history and risky home environments; and as having high rates of sexual assault victimization. Another group, called the "Volatile," the youngest group of women, were most likely to be alcohol dependent, with high rates of public order, property, and violent crimes. They exhibited relatively high rates of mental illness and the highest rates of sexual assault victimization while identifying few resources within themselves and exhibiting a tendency to be pessimistic about life. This group showed a high incidence of depression and posttraumatic stress disorder (PTSD). They had also experienced incarceration of family members and difficult and harmful home environments (Martin & Hesselbrock, 2001, pp. 38-39). Women in these groups needed intensive mental health interventions combined with substance abuse treatment and attention to PTSD issues. In sum, the women in prison with the greatest mental health needs had experienced the greatest levels of violence as children, had few social supports, and exhibited the greatest risk for violent behavior.

It is not always easy to identify when mental illness is escalating or even when it has reached critical proportions. It is nearly impossible to understand when a mentally ill inmate will react in a way to cause harm. If even once in a while violence occurs without warning and without a basis that can be understood, it is that much more difficult to forget. A young woman named Lilly lined up with many other inmates at the unit door for the school line run. Another inmate, Wanda, also joined the line but quickly reached out and slashed Lilly across the cheek so deeply that her teeth were exposed. The escort officer was standing right next to the line, and there were more than 30 inmate witnesses. Lilly had never even spoken with Wanda, and Wanda never explained why she slashed Lilly, a person she appeared not to know. Wanda, who had a lengthy mental health history, was so ill that she was transferred to the psychiatric center. However, Wanda left confusion, fear, and anger in her wake, and that fear encompassed all mentally ill inmates.

Although hearing officers conduct a review of a woman's mental status in cases of misconduct, this does not guarantee that mentally ill women will be kept out of cell confinement or the Special Housing Unit (SHU). Most prisons have not come to view requiring individual counseling or placement on a specialized unit as a disciplinary measure. Jamie Fellner (2006, p. 400) of Human Rights Watch described such occurrences in the Georgia Department of Corrections and pointed out that correctional agencies have just begun to struggle with concepts of fairness and punishment for mentally ill inmates. It is clear, as in the above case with Wanda and Lilly, that the prison must protect other inmates and staff. It is also clear that at times transfer to a secure hospital is an acceptable answer.

In our society, we have almost eliminated the use of insanity as a defense for behavior, and many states have actually eliminated insanity as a defense for criminal behavior. It is ironic, then, that when managing mentally ill women, the prison system is now displaying increased sensitivity to the impact of their illness on their behavior. Nevertheless, it is difficult if not impossible in the paradigm of corrections to use the disciplinary process for some inmates but not for others, unless those others are mentally ill women in specialized residential programs. Even then, the specter of violence has an untold impact on how staff and other inmate participants react.

PRISON MENTAL HEALTH UNITS

Over the more than 20 years that I worked at Bedford Hills, there were only three alternative mental health programs within the facility designed to address the needs of the mentally ill. These programs were operated by the Office of Mental Health, another state agency. The first was a 13-bed unit for inpatient care of women at the secure psychiatric hospital (beds that were shared with county jails). The second program, the Satellite Unit, contained both short-stay observation cells for women who were dangerous to themselves or others and a small dorm. These units were not integrated with other general population units but rather were located in the health building where the medical clinics and infirmary were located.

The third program, ICP, was operated under a therapeutic community model and was located within the facility to provide a place for inmates to live who could not adjust to living within the general population units because of their mental illness. The ICP was staffed jointly by the corrections agency and the mental health agency. Admission to the ICP was decided by a joint committee, but admission to the Satellite Unit was a decision made by a mental health professional.

On the ICP, most of the actual work involved getting women out of their cells in the morning to participate in simple unit activities. These women were primarily quietly psychotic. Other inmates strived to help these women by developing a self-care, self-esteem program on the ICP. Bulletin boards were hung to keep track of bed making, personal hygiene, hair care, cleanliness of a cell, and similar skills. There was no alternative setting for those women with severe behavior disorders. Correctional staff used to argue that the mental health clinicians needed to put the most disruptive women with serious behavior problems on the ICP. However, the few times that this occurred, we quickly learned that these highly aggressive women took advantage of the other ICP women or instigated them to act inappropriately or dangerously. In any case, most of the mentally ill women had to be managed within the general population housing units because there were simply not enough spaces in the specialized mental health units.

