

FROM THE ASYLUM TO SOLITARY:
TRANSINSTITUTIONALIZATION

Sol Wachtler & Keri Bagala***

I. INTRODUCTION

England, by a decree of 1697, and as a mark of civilization, established *houses of correction for persons with mental illness*.¹ These mentally ill persons were penned up with other “socially deviant persons” because it was felt that undesirable behavior could be corrected by punishment.² In those times, mental illness was considered a “*curse, corruption of the soul, or possession of demons*.”³ And so the mentally ill were put in asylums—a form of imprisonment.

In the 1840s, in the United States, Dorothea Dix discovered that the mentally ill were being confined in the nation’s prisons.⁴ She began a nationwide crusade to remove these persons from prison—to see to it that they were put in treatment facilities.⁵ Speaking before the Massachusetts Legislature she said:

I proceed, gentlemen, briefly to call your attention to the
present state of insane persons confined within this
Commonwealth, in *cages, closets, cellars, stalls, pens!*

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Apologia: Using the personal reference to time which I spent in solitary confinement, or the reference to my autistic godchildren, should not be attributed to my very talented co-author Keri Bagala. I am grateful both for her assistance in writing this article, and for the fact that she was never in the SHU.

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¹ Paul F. Stavis, Address at the National Conference of the National Alliance for the Mentally Ill: Civil Commitment: Past, Present, and Future (July 21, 1995), <http://www.treatmentadvocacycenter.org/component/content/article/360>.

² *See id.*

³ Such views have been consistently held in multiple cultures. *See Module 2: A Brief History of Mental Illness and the U.S. Mental Health Care System*, UNITE FOR SIGHT, <http://www.uniteforsight.org/mental-health/module2> (last visited Apr. 17, 2014).

⁴ HELEN E. MARSHALL, DOROTHEA DIX: FORGOTTEN SAMARITAN 98, 108 (1937).

⁵ *Id.* at 99.

*Chained, naked, beaten with rods, and lashed into obedience.*⁶

As a result of her crusade, states created psychiatric hospital systems and the number of severely mentally ill prisoners nationwide was reduced to less than 1%.⁷ However, these psychiatric hospitals, or “asylums,” were underfunded, overcrowded, and poorly staffed.⁸ Over the years, most of these institutions have been virtually abandoned.⁹ Since 1970, almost 90% of these psychiatric hospital beds have been closed and the mentally ill are again being put into our prisons.¹⁰ Today, there are likely more than 350,000 seriously mentally ill prisoners behind bars; or an estimated 16% of our jail and prison populations.¹¹

We have *transinstitutionalized* these prisoners from the psychiatric hospitals into the cells. It has reached the point where law enforcement personnel, correction officers, and the criminal justice system are primarily responsible for persons who are in psychiatric crisis. In the United States, “jails and prisons treat more people with serious mental illness than hospitals” and “have become the insane asylums of the 21st Century.”¹² It would appear that we have come full circle—prisons are once again being used to house many who are seriously mentally ill.¹³ They are, once again: *houses of correction for persons with mental illness.*

Imprisonment for a person with normal brain function can be Kafkaesque, but imprisonment for a mentally ill person can be beyond the pale of imagination. Prisons are governed by strict rules—institutionally and nuanced codes among the prisoners themselves. The mentally ill inmate often cannot comprehend or even vaguely understand these rules. In addition, mentally ill prisoners are often provocatively irritating and offensive to other prisoners and prison guards. Screaming obscenities, removing clothes in a rage, throwing food, and setting fires to purge their cells

⁶ DOROTHEA L. DIX, MEMORIAL TO THE LEGISLATURE OF MASSACHUSETTS: 1843, at 2 (1843).

⁷ E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 2, app. at 14 (2010).

⁸ *See id.* at 8.

⁹ *See id.* at 3.

¹⁰ *See id.* at 2–3.

¹¹ *Id.* at 4, 6.

¹² *Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences: Hearing Before the Subcomm. on the Constitution, Civil Rights and Human Rights*, 112th Cong. (2012) (written statement of Jennifer J. Parish, Dir. of Criminal Justice Advocacy, Urban Justice Ctr.), available at http://www.urbanjustice.org/pdf/press/ujctestimony_19june12.pdf.

¹³ TORREY ET AL., *supra* note 7, at 3–4, 6.

of the devil are not unusual behavior patterns for these seriously mentally ill inmates.

