

Mental Health Treatment in Texas Prisons: A Patient's Perspective

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INTRODUCTION

Treatment provided to mentally ill prisoners in the Texas Department of Criminal Justice - Correctional Institutional Division (TDCJ-DIC) has made tremendous advances over the past 30 years, but for many reasons still falls short of providing the range and quality of treatment opportunities that would reduce prison recidivism and lower the crime rate. Approximately 16 per cent of adults and 20 per cent of youths in the criminal justice system are mentally ill, and up to 40 per cent of mentally ill adults nationally will be caught up in the criminal justice system at some point in their lives. Despite these numbers, state and federal government officials have done little to address the problem. (Rigby, 2005)

As an example of the lack of budgetary concern for treating mentally ill prisoners, on October 30, 2004, President George W. Bush signed the *Mentally Ill Offender Treatment and Crime Reduction Act*, which began as \$100 million in grant money to promote various criminal and juvenile justice programs aimed at keeping mentally ill offenders out of jails and prisons. By the time of signing, however, the grant had been reduced to \$50 million. In a statement attached to the bill, former U.S. Senator Tom Daschel noted that:

For mentally ill persons in the United States, needless imprisonment sometimes becomes a way of life. All too often, people with mental illness repeatedly rotate between the criminal justice system and our communities, committing a (series) of minor offenses. These offenders generally wind up in prisons or jails, where they receive little or no appropriate treatment. (Quoted in Rigby, 2005, p. 24)

Quoting from a 2003 *Human Rights Watch* report, Senator Daschel pointed out their findings: "Our jails and prisons have become the nation's **default** mental health system" (Rigby, 2005, p. 24).

Beginning in the early 1990s, when George W. Bush was governor of Texas, the state began experiencing major cutbacks in mental health spending, as had been occurring at the federal level since the early 1980s. There were numerous Mental Health - Mental Retardation (MHMR) school

closings, as well as closings of other mental health care facilities across the state. Funding for treatment of obsessive-compulsive disorders such as drug and alcohol addiction was taken from state hospitals and put into criminal justice run programs, thus closing alcohol and drug treatment units at state mental institutions. Many would-be patients who suffer these types of disorders also suffer other mental disorders, and early screening and treatment might divert them from jails and prisons.

Low income families, however, are hard pressed to find resources to address mental health problems. The assistance is often not available, and for families without private health insurance, their options are limited. Many mentally ill persons in Texas are not diagnosed until they become involved with the criminal justice system. Even then, the diagnosis is sometimes ignored and the patient/prisoner does not receive treatment. If they can function in the controlled environment and perform the tasks expected of them, prison medical personnel tend to view this stabilization as an optimum goal.

Huge psychiatric caseloads are evidence that thousands of mentally ill persons from across the state have wound up in prison. Between 1993 and 1999, the prison population exploded from approximately 55,000 to approximately 154,000. Texas now has over 110 prison units in operation, and several thousand prisoners wait in county jails for a prison bed. In view of the fact that there was no great increase in the crime rate during the years when this population explosion occurred in the prison system, one might suspect that the MHMR facility closings and major cutbacks in mental health spending contributed to the rapid prison growth.

A large percentage of the prison population are parole violators and other recidivists, many of whom are mentally ill and became symptomatic after leaving the environment of prison and being confronted with the complexities of life on the outside. Although certainly a drastic reduction in the quality of life, the regimentation of prison is often easier for the mentally ill to manage than life on the outside. In the absence of comprehensive treatment and care, many mentally ill parolees become frustrated and revert to behaviours that lead them back to prison. Many quit taking medication and fail to show up for appointments with mental health care providers.

In addressing this topic I am hindered by my limited access to official information. The state of Texas does have an *Open Meetings and Open Records Act*, similar to the federal *Freedom of Information and Privacy Act*, but the Texas law has a provision that excludes incarcerated persons from

access to many documents. This exclusionary provision is complemented by a prison rule that makes it a major disciplinary infraction to possess unauthorized documents. Therefore, I do not have access to information that could validate the many criticisms I might otherwise offer, and the contents of this article are based on my personal observations and experience, interviews with fellow patients and treatment staff, and upon my personal perception and interpretation of events over the past 30 years.

I am a 50 year old Caucasian male. I have bipolar disorder. I have spent 25 years in Texas prisons on four different commitments beginning in 1976. In that time I have been the “subject” and the “victim” of many different approaches to treatment. Prior to 1976, I had been in several county and state hospitals as a juvenile for behavioural problems related to mental illness. At age 22, I was sentenced to prison. After going through the diagnostic process in Huntsville, the hub of the state’s prison system, I was sent to the Central Unit in Sugarland, Texas. Sugarland is located 25 miles southwest of Houston. It is hot and humid eight months of the year. The ground is fertile, and the Central Unit and other nearby prison farms played a big role in the prison’s agriculture production. Other than ploughing and hauling, most farming tasks were performed by convict work crews under the supervision of armed guards on horseback and inmate guards referred to as “lead rows”, “tail rows”, and “strikers”. These inmate guards were used to push the work crews and maintain a fast work pace. Their task was accomplished through violence and threat of violence. Prison officials at that time relied heavily on the use of inmate guards to control the mass of labourers, many of whom were mentally ill, and to maintain agricultural and industrial production. Those who could not withstand the work pace were often beaten. It was a brutal system where the mentally ill did not fare well. Inmate guards were also used in living areas (building tenders) and to operate security doors (turnkeys), so the threat of violence was constant.