THE STEP-UP PROGRAM

Too often, we noticed that women who moved from the ICP to general population returned to a mental health unit within a few days or weeks. Therefore, around 2000, the facility created another therapeutic program unit called Step-Up, a 60-cell unit geared to helping women transition from the ICP or Satellite Unit to general population.

It had become apparent to us that if we were going to view the facility as a community in terms of mental health, and if we were serious about integrating the mentally ill women returning from specialized mental health programs or the psychiatric hospital to the general population, we needed to develop programs within the general population to ease the transition. We wanted to reduce the feelings of trepidation and alienation of women who left the relative safety of the mental health unit when they moved to general population.

One of our counselors worked with inmates to create this unit for transitioning from the sheltered residential ICP or the more acute services of the dorm or hospital. Most of the cells in the newly created unit were occupied by inmates who had had serious involvement with mental health services and felt awkward in the general population or found themselves cycling from mental health programs to general population and then back again. These women said they did not always need to be in a special mental health unit, but they did feel more comfortable on a therapeutically focused unit, where support was provided and where people knew that they had mental health problems.

The counselor ran the overall program and held daily meetings on the unit. Several inmate program aides were assigned to assist in the operation of the program. Inmates were asked to volunteer for this position, and several of the volunteers had valuable prior experience dealing with family mental health issues. One woman wanted to help because she had a brother who was mentally ill and had been in and out of hospitals as a child. Another had a mother who had problems with mental illness. Several had prior histories of some mental health involvement prior to incarceration. Both volunteers and participants were willing to share their experiences. In one case, a woman stood up at a community meeting (at the behest of many of the other women) and announced that she had not cut herself in several months, the longest time that she could remember, to the cheers of the other residents. Another woman stood up and indicated that she would try to accomplish the same goal; she was met with equal enthusiasm.

These women found a great deal of support on the Step-Up Unit. The counselor reported that a woman recently released from a mental health program would usually stand at the far end of the dayroom where unit meetings were held, illustrating how stigmatized these women felt. The counselor would often encourage the inmate to move closer, saying that everyone on the unit knew what it was like to be coming out of a mental health program and asking her to at least take a chair. Over a period of several days, the woman would push her chair closer to the circle as she began participating.

Women had to submit a request to participate in the Step-Up Unit, and they had to agree to certain behavior. Everyone worked to help them maintain this behavior, including the officers. The number of misbehavior reports decreased, as did problems reported in other areas when Step-Up women went to school or work. The tenor of the entire facility was positively affected, and women in the Step-Up Unit were not as despised or isolated as they had been before. In addition, because they formed a supportive group, they had an easier time in work and school settings as well. These inmates also appeared to be able to move back onto regular units with greater ease once they were established: working in the mess hall, cutting the grass, or other assigned prison activities where they had routine interactions with inmates in the general population.

Step-Up encompassed several characteristics that Merry Morash and her research colleagues at the University of Michigan identified as critical for women inmates: Participants were screened, staff served as role models, security staff were supportive and avoided aggressive use of power, the administration clearly supported the program, peers provided support

and expectations of increased normative behavior, inmates helped to run the program, and the programming was continuous and comprehensive (Morash, Bynum, & Koons, 1998).

The facility went on from this success to increase involvement of inmates from the general population in the ICP and to develop in conjunction with mental health staff a suicide prevention and response program that deeply involved inmates in the general population in reducing the incidents of self-harm and responding to serious incidents. This program built on the positive impact of training not only staff but also inmates to recognize signs of mental illness and/or suicidality. This increased knowledge also helped to sensitize this segment of the prison community's population to issues confronting the mentally ill.