It is this aberrational behavior which results in a disproportionate number of these inmates being put in solitary confinement. There is no disciplinary hearing or due process preliminary to an inmate being so confined. Prison guards need little provocation, and are the sole judges of who and for how long an inmate can be put in solitary. Once a seriously mentally ill prisoner is put in solitary confinement, a new tragedy unfolds.

Locking up a seriously mentally ill person in solitary, claustrophobic eight-by-ten cells for twenty-three hours a day, with only one hour in an outdoor zoo-like cage, isolated and idle, only exacerbates their symptoms and leads to greater mental dysfunction.

I have seen and been with mentally ill prisoners in solitary confinement. They are mostly untreated or under-treated and as a consequence of neglect, they deteriorate. Their behavior becomes unpredictable—they may react violently to the goading of other inmates, or they may rant or engage in incoherent babble which infuriates their guards. They may not respond to direction and, instead, cower silently. They may respond to voices only they can hear, or talk to invisible persons in a world constructed from their own hallucinations. They may self-mutilate and riddle their bodies with scars. Many try suicide. This acting out, this aberrational behavior, constitutes infractions which are punished by their keepers, most often by continuous and protracted interment in a Secure Housing Unit, otherwise known as the SHU.

This explains why a disproportionate number of the eight thousand seriously mentally ill in our New York State prisons end up serving an average of over three years in the SHU.¹⁴ Because of the closing of our mental hospitals, there has been a dramatic increase of prisoners diagnosed with serious mental illness. Placing them in the SHU is both uncivilized and counterproductive.

When the linear thinking of a seriously mentally ill inmate, or the autistic inmate, in the SHU does not allow him to understand that his misbehavior is the reason for his punishment, he continues to act out while in the SHU. To further punish him, he is fed the “loaf”—a brick-like mixture of vegetables and flour served with a

¹⁴ THE CORR. ASS'N OF N.Y., MENTAL HEALTH IN THE HOUSE OF CORRECTIONS: A STUDY OF MENTAL HEALTH CARE IN NEW YORK STATE PRISONS BY THE CORRECTIONAL ASSOCIATION OF NEW YORK 50 (2004).

dish of raw cabbage and water.¹⁵ As a spokesperson for the Department of Correctional Services once said, “the loaf is ordered when ‘there’s nothing left to take away.’”¹⁶

Bread and cabbage given for punishment has been condemned by the American Correctional Association, and was eliminated from federal prisons and most state prisons—but *not in New York*.¹⁷ In fact, during the Pataki years, use of the loaf diet was increased by over 100% and many of those put on the diet were seriously mentally ill.¹⁸

Recognizing the barbarism of this treatment, and after an enormous effort by individuals and organizations, the New York State Legislature passed the “SHU” bill.¹⁹ It took a law suit, the weathering of an inexplicable Pataki veto, and the commitment of dozens of individuals and organizations over a period of many years to have the legislature, with almost unanimity, provide more appropriate and humane in-prison residential and treatment services for prisoners with psychiatric disabilities.²⁰ The SHU bill also ensured that correctional officers would be provided with adequate mental health training.²¹

Although the law was not scheduled to take effect until 2011, in his final Executive Budget, Governor Paterson proposed to diminish and delay, for an *additional three years*, the protections afforded by the SHU bill, putting off implementation of the bill until 2014.²² Accompanying legislation also called for the elimination of about half of the correctional beds from the requirements of the SHU bill, and cut the training requirements for correctional officers.²³

I was asked to testify at the budget hearings related to Governor Paterson’s effort to amend the SHU Bill. I arrived at the Empire State Plaza before the hearing began and wandered into the large

¹⁵ Matthew Purdy, *What’s Worse than Solitary Confinement? Just Taste This*, N.Y. TIMES, Aug. 4, 2002, at 27.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ See CORR. ASS’N OF N.Y., LOCKDOWN NEW YORK: DISCIPLINARY CONFINEMENT IN NEW YORK STATE PRISONS 29 (2003) [hereinafter LOCKDOWN NEW YORK].

¹⁹ Bob Corliss, Letter to the Editor, *New SHU Bill is Historic in Scope*, LEGIS. GAZETTE, Jan. 22, 2008, at 5.

²⁰ “*Boot the SHU*” Bill Gains Momentum, *Despite Governor’s Veto*, PRO SE, Dec. 2006, at 1 [hereinafter “*Boot the SHU*”]; *The “SHU” Has Finally Dropped*, CORRECTIONAL ASS’N OF N.Y. (Feb. 1, 2008), <http://www.correctionalassociation.org/news/the-shu-has-finally-dropped>.

