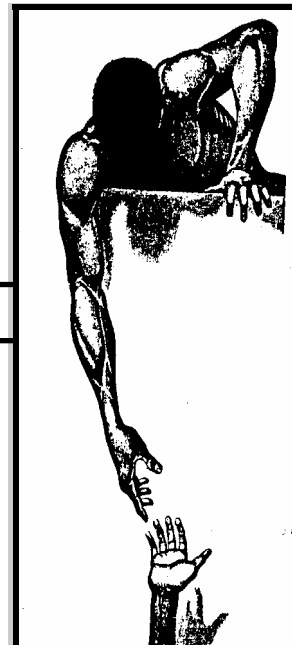


CURE-NY *Newsletter*

To Reduce Crime and Uplift Society

Winter '03-'04

Published by the New York Chapter of CURE, *Citizens United for the Rehabilitation of Errants*
Box 102, Katonah, NY 10536, cureny@bestweb.net, www.bestweb.net/~cureny



"He Ain't Heavy"
by Gilbert Young

Restorative Justice 2

by Jim Murphy

In the last CURE-NY newsletter, I wrote an introductory piece on restorative justice. There were questions asked whether restorative justice principles work in a prison setting.

In England, Tim Newell, the former Governor of Grendon and Springhill prisons, has lectured widely on the use of restorative justice principles. As Governor (warden to us), he created a therapeutic environment with the purpose of helping the men imprisoned there to understand themselves, acknowledge their problems and actions and to change their behavior. That environment goes against the grain of most prisons and requires a change in the culture of prisons, but in Grendon prison the staff and inmates are involved in an environment that uses an inclusive process involving everyone. The results are the highest involvement of prisoners in programs, and the lowest escape and assault rate within England. There is movement to expand this therapeutic model throughout the English prison system and to introduce it as prisoners prepare for release from prison. Upon release, there is a formal Circle of Support and Accountability to support and hold them accountable to the plans that they developed. (See *CURE-NY Newsletter Summer '03*)

For more info, you can check - www.restorativepractices.org on the web. It lists a number of different programs including the use of conferencing circles. England with a population of 49 million has a prison population of 72,000 which is slightly more than NY's DOCS. New York's population is 19 million.

How might such an idea work in NY's prisons? We won't know unless we try, but there has been an example of a successful program in Greenhaven, where John Mackenzie started a Victim's Awareness Program (VAP) in 1997. That program consisted in 16 three hour sessions in which men convicted of violent offenses acknowledged and accepted responsibility for what they had done. Sessions included discussions and role playing, and crime victims and the family members of murder victims were present and involved. The program was discontinued when John was transferred to Woodbourne, but according to an Orange County

Family Court Judge it was so successful that he is working on using it in his County.

Assemblyman Howard Mills ranking minority member on the Assembly's Corrections Committee has advocated its greater use with Commissioner Goord.

John MacKenzie, who has spent more than 27 years on his 25 to life sentence has been trying to get VAP started in Woodbourne and apparently the Administration is considering it.

I can relate my experience as Director of the NYS Coalition for Criminal Justice in the late 1980's and early 1990's with John's efforts. In all the meetings I had with John and the Pre-release and lifer's committees, particularly in Greenhaven and Auburn, their legislative agenda included restitution for victims and family of victims as well as the acknowledgment of offender responsibility. The Good Time bills that they proposed stressed the need for offenders to show a change of life and to earn freedom through responsible behavior. The late Commissioner Thomas Coughlin endorsed the bill, but the "tough on crime" climate has so far dominated recent criminal justice policy. Its way past time to look at the approach adopted in England and suggested by VAP.

CONFERENCE ON RESTORATIVE JUSTICE

"Building a Global Alliance" conference, August 5-7, 2004, in Vancouver, Canada. The International Institute for Restorative Practices (IIRP) is holding the second in a series of three conferences dedicated to the theme of "Building a Global Alliance for Restorative Practices and Family Empowerment."

This will be the IIRP's Fifth International Conference on Conferencing, Circles and other Restorative Practices, bringing together social workers, probation officers, police, teachers, administrators, judges, researchers, criminologists, counselors, peacemakers, academicians, public planners, corrections officers and others.