After one suicide occurred on a housing unit, trained inmates accompanied a clinician and me to the unit. Inmates on the unit were obviously tense and in distress. After a discussion with the watch commander, we delayed the lock-in count, which would have resulted in the women on the unit being locked in their cells for the night within minutes of the suicide. Instead, we obtained cookies and coffee from the mess hall and sat and talked with small groups of inmates about their feelings. Those most disturbed by the suicide were directed to the clinician for immediate follow-up by both the staff and the trained inmates who had accompanied me. Only when the unit had returned to a calmer state was the lock-in carried out. This was an almost unprecedented occurrence. Lock-in counts occur several times throughout the day and really symbolize the enormous role of security in prisons. They exist to maintain the safety of the community and the security of the institution. Any change in the lock-in procedure is taken very seriously.

COURT INTERVENTION

Legal action is not always bad news for superintendents; in some cases, it actually forces necessary changes in procedure that open new ways of reacting to incidents or groups or provides funding for staff and space for new programs. For example, in *Langley v. Coughlin* (1989) decided by the U.S. District Court, Southern District of New York in 1987, Bedford Hills was sued over the noise and havoc that was created in the disciplinary segregation unit when several mentally ill women were placed there. The disciplinary segregation unit was small, with 12 cells on each side of a central control station. The 6 cells facing each other on either gallery were separated by a cement wall that served only to bounce the sound through the unit. One woman in particular, Miriam, was continuously yelling and banging and was so disruptive that unit operations often stalled, and the cacophony set the staff and other inmates completely on edge.

As a deputy superintendent, I had conducted a disciplinary hearing on Miriam while she was housed in the disciplinary segregation unit, known as the SHU, after she had assaulted others. I cannot remember the exact charges, but the incident had been serious, and Miriam had been immediately moved to the SHU. Miriam weighed nearly 300 pounds and was quite strong. As I was conducting the hearing, I asked Miriam how she wanted to plead to the charges. She abruptly got up, walked to the door, and began to smash her head violently against the steel door, yelling at the same time, "I'm criminally insane. I'm criminally insane. That's what I have to plead." I certainly agreed with Miriam on her mental instability, but I went on with the hearing, knowing that the mental health clinicians would refuse

to intercede or admit her to the Satellite Unit or ICP and instead would admonish me for letting Miriam get away with assaultive behavior.

On another occasion, I was doing rounds in the SHU when I came to Miriam's cell and asked her how she was doing. She began to cry and said, "Here, I'll show you." She shoved her breast through the food slot. It was covered with fresh and bloody self-inflicted bite marks. I asked if she wanted to go to the mental health unit, and she answered yes. Miriam should not have been assaulting others, but she should not have had to assault herself to get necessary relief or necessary services.

Miriam suffered from serious personality disorder, and as such, the mental health staff had indicated she was not amenable to treatment. They felt that they could not help Miriam and that their efforts would be better spent on other women who would benefit from available mental health services. In an effort to obtain services for Miriam, we began to keep a daily record of the screaming and banging or any other disruptive activity that interfered with the operation of the unit. Pages and pages of these accounts came to me every day, but the mental health staff remained unmoved.

Finally, we went to trial in the *Langley* case when the other inmates in the SHU brought suit over the unbelievable stress created by the noise and constant upset of routines, primarily caused by Miriam's presence. As superintendent, I testified. Answering an attorney's question, I indicated that I did not want to keep Miriam in the SHU, but I had no alternative to protect other inmates and staff in the general population. The attorneys attempted to continue with their questioning, but the judge asked me to repeat my reply. I said again that I did not want to keep Miriam in the SHU but had no alternative because I was also responsible for the well-being of inmates and staff, several of whom had already been hurt by her behavior. I did not have the power to override the decision of the mental health professionals, and I could not simply let her out of SHU to continue terrorizing the prison community.

The judge told the attorneys to put their heads together with the mental health staff and come up with an alternative for Miriam. In the end, an arrangement was made for Miriam to live in the mental health programs at Bedford and to transfer to the secure psychiatric hospital when her behavior appeared to be escalating to violence. The key, everyone agreed, was to transfer her before a violent incident occurred so that she was not getting away with assault but rather was moving to an alternative setting for treatment. Miriam never again went to the SHU. This was not a case of getting rid of Miriam; she was still in the facility far more than she was at the secure psychiatric facility. However, by having the ICP, Satellite Unit, and secure psychiatric hospital available as alternative programs, there were a range of settings, a range of staff, and a range of fellow inmates through which Miriam could be moved and interact.