²¹ “*Boot the SHU*”, supra note 20, at 2.

²² *Two Steps Back: Budget Fix Targets Incarcerated People with Mental Illness*, CORRECTIONAL ASS’N OF N.Y. (Dec. 7, 2008), <http://www.correctionalassociation.org/news/two-steps-back-budget-fix-targets-inmates-with-mental-illness>.

²³ *Id.*

auditorium, which was adjacent to the room where the hearing was to be held. The auditorium was jammed with legislators, the press, and members of the public. Several members of the clergy were speaking, and various religious icons were displayed: the subject of this gathering was to condemn same-sex marriage and the sin of homosexuality. Next door, when I was asked to speak, I presumed to note that if Jesus were at the Empire State Plaza that day, he would be more interested in what was transpiring with respect to our treatment of the mentally ill in prison than with the rally taking place in the auditorium next door.

During those hearings I testified that the SHU bill was already a carefully worked out compromise and that the administration's effort to significantly alter and scale back the scope of the legislation by way of the budget process was shameful. The Governor seemed to be simply and arbitrarily walking away from the State's commitment to provide humane treatment to those with psychiatric disabilities who are most vulnerable. Fortunately, the legislature rejected the Governor's bid to postpone the implementation of what became known as the SHU Exclusion Law.

II. THE SHU EXCLUSION LAW

The SHU Exclusion Law,²⁴ which went into effect on July 1, 2011, was designed to remove inmates with serious mental illness who are put in segregated confinement as a disciplinary measure, and to give these inmates the help and treatment they need.²⁵

Generally, under this law, the Department of Corrections and Community Supervision (DOCCS) and the Office of Mental Health (OMH) are required to conduct mental health assessments within either one day or fourteen days of an inmate being placed into the SHU, depending on whether the inmate is in a level one,²⁶ level two,²⁷ level three,²⁸ or level four²⁹ facility.³⁰ Once an inmate is

²⁴ See N.Y. CORRECT. LAW § 137 (McKinney 2014).

²⁵ See *id.*

²⁶ A level one facility is defined as "a correctional facility at which staff from the office of mental health are assigned on a full-time basis and able to provide treatment to inmates with a major mental disorder. The array of available specialized services include: residential crisis treatment, residential day treatment, medication monitoring by psychiatric nursing staff, and potential commitment to the central New York Psychiatric Center." *Id.* § 2(27).

²⁷ A level two facility is defined as "a correctional facility at which staff from the office of mental health are assigned on a full-time basis and able to provide treatment to inmates with a major mental disorder, but such disorder is not as acute as that of inmates who require placement at a level one facility." *Id.* § 2(28).

²⁸ A level three facility is defined as "a correctional facility at which staff from the office of

placed in the SHU, prior to their mental health assessment, they are required to have a suicide prevention screening to assess their risk of suicide by either a staff member of DOCCS or OMH.³¹ If the inmate is found to have a suicide risk, an OMH clinician must be consulted and safety precautions must be taken, “such as a transfer to an observation cell in a Residential Crisis Treatment Program (“RCTP”) and placement on suicide watch.”³²

After the suicide prevention screening, an inmate in the SHU must have a mental health assessment to determine whether the inmate suffers from what the law defines as a “serious mental illness.”³³ Once an inmate is determined to have a serious mental illness, the inmate must be removed from the SHU and placed in a residential mental health treatment unit (RMHTU) as soon as possible, “but in no event more than seventy-two hours from the completion of the administrative process,” absent “exceptional circumstances.”³⁴

As has been mentioned, prior to the implementation of the SHU Exclusion Law, mentally ill inmates in the SHU, as enhanced punishment, were often fed that tasteless, dense, binding mixture of flour, potatoes, and carrots served with a side of raw cabbage—the “loaf.”³⁵ Under the new law, inmates with serious mental illness that are not diverted or removed from the SHU can no longer be put on a “restricted diet” (a euphemism for the loaf) unless it is determined that it is necessary for safety and security reasons.³⁶ The restricted diet, in this case, is limited to seven days.³⁷ If exceptional circumstances exist, however, there is no time limit for how long an inmate with a serious mental illness may be put on a

mental health are assigned on a part-time basis and able to provide treatment and medication to inmates who either have a moderate mental disorder, or who are in remission from a disorder, and who are determined by staff of the office of mental health to be able to function adequately in the facility with such level of staffing.” *Id.* § 2(29).

²⁹ A level four facility is defined as “a correctional facility at which staff from the office of mental health are assigned on a part-time basis and able to provide treatment to inmates who may require limited intervention, excluding psychiatric medications.” *Id.* § 2(30).

³⁰ *Id.* § 137(6)(d)(ii)(A)–(B).

³¹ *Id.*

³² Memorandum from The Prisoners’ Rights Project to New York State Prisoners 2 (on file with author).

³³ CORRECT. LAW § 137(6)(d)(ii)(A)–(C); *see generally id.* §137(6)(e) (describing what constitutes a serious mental illness).

³⁴ *Id.* § 137(6)(d)(i), (ii)(C).

³⁵ LOCKDOWN NEW YORK, *supra* note 18, at 28.

³⁶ CORRECT. LAW § 137(6)(d)(iv).

³⁷ *Id.*

restricted diet.³⁸ Exceptional circumstances exist “whe[n] the joint case management committee determines that limiting the restricted diet to seven days would pose an unacceptable risk to the safety and security of inmates or staff.”³⁹ There is currently no use of the loaf in RMHTUs, but, as evidenced by the SHU Exclusion Law, it is, regrettably, still used in the SHU on certain occasions.

To ensure that inmates with serious mental illness are being adequately provided for, the SHU Exclusion Law has set out specific guidelines and training for new staff members.⁴⁰ New correction officers and other staff that regularly work with these inmates in programs providing mental health treatment, as well as staff that transfer into RMHTUs, must have a minimum of “eight hours of training about the types and symptoms of mental illnesses, the goals of mental health treatment [and] the prevention of suicide and training in how to effectively and safely manage inmates with mental illness.”⁴¹ These staff members must also receive an additional eight hours of training every year they work in a RMHTU.⁴²

Since the SHU Exclusion Law has been enacted, “a significant number of [inmates] with serious mental illness have been diverted from the SHU to RMHTUs.”⁴³ The number of treatment beds in these units has also expanded so more inmates receive increased mental health services rather than additional time in the SHU.⁴⁴ While the total number of mentally ill inmates has remained relatively constant, more inmates are now receiving mental health treatment.⁴⁵ The majority of mentally ill inmates were in a disciplinary mental health treatment program as of June 2011, while only 35% were receiving “intense mental health services” in 2007.⁴⁶ As of 2011, the percentage of the SHU population on the OMH caseload had also dropped from 19% to less than 14%.⁴⁷ Even

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ See N.Y. CORRECT. LAW § 401(6) (McKinney 2014).

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Reassessing Solitary Confinement: Hearing Before the Subcomm. on the Constitution, Civil Rights and Human Rights*, 112th Cong. (2012), at 2 (written testimony of Corr. Ass’n of N.Y.), available at <http://www.correctionalassociation.org/wp-content/uploads/2012/10/testimony-solitary-confinement-june-2012.pdf> [hereinafter *Reassessing Solitary Confinement*].

⁴⁴ *Id.*

⁴⁵ See *id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

though there were still about eight hundred OMH patients in some form of disciplinary mental health housing, more of those patients were receiving “more intense mental health services” than before.⁴⁸ All inmates with a serious mental illness who were previously confined in Special Treatment Program units were transferred to RMHTUs.⁴⁹ These patients were receiving much more intensive mental health services in a “more therapeutic environment.”⁵⁰

On December 15, 2009, a one hundred-bed RMHTU “opened at Marcy Correctional Facility . . . for male inmates with serious mental illness and disciplinary confinement sanctions.”⁵¹ These inmates are “offered at least four hours per day of out-of-cell treatment and programming, primarily in open group settings.”⁵² Attica Correctional Facility and Five Points Correctional Facility have also established RMHTUs.⁵³ Bedford Hills Correctional Facility in Westchester County offers a Therapeutic Behavioral Unit “for female inmates with serious mental illness and disciplinary confinement sanctions.”⁵⁴ Great Meadow Correctional Facility and Sullivan Correctional Facility each have a Behavioral Health Unit,⁵⁵ which is similar to a Therapeutic Behavioral Unit. However, there are still inmates with mental illnesses in solitary confinement because they are not considered to have a serious mental illness.

The benefits of the SHU Exclusion Law are obvious, and those who campaigned so hard for its passage, as well as the New York State Legislature and the Department of Corrections, have come a long way. But there is a great deal which still must be done.

While mentally ill inmates in New York state prisons are protected under the SHU Exclusion Law, those in city jails are not. In 2012, the Department of Correction expanded its solitary confinement capacity from 27% in 2011 to 44% in 2012.⁵⁶ “New

⁴⁸ *Id.*

⁴⁹ *Id.* at 7.

⁵⁰ *Id.*

⁵¹ Press Release, Dep’t of Corr. and Cmty. Supervision, DOCS, OMH Open Residential Mental Health Unit at Marcy Correctional Facility (Dec. 15, 2009), *available at* <http://www.doocs.ny.gov/PressRel/2009/MarcyRMHU.html>.

⁵² *Id.*

⁵³ Although Attica Correctional Facility and Five Points Correctional Facility also established RMHTUs, the SHU Exclusion Law no longer recognizes these as RMHTUs. *Reassessing Solitary Confinement*, *supra* note 43, at 9 & n.27.

⁵⁴ Press Release, *supra* note 51.

⁵⁵ TESTIMONY, *supra* note 43, at 9.

⁵⁶ Stephon Johnson, *Rally Against Solitary Confinement in City Jails*, N.Y. AMSTERDAM NEWS, Apr. 11, 2013, at 6.

York City [as of 2013] ha[d] one of the highest rates of solitary confinement in history, and the DOC ha[d] more [solitary confinement] cells than it did in the 1990s.”⁵⁷ When a mentally ill inmate is sentenced to solitary confinement in the New York City jails, “a mental health clinician determines whether he or she needs to be monitored by mental health staff while in [solitary confinement].”⁵⁸ If the inmate needs to be monitored, he will be transferred to a Mental Health Assessment Unit for Infracted Inmates (MHAUII).⁵⁹

However, the MHAUII is not much different from solitary confinement because the inmates are usually held in small cells, “isolated from others; and condemned to idleness.”⁶⁰ Although mentally ill inmates in “MHAUII should receive individual and group therapy and psychotropic medication as clinically indicated, including no less than one individual interview per week [this still] does not mitigate the punitive environment of these solitary confinement units.”⁶¹ It is still the correction staff that has almost complete control over the inmates in these units and they determine which inmates “are allowed to come out of their cells to participate in group therapy.”⁶² If the correction officers do not want to feed these inmates or take them to sick call, they do not, and there is not much else the inmates can do “to make their needs known.”⁶³

One of the biggest complaints of inmates in MHAUII is that in order for them to participate in their one hour of outdoor recreation that DOCCS is required to provide, they must be standing at their cell door early in the morning when an officer walks by.⁶⁴ However, the officers do not take into account that some inmates are on psychotropic medications that sedate them, making it difficult for them to wake up on their own that early in the morning, thus missing their only opportunity to leave their cells and get fresh air that day.⁶⁵ These mentally ill inmates still suffer from lack of food,

⁵⁷ *Id.*

⁵⁸ *Oversight Hearing—Examining Violence in New York City Jails*, New York City Council (Apr. 4, 2013), at 2 (Testimony of Jennifer J. Parish, Dir. of Criminal Justice Advocacy, Urban Justice Ctr.), *available at* <http://nyc.legistar.com/View.ashx?M=F&ID=2415890&GUID=82D85006-3073-4166-A31F-73A100059B6B>.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.* at 3.

⁶⁵ *Id.*

medical treatment, and verbal abuse.⁶⁶ This suggests that the SHU Exclusion Law may be too narrow, as it does not provide any protection for inmates with a serious mental illness in city jails.

More recently, however, the New York City Department of Correction has put an end to its use of solitary confinement for mentally ill inmates who violate the rules.⁶⁷ Inmates held in MHAUI who have a more serious mental illness are instead sent to the Clinical Alternative to Punitive Segregation (CAPS) where they receive individual and group therapy in a more “secure therapeutic setting” until they can rejoin the general population.⁶⁸ Inmates with a less serious mental illness are sent to the Restrictive Housing Unit, which still includes solitary confinement.⁶⁹ In the Restrictive Housing Unit, inmates can stay out of solitary confinement “through good behavior and participation in clinical treatment programs.”⁷⁰ While this has been tremendous progress for mentally ill inmates, “[i]t is not clear that individuals with serious mental illness who have not violated jail rules will not also be housed in CAPS.”⁷¹ Likewise, the Restrictive Housing Unit is exceedingly punitive in all but its name, and inmates are still kept in their cells for extended periods of time.⁷²

But perhaps the greatest deficit in the law is that it creates a hard, clear-cut line of what constitutes a serious mental illness.⁷³ Therefore, for those inmates in the SHU who have some form of mental illness, even a diagnosis that many would consider serious, if they do not fit within the serious mental illness category set out in the law, they receive little to no mental health treatment.⁷⁴

Since the SHU Exclusion Law was enacted, “the number of inmates diagnosed with severe mental illness has dropped.”⁷⁵ Since 2007, there has been a 33% decrease in the number of inmates

⁶⁶ *Id.*

⁶⁷ Sean Gardiner, *Solitary Jailing Curbed: New York City Department of Correction Stops Solitary Confinement for Mentally Ill Inmates Who Break Rules*, WALL ST. J. (Jan. 5, 2014, 9:56 PM), <http://online.wsj.com/news/articles/SB10001424052702304617404579302840425910088>.

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ TESTIMONY, *supra* note 43, at 7.

⁷⁴ *Id.*

⁷⁵ Christie Thompson, *New York placing mentally ill inmates in solitary*, SALON (Aug. 16, 2013, 8:15 AM), http://www.salon.com/2013/08/16/new_york_denying_health_care_to_mentally_ill_inmates_placing_them_in_solitary_partner/?source=newsletter.

diagnosed with a serious mental illness, while at the same time the state's total prison population has decreased by 13%.⁷⁶ For example, between 2007 and 2011, the percentage of inmates with a primary diagnosis of schizophrenia or another psychotic disorder significantly decreased.⁷⁷ On the other hand, during this same time, the percentage of inmates diagnosed with an anxiety, personality, or adjustment disorder increased.⁷⁸ This "raises serious concerns about the possibility of under-diagnosis" due to this law.⁷⁹ While all inmates are screened to determine if they have a "serious mental illness," OMH tends to be overly conservative. While it is unclear what motivating forces are causing this drop in serious mental illness diagnoses, as Jack Beck, director of the Prison Visiting Project put it, "whenever you draw a magic line, and somebody gets all these rights above it and none below it, . . . you create an incentive to push people below."⁸⁰ Additionally, the SHU Exclusion Law still permits inmates with a serious mental illness to be held in the SHU under "exceptional circumstances."⁸¹

III. THE INMATE SUFFERING FROM AUTISM SPECTRUM DISORDER

Adding to the present problem of misuse of solitary confinement is an ominous storm about to break over the unprepared and untrained corrections system. I am talking about the flood of autistic children just now reaching adulthood, a very small but growing number of them who will soon be tossed into a corrections system which is totally unprepared to deal with them.

I speak of those who have been diagnosed with Autism Spectrum Disorder (ASD) and who suffer from neurodevelopment disorders.

⁷⁶ *Id.*

⁷⁷ TESTIMONY, *supra* note 43, at 8.

⁷⁸ *Id.*; Thompson, *supra* note 75.

⁷⁹ TESTIMONY, *supra* note 43, at 8.

⁸⁰ Thompson, *supra* note 75.

⁸¹ N.Y. CORRECT. LAW § 137(6)(d)(ii)(E); *see also* Jean Casella & James Ridgeway, *New York's Black Sites*, THE NATION (July 30–Aug. 6, 2012), at 18, 23, *available at* <http://www.thenation.com/article/168839/new-yorks-black-sites>. Such exceptional circumstances include:

(1) when the reviewer finds that removal would pose a substantial risk to the safety of the inmate or other persons, or a substantial threat to the security of the facility, even if additional restrictions were placed on the inmate's access to treatment, property, services or privileges in a residential mental health treatment unit; or (2) when the assessing mental health clinician determines that such placement is in the inmate's best interests based on his or her mental condition and that removing such inmate to a residential mental health treatment unit would be detrimental to his or her mental condition.

CORRECT. LAW § 137(6)(d)(ii)(E).

The current estimates are that one out of eighty eight children will suffer from ASD, with males four times more likely than females.⁸² Although there are some milder forms of ASD, including Asperger's syndrome, the characteristic of autistic children, which is shared by almost all of them on the spectrum, is a tremendous deficit in socialization skills, including the inability to act and speak appropriately in social situations.⁸³ As they age, these socialization deficits become writ large.⁸⁴

As the godfather of two autistic children, one now an adult, I have become deeply involved in the "Alice in Wonderland" world of parents with autistic children. Virtually all of them have experienced or heard of nightmare interactions of autistic children with untrained and unknowing police departments or school administrators. Yet these same parents, and the organizations dealing with autism, are repelled by the thought of their children being classified as "mentally ill."

Autistic children are treated by society as ciphers, the term "autistic" being the total description necessary to capture their personalities and character as far as the public is concerned. The truth is that autistic children have personalities as different from each other as does the population of non-autistic children.

One example of how these deficits can and have resulted in imprisonment is a young teenager who was imprisoned for "sexual molestation" because in the present zero-tolerance atmosphere of schools, he frightened a young woman by pinching her on the bottom. He did it because the day before he saw another boy do that to her, and she laughed and put her arm around him. The nuance of pinching a friend on the bottom and having a boy, who everyone already was considered strange do the same thing, was lost on him. Unfortunately, it was also lost on law enforcement which, in this case, considered this to be the criminal act of "forcible touching."

Another example is an eighteen year old boy who was arrested by police as a possible pedophile for kissing a baby in a baby carriage. It was not a romantic kiss, it was a peck on the cheek, but it was understandable that the mother of the baby was terrified when a tall young man whom she did not know suddenly descended on her

⁸² *Autism Fact Sheet*, NAT'L INST. OF NEUROLOGICAL DISORDERS & STROKE, http://www.ninds.nih.gov/disorders/autism/detail_autism.htm (last updated Dec. 30, 2013).

⁸³ *See id.*

⁸⁴ *See id.* ("A child with ASD may appear to develop and then withdraw and become indifferent to social engagement.")

little baby. Why did he do it? “I like babies.” He did not understand that what was proper to do with babies he knew, was not proper to do with babies he did not know. His parents were able to convince a prosecutor that no charges should be lodged against him; but what of the perpetrator who has no parents to care for and protect him?

Many autistic individuals are not able to maintain eye-to-eye contact, which they find intimidating.⁸⁵ As a result, when questioned, that inability to maintain eye contact is often considered “evasive[] or decepti[ve].”⁸⁶ As has been noted,

for an autistic individual, the process of being questioned/interrogated by law enforcement is an extremely stressful situation for a number of reasons. If the officer conducting the interview is not knowledgeable about Autism, he or she may ask questions too rapidly for the person to process, leading the individual to either shut down completely, or perhaps become combative. . . . The autistic person may make an admission in an attempt to please or befriend the interviewer, or because they think that if they admit something, the interview will be terminated.⁸⁷

The effect of this behavior in the context of criminal prosecution and in the context of imprisonment is obvious.

What is most devastating is the still not understood tendency of even very high functioning autistic children and young men to melt down—no trigger, no change in medication—just a total flip out, screaming nonsensical words, sometimes hitting themselves, more rarely hitting others, and almost always ripping at their clothes or rampaging through furniture or anything within reach. To an untrained corrections officer, this kind of rage is dealt with by the use of solitary confinement.

Putting an autistic prisoner in solitary confinement is counterproductive and grossly unfair. It does not result in condign punishment because the behavior was not controllable by the offender. The confinement is terrifying to the autistic person and can destroy years of progress. The offender does not even understand why he or she is being punished. And the use of punishment rather than treatment assures that there will be no

⁸⁵ *Autism and Law Enforcement: Facts for Prosecutors*, AUTISM SOC'Y OF ME., http://www.asmonline.org/programs_law_prosecutors.asp (last visited Jun. 9, 2014).

⁸⁶ *Id.*

⁸⁷ *Id.*

rehabilitation. It follows that his continued misbehavior in solitary confinement will assure a continued stay in the SHU, often accompanied by servings of the “loaf.”

In penology, autism is not considered as a “serious mental illness,” and with the hard line definition now in place, those who are afflicted will not receive treatment, diversion, and other protections afforded by the SHU Exclusion Law.