(see also page 7 for other groups)

NYS Catholic Bishops' Criminal Justice Reform Positions

Criminal justice reform has been cited as a prime moral issue by most major religions. The internet now gives new and powerful voices to these calls for justice. One of these is the voice of the NYS Catholic Conference through its website at www.nyscatholic.org. The full text of their pastoral statement called "Restoring All to the Fullness of Life; Criminal Justice, the Need for Reform," is on the web at www.nyscatholic.org/pages/news/show_newsDetails.asp?id=82&cat=Bishops%20Statements. Their six current criminal justice issues are excerpted and summarized below, and more complete explanations of each can be obtained at www.nyscatholic.org/pages/our_agenda/show_issues.asp?issue=Criminal%20Justice#top

1. Modify the sentencing provisions in the Rockefeller Drug Laws and increase use of addiction treatment programs

New York State's drug sentencing laws must be modified to permit greater judicial discretion in considering the circumstances and disposition of drug offenses. We seek reduction of current sentencing terms, judicial review of current sentences considered miscarriages of justice and increased state resources dedicated for alternative sentencing treatment and addiction treatment programs in prison and in our communities.

2. Increase funding for alternatives to incarceration

Many of those incarcerated in New York State prisons are afflicted with mental health or addiction problems. These individuals, and the greater society, would be best served by offering lower-cost alternatives to incarceration to address the problems that are at the root of their criminal activity.

3. Support rehabilitation, education and transitional services, including community-based offender reintegration programs

Community reintegration programs for ex-offenders should be established. Programs might include but are not limited to select counties establishing resource centers, faith-based communities recruiting volunteer mentors and, if possible, providing a halfway house, and the inclusion of returning ex-offenders in parish social ministry programs.

4. Enhance the use of "merit time" as an earned rehabilitation incentive for early release of inmates

Merit time represents a concrete incentive to encourage prisoners to undertake long and difficult rehabilitation programs. Participation in meaningful programs ultimately increases public safety and could reduce unnecessary prison cost for inmates who have earned early release by demonstrated rehabilitation. The Conference supports an expanded use of merit time to include a greater number of

inmates and a greater incentive for completion of specific rehabilitative accomplishments.

5. Support the compassionate release of elderly and/or sick prisoners.

The Catholic Conference supports the compassionate release of elderly and sick prisoners who no longer represent a threat to public safety. The state must also ensure post-release support, including housing, health care and transitional services.

6. Ensure humane conditions of prison confinement and appropriate access to worship and ministerial services

The Catholic Conference seeks to ensure that disciplinary options within the correctional system be designed in a way that respects the dignity of the human person, guarantees access to religious counsel and worship and ensures no further harm will come to the disciplined individual.

Ultimate Pork Barrelism: The War on drugs

Excerpts from a letter by Henry Halm

Will Governor Pataki/the legislature ever make meaningful changes in drug laws? Of course not! In New York State, the War on Drugs has become the ultimate in pork barrel politics. It is now just a strategy generating so many political benefits that it will be made to grind on for centuries to come.

The Drug War now creates two million government jobs, and directly or indirectly accounts for half of all prisoners. The Drug War dramatically increases all kinds of crime and finances gangs, just as alcohol prohibition did.

Ultimate pork barreling is blatant in prison towns. Two prisoners mean one correctional employee. Just two thousand Drug War prisoners can keep alive a town of 10-15,000 people. And prison towns are eligible for more government aid because of all those (prisoner) residents.

Playing on drug fears not only gives politicians an easy and safe way to gain votes, but unemployment rates [of course, not counting prisoners unemployed] are lowered.

This un-American, destructive prohibition squanders around one hundred billion dollars per year. If it were ended, other billions would stop flowing to drug cartels because all necessary drugs could be grown or manufactured in America. Additionally, billions spent on foreign interdiction would end. Like alcohol and tobacco, drug use would become a health issue. Users that abuse or risk other's lives would be dealt with as those that abuse/misuse alcohol. Drug sale taxes could pay for treatment, education, prevention, etc..

Sadly, because the drug war's fodder is primarily America's powerless expendables (Blacks and Hispanics), few Americans care about the harmful, un-American, racism that the War has become. But, if New Yorkers ever become aware of its total cost and its horrendous impact, this evil form of pork barrelism would quickly end.