As a result of this court case, the facility was mandated to have a court monitor visit quarterly to review which inmates were being held in the SHU, to ensure that additional training was conducted, and to determine whether the mental health staff had recommended anyone for release from SHU and the reaction by facility staff. There was no case in which the facility ever denied a request by the mental health staff to remove someone from SHU. As part of the court settlement, additional mental health staff were added to the facility, and a mental health professional was required to be in the SHU for a part of each business day. A new unit chief was assigned to work closely with correctional staff, and we began the unprecedented practice of running group therapy in the SHU. It took a court case to implement what every person in the prison—from administrator to officers to inmates—had known was needed all along.

WHERE DO WE GO FROM HERE?

Prisons can and do—out of necessity—develop programs that address issues of mental health. However, they provide the worst environment possible for the implementation of such programs because, ultimately, prisons operate on the basis of power and control. Prisons are not the best places for the mentally ill to develop a sense of autonomy or to experiment with new interpersonal skills. Women in particular feel the burdens of imprisonment, and sometimes their “crazy” actions only hint at the inner psychic pain that they endure. Furthermore, prisons are antithetical to the issues of family relationships that sometimes underlie the mental illness of incarcerated women.

Barbara Bloom, a noted sociologist who has studied incarcerated women, and her coauthors pointed out that “the dominant theme of connections and relationships threads throughout the lives of women offenders,” and they argued that “when correctional policy ignores this theme, the ability to improve women’s lives through correctional intervention is significantly diminished” (Bloom, Owen, & Covington, 2006, p. 9). However, this is exactly the problem with placing mentally ill women in prison. It is hard enough for anyone to be in prison, but prison is a place where touch (referred to as *physical contact* in many prisons, with a pejorative connotation), a primary part of a woman’s interpersonal relationships with her family members, especially children, is increasingly not permitted during visits. Sometimes, children are forced to talk to their mothers over the phone through a glass partition. When women leave prison, although they may have formed positive friendships and supportive groups over the years which can be crucial to successful reentry, they are not permitted to have contact with other offenders, leaving many women who are mentally ill once again isolated and lonely.

Women react to incarceration differently than do men, and most prisons for women have a different feel to their atmosphere. Women’s prisons are less violent places than are men’s facilities. Women place great weight on their relationships with others, and they see themselves in terms of their relationships: as mothers, sisters, daughters, wives, partners, or friends. Women bring this focus on the importance of relationships with them to prison, and it provides fertile ground for the development of programs as well as positive community networks within the prison and on release. Women are extremely interested in self-improvement and generally use their time in prison to participate in available educational or counseling programs, so much so that they often create long waiting lists and are always lobbying for more programs.

With this huge influx of mentally ill women, prisons have had to struggle to make appropriate changes from the ways they have traditionally operated. Cassandra Newkirk, MD, vice chair of the American Psychiatric Association’s Council on Social Issues and Public Policy, who has worked in several correctional institutions both for men and women, said,

Women come with much different histories when they’re incarcerated than men. The majority have children. What they bring in with them is different. It was a rude awakening—switching from a male institution was a big eye-opener for me. We worked with several women who I thought were suffering from bipolar disorder but were really suffering from posttraumatic stress disorder, and many of the things we did re-traumatized them, such as locking them in a single room. Many of them had a history of being locked in closets and sexually abused. We’re much more sensitive to that now. (quoted in Sherer, 2006)

What Newkirk described certainly mirrored our experiences at Bedford Hills. However, despite our sensitivity to mental illness and the willingness of staff to adapt and accommodate, these efforts were like drops in the proverbial bucket. In fact, as often happens in periods of growth and construction or renovation—processes that are expensive in and of themselves—programs were the first things to be cut back, resulting in fewer services precisely when the numbers of inmates were expanding.

It is clear that no matter how violence prone these mentally ill women are at any moment, whether they act out or self-harm, or both, they are extremely vulnerable and fragile, an indication of how devastatingly dreary, difficult, violence ridden, and bereft of hope their lives had been prior to incarceration. To experience prison as better, calmer, and safer than their lives in the community is not a measure of how the prison is run but a measure of the destructive forces that have shredded their lives in the community. Prison most clearly does not answer the needs of mentally ill women who sometimes do not have the ability to care for even their basic needs and who too often remain on the outside of friendship groups that develop within the prison as women help each other out, sharing food and other personal items, providing emotional support and encouragement.