The practice of using inmates to enforce discipline was possible because the cliques (possibly the largest and most powerful to ever exist in any North American prison system) were supported and largely controlled by prison officials. Thanks to the “unofficial” support of prison officials, rules prohibiting assault simply did not apply to inmates who worked as quasi-prison guards. It was an abusive system and operated like a plantation. The guards to this day are called “boss”, and the plantation mentality and slavery are still in existence in Texas prisons.

Prior to 1982, when a United States district judge found conditions in Texas prisons to be in violation of the Eight Amendment prohibition against cruel and unusual punishment and ordered sweeping prison reforms, the physically weak and mentally ill were routinely victims of sexual assault, extortion, and many forms of psychological torture.

The only counseling I received that I benefited from in any way came from a security lieutenant who was only months away from retirement. In a one-on-one orientation session, he told me that the first punch usually wins the fight in the penitentiary. His advice was that should anyone hit me, hit them back. Or, if I thought someone was going to hit me, to hit them first. I asked him if I would be in trouble if I hit someone and the old guy grinned at me and said, "Not near as much as you'll be in if you don't hit them." Thus began a quarter century of prison life with bipolar disorder that went untreated for most of those years.

THE HOUSE OF PAIN

In the science fiction novel, *The Island of Doctor Moreau*, by H.G. Wells, when the creatures which were part human, part animal misbehaved, they were sent to a cave and beaten. The creatures referred to the cave as "The House of Pain". A movie version of this story was shown to the prisoners at the Eastham Prison Farm in 1978. From that day forward, Eastham has been known to its prisoners as "The House of Pain". It was a brutal place for many years. Located on the banks of the Trinity River in rural East Texas, Eastham is surrounded by thousands of acres of farm land. Some of the most vicious and proficient killers in Texas history have been housed there.* Escape attempts and murder became more the norm than the exception at Eastham. Then, in September, 1985, Texas Governor William P. Clements ordered a system-wide lock-down. At that time, the Department of Corrections

* On an historical note, Eastham is the Texas prison from which Clyde Barrow and Bonnie Parker helped their friend, Raymond Hamilton, escape. They hid a .45 caliber, semi-automatic pistol in a cotton field for him, and then hurried him away after he shot a prison field major off his horse. A few days later the gang was ambushed by police outside Arcadia, Louisiana, and Bonnie and Clyde were killed in the ambush. Raymond Hamilton was captured and later executed in the electric chair in Texas. The desperation of that escape was a defining moment in the history of the Eastham Prison Farm.

implemented a plan to segregate prison gang members and persons who were prone to committing acts of violence against other prisoners or staff.

The 1985 lock-down came after a three year killing frenzy that began when inmate guards were disempowered and taken off jobs as building tenders and turnkeys, thus becoming targets of violence themselves. An 1985 *Newsweek* cover story about Eastham entitled, "Inside America's Toughest Prison", told a grim story of an asylum in turmoil.

I arrived in Eastham in 1981 and left in 1988. My last two years were spent in a five by ten foot administrative segregation cell. Before being placed in segregation I did a lot of field work and picked a lot of cotton. Still living with bipolar disorder, I was offered no treatment for my first few years there. I did a lot of fighting, with both guards and prisoners, and I got into a great deal of trouble. In spite of my diagnosis, it was not until early 1984 when I began to suspect that something was truly amiss and that the life I was living in Eastham was in no way a "normal" one, not even by prison standards. This moment of clarity came to me one day while sitting in the dayroom playing dominoes. A friend was sitting on a nearby bench thumbing through a Texas Almanac. He got my attention and pointed out an entry in the book for the Eastham Prison Farm. It was described as the Texas prison unit for the criminally insane. I told my friend there had been a mistake and that I should not be there. I soon wrote to the warden, told him there had been a mistake and that I should not be there. I soon wrote to the warden, told him there was nothing wrong with me, and requested a transfer. A few days later I got a reply from the office of Senior Warden Edward Turner informing me that I was "properly assigned".

Due to reform orders mandated in the landmark prisoner rights suit, *Ruiz v Estell*, 679 F.2d 115 (1982), medical care was undergoing drastic improvements by 1984. "Medical Captains" were replaced with full-time medical doctors, and infirmaries were being staffed with