Excerpts from Testimony on SHUs

**Jennifer Wynn, Director, Prison Visiting Project
The Correctional Association of New York
November 18, 2003**

My testimony is based on findings from a recently completed two-year research study, of which I served as principal investigator. The study examined the quality of mental health care in New York prisons and involved site visits to 23 correctional facilities by project staff and outside psychiatrists.

While inmates with mental illness constitute approximately 11% of the general prison population in New York, their representation in 23-hour disciplinary lockdown is more than double that percentage: fully 23% of the inmates in disciplinary lockdown are mental health patients. Inside these prisons within prison, officially known as Special Housing Units, or SHUs, inmates can spend months or even years isolated in a concrete cell measuring 56 square feet with little natural light, no programs and minimal human interaction. Essentially, inmates in SHUs are warehoused, with little to do but read, pace or stare at the walls. They are "cell-fed" through "feed-up" slots in thick metal doors. If they choose to leave their cell for their hour of court-mandated recreation, they are mechanically restrained with handcuffs attached to waist chains, and leg irons if deemed seriously violent or escape-prone.

Attesting to the seriousness of their mental illness, nearly one-third of the inmates in our sample reported prior stays in psychiatric hospitals. Of interest was that 40% were housed in disciplinary lockdown for nonviolent offenses (operationalized as refusing to obey a direct order or use or possession of drugs). A more striking finding was that inmates with mental illness have SHU sentences that are six times longer than the average SHU sentence: 38 months (slightly over three years) compared to DOCS' figure of 6.5 months for inmates generally.

When inmates act out in lockdown, whether or not their behavior is related to mental illness, they are often disciplined through a regimen of increasingly harsh punishments known as deprivation orders. Common deprivation orders include the loss of such basic necessities as showers, recreation and cell-cleaning supplies. Equally if not more serious, additional SHU time can be added to an inmate's sentence for repeated rule violations, turning lockdown into a kind of quicksand from which inmates can only emerge when their prison sentence expires. A mental health counselor at Sing Sing told us: "Six months of SHU time can turn in to 16 years for guys with mental illness." A striking example is an

inmate on the mental health caseload we encountered at Wende Correctional Facility, who was sentenced to 35 years in solitary confinement.

Given the harsh conditions, it is not surprising that a disproportionate number of suicides take place in disciplinary lockdown. A recent study by the Poughkeepsie Journal found that more than half (52%) of prison suicides in New York between 1998 and 2001 took place in disciplinary lockdown, though disciplinary lockdown contains less than 10% of the inmate population. Of the inmates in our sample, 53% had histories of suicide attempts in prison. This figure, on its face, is extraordinary—more akin to what one would expect to find in a mental hospital than a prison.

Another indication of the pathology bred in disciplinary lockdown is the high rate of self-mutilation, a form of self-directed violence that typically involves cutting or slashing one's wrists, arms or abdomen as a way to alleviate stress or to counteract feelings of psychological numbness. It was not unusual for inmates to extend their forearms through the bars and show us arms laced with scars. ...In our sample, 40% of inmates reported that they engaged in self-mutilation during their current incarceration. As incredible and misguided as it seems, the act of "inflicting self-harm" is an official violation of DOCS policy. Correction officials issue misbehavior reports to inmates who attempt to kill or cut themselves, purportedly to discourage malingering. Over half (54%) of the inmates in our sample reported receiving a ticket for an act of self-harm. Roderick Hall, Ph.D., Director of Mental Health Services for the Florida Department of Corrections, was astonished when we asked him whether inmates in Florida can receive tickets for self-harm. "Many years ago we gave tickets for self-harm," he said, "but certainly not now."

In our research, on nearly every site visit, we encountered at least one or two individuals in disciplinary lockdown who were actively psychotic, delusional or immobilized by depression. We interviewed men who were weeping in their cells, who mutilated their own flesh, who hadn't left their cell in months, who smeared feces on themselves or repeatedly attempted suicide. "The COs rape me," a delusional inmate at Five Points told one of our interviewers. Of the 15 years he has been incarcerated, he has spent 13 years in solitary confinement. The inmate's arms were covered with scars. On his neck was a five-inch gash from when he attempted suicide by slashing his own throat. "I hear voices telling me to kill myself," he said. "No one does nothing. I have no faith in anybody."