IV. CONCLUSION

Due to the SHU Exclusion Law, significant progress has been made in providing mental health treatment to mentally ill inmates in New York State correctional facilities. Inmates with a serious mental illness have been largely removed from solitary confinement and transferred into RMHTUs and such inmates are receiving more mental health treatment in a more therapeutic environment. The improvements made by this law have, for inmates diagnosed with a serious mental illness, “[sped] up an inmate’s return to the general population.”⁸⁸

The positive impact this law has had on seriously mentally ill inmates can be seen clearly when compared to seriously mentally ill inmates in other jurisdictions. Colorado is an example.⁸⁹ In Colorado, even though the number of inmates in solitary confinement has decreased, the number of seriously mentally ill inmates in solitary confinement has continued to increase.⁹⁰ A Colorado study determined that “[i]t is time for the state of Colorado to stop warehousing seriously mentally ill prisoners in long-term solitary confinement and to begin providing these prisoners with the intensive mental health treatment they need to allow them to be productive members of society upon release.”⁹¹ This is exactly what the implementation of the SHU Exclusion Law in New York State has begun to do. This law is a paradigm for other states to see that, with the proper mental health treatment and environment, seriously mentally ill inmates can, in fact, be model inmates.

Despite the substantial decline in inmates throughout the New York State correctional facilities, however, there are more and more

⁸⁸ Thompson, *supra* note 75.

⁸⁹ See *ACLU of Colorado Finds Growing Number of Mentally Ill Put in Solitary Confinement in ‘Out of Sight, Out of Mind’ Study*, HUFFINGTON POST (July 25, 2013, 12:47 PM), http://www.huffingtonpost.com/2013/07/24/colorado-solitary-confinement-aclu_n_3645271.html.

⁹⁰ *Id.*

⁹¹ *Id.*

inmates who are finding themselves in the SHU. As of 2013, there were approximately five thousand beds in the SHUs throughout thirty-nine New York State correctional facilities.⁹² However, these correctional facilities only have the capacity to house a combined total of 1,400 inmates in the RMHTUs.⁹³

Currently, there are approximately 57,000 inmates incarcerated in New York State correctional facilities, and of those, about 15% receive mental health care from OMH.⁹⁴ Approximately 4% of the total inmates in these correctional facilities are diagnosed with a serious mental illness, totaling about 2,280 inmates.⁹⁵ Even with the passage of the SHU Exclusion Law, there are still approximately six hundred mentally ill inmates in the SHU because their diagnoses do not fit the hard line definition of a “serious mental illness.”⁹⁶ This also includes inmates diagnosed with ASD.

There is an overwhelming need to broaden the definition of a “serious mental illness,” not only to ensure the safety of the correctional facilities in general, but also to ensure the safety of mentally ill inmates who are not acting out intentionally in a fit of rage, but are acting out uncontrollably because they do not understand the reasons for the conditions they are in. The proper and only conscionable way to deal with these types of inmates is to give them the treatment and help they so desperately need and deserve. This will not only guarantee that the prison system functions more smoothly and efficiently, but it will help to rehabilitate these individuals and prepare them to reenter society. Without broadening the definition of a seriously mentally ill inmate, the prison system will never fully flourish. There will continue to be inmates uncontrollably acting out due to their illness, which, if the definition were broadened, would not happen.

Implementing the SHU Exclusion Law in local jails throughout New York State, in addition to the correctional facilities, would correct the problem of out-of-control inmates before they are

⁹² N.Y. STATE CATHOLIC CONFERENCE, 2013 FORUM WATCH 5 (Mar. 12, 2013), http://www.nyscatholic.org/wp-content/uploads/2011/12/Forum-Watch_2013.pdf.

⁹³ COMM’N ON QUALITY OF CARE & ADVOCACY FOR PERSONS WITH DISABILITIES, A REVIEW OF: MENTAL HEALTH SCREENING, ACCESS TO MENTAL HEALTH SERVICES, AND THE MENTAL HEALTH STATUS OF PEOPLE IN SEGREGATED CONFINEMENT IN NEW YORK STATE CORRECTIONAL FACILITIES 8 (2013), *available at* <http://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/MH%20DOCCS%20Report.pdf>.

⁹⁴ *Id.* at 1.

⁹⁵ *Id.*

⁹⁶ *See* 2013 FORUM WATCH, *supra* note 92, at 5.

transferred to the correctional facilities. These mentally ill inmates would have already been seen by an OMH clinician at the local jail and would be on medications and in a therapeutic environment which would help avoid any serious behavioral problems. They would already be on the path to rehabilitation before arriving at the correctional facility.

Perhaps someday we will return to and improve the government's obligation to adequately treat the seriously mentally ill in a civil setting. Until that day arrives, and while the jails and prisons are still our largest mental health treatment facilities, morality and civilization demand that the seriously mentally ill prisoners be treated both therapeutically and humanely.