Correctional agencies have many fine administrators and staff members who want to not only confine women according to the law but also provide opportunities for rehabilitation. With the mentally ill women, we were aided by many inmates who wanted to build a positive community, increase the chances for everyone's success, and create a decent and humane atmosphere. There are many examples of things that went right for the mentally ill women at Bedford Hills. However, they were basically the result of decisions and actions initiated and carried out by people of good will. There was no systemic, sustained recognition of the management problems faced by the facility or its staff or the danger to staff and to inmates that was created by mixing so many seriously mentally ill women within the population. We cannot treat such severely mentally ill women in such a punitive setting. By the very nature of their illnesses, they will violate the myriad institutional rules that overlay correctional management. Bedford Hills did a very good job keeping people confined, keeping them out of the larger community, until their release on parole. However, given that more than 90% of the budget of any facility is expended on security, this left very little funding for programs to address the underlying issues of the mentally ill.

Litigation has forced corrections and mental health systems to provide more appropriate treatment and services for the seriously mentally ill. Correctional agencies themselves, aided by many other governmental and private interest groups, have begun to create policies and procedures or new standards to deal with the mentally ill in prison that hopefully are gender responsive. However, these efforts and related court decisions do not address the essential issue in most cases: Seriously mentally ill women do not belong in and cannot be treated in prisons.

Even more distressing, court decisions cannot change the way our society thinks. I do not believe that corrections, for all its good will and excellent efforts, will be any more successful in dealing with the most mentally ill women in its prisons than community programs have been in the past. Mentally ill women get caught up in the web of custody and control that rules prison management, that is the very nature of prison culture, and short of throwing out this basic prison dynamic, mentally ill women will continue to be entangled in prison rules and regulations, will continue to serve longer sentences, and will remain our most complex group for transition to the community. As Zaitzow (2004) noted,

“Under the prison system, dependence on authority figures is maximized, and opportunities to learn and experience responsible personal decision making are minimized” (p. 46). We have not systematically addressed the needs of the mentally ill who are incarcerated; we have not helped them to maintain their dignity or reduced their suffering; we have not relieved the suffering of staff and other inmates who are adversely affected by the presence of the mentally ill within correctional institutions.

Severely mentally ill women need to be in hospitals, even if that means reviewing civil commitment statutes and revisiting policies about forced medication. Those women who have proved themselves to be dangerous need to be maintained in secure hospital settings, just as we have begun to do with serious sex offenders. Staff at Bedford Hills used to sometimes stand at the top of the hill overlooking the front gate as a severely mentally ill woman was being released with little to no supervision, having served every day of her sentence. They would sometimes take bets on how much time would elapse before one of these women returned. Almost always, the staff member who had bet on the shortest amount of time won the bet.

I stopped being a superintendent in part because I no longer believed that the levels of confinement that we support in this country, particularly of mentally ill women, made any sense. My training and that of my staff did not prepare us for the role that society has imposed on prisons such as Bedford Hills. Over the years and during the vast expansion of the prison population, programs to help women succeed on release were not expanded but rather reduced, just at a time when they were needed most. The courts may have forced us to have more clinicians and in the present climate may force us to do better initial screening and to develop even more appropriate treatment. But the operative words here are *forced* or *forcing*, and we continue to delude ourselves as a society. We do not have the will to even consider, much less implement, the changes that are necessary to address the treatment needs of mentally ill women who commit crimes, most of whom commit these crimes as a result of their mental illness. In fact, we have eliminated or eviscerated most of our laws concerning insanity, catching these women up in our anger and vengefulness and in our claims that they must be held responsible for their behavior.

It is not that we do not know how to create meaningful changes to our prison and mental health systems, it is that we do not have the will to do so. It is far easier to put people who are dangerously ill behind walls and fences; in that way, we will never have to acknowledge their suffering.

NOTE

1. The names of all female prisoners in this article have been changed to protect their identities.

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