Excerpts from Testimony on Prison Health Care

Jennifer Wynn, Director, Prison Visiting Project
The Correctional Association of New York
November 13, 2003

On monthly monitoring visits and in the hundreds of letters we receive each year from inmates, inadequate medical care ranks as a leading complaint. Annual grievance reports from New York State correctional facilities uniformly list medical care as inmates' first or second most frequently grieved issue. In surveys we conducted with 301 prisoners at nine facilities over the past two years, 64% rated medical care as poor, 26% as average and only 10% as good. Sixty percent of inmates said that they do not have timely access to medical care, and one-fifth of inmates cited better medical care as the single most important improvement they would like to see result from our visit, a particularly telling finding given the many changes that inmates could recommend to improve life behind bars.

From interviews with inmates and staff conducted over the past two years, four key deficiencies in medical care emerged:

1. Understaffing. With the exception of Green Haven, where medical services are overseen by consent decree, staffing vacancies existed at every facility we visited. At Coxsackie, which we visited in June 2002, there was only one physician for over 1,000 inmates. At Queensboro, which we visited this past July, there was no medical coverage-not even a nurse-on site after 10 p.m. at the facility and only 8 hours of medical coverage during weekends. At Southport, a total lockdown facility where over 700 inmates are confined to their cells 23 hours a day, the Nurse Administrator reported that inmates' medical concerns often go unaddressed because of insufficient staff to conduct cellside screenings. In sum, these medical staff vacancies, largely due to noncompetitive state salaries, compromise the delivery of routine health services in many state prisons.

2. Long Waits to See a Physician. Many inmates reported delays of 2 to 4 weeks to see a physician. At Arthur Kill, inmates complained bitterly that medical exams are cursory and that it can take a month or longer to see a doctor. At Woodbourne, which has a high concentration of inmates with mental illness and as well as chronic medical conditions, inmates reported a 3- to 4-week waiting period to see a physician and that Tylenol is the universal form of treatment. At Otisville, inmates' leading complaint was the up to 2-month delay to see a doctor, and the brusque, often superficial medical exams where medical staff sometimes fail to take inmate vital signs or sometimes even touch the patient.

3. HIV Care. With some 6,000 HIV-infected inmates, the New York State prison system has the highest number and rate of HIV-infected inmates of any state department of corrections in the country. Most prisons we visit lack an HIV-specialist to provide vital monitoring and clinical management of HIV-positive inmates and fail to ensure access to infectious disease specialists with the expertise to care for inmates with complex and chronic diseases.

4. Hepatitis C Care. DOCS estimates show that about 14% of incoming male inmates and nearly 25% of incoming female inmates are infected with Hepatitis C, creating what some health care experts say is a prison epidemic and the costliest health crisis since AIDS. Yet, at most prisons we visit, inmates routinely report that testing and treatment for Hepatitis C is discouraged and that little patient education is provided. Facility medical staff reported concern about the growing roster of HCV-infected inmates and the insufficient access to treatment due to cost and insufficient staff training regarding the clinical management of Hepatitis C. At Great Meadow, which we visited in December 2002, only three of the 200 HCV-infected inmates were receiving treatment.

At Woodbourne Correctional Facility, which we visited last March, two inmates with Hepatitis C were told by the facility medical director that they could not receive treatment for HCV unless they agreed to stay in prison past their conditional release date, in order to satisfy the requirement that inmates seeking treatment have 12 months left on their sentence. A more progressive practice, which some other state Departments of Correction carry out, would be to connect inmates with community providers that would continue treatment upon release. Keeping a person in prison at \$32,000 annually is more expensive than treatment alone.

Oversight. While the New York State Department of Health reviews the quality of care in hospitals and clinics in the community, its oversight does not extend to prisons where it is needed the most. Essentially, the largest HIV practice in the country is being conducted in a place where the state agency responsible for public health is not authorized to intervene or even monitor. At a time when fiscal austerity demands careful use of resources, identifying deficiencies and scrutinizing practices are important and intelligent first steps. Requiring the Department of Health to evaluate the care given to a sprawling and disproportionately infected inmate population will not only benefit the inmates involved, but also safeguard the public health of the communities to which they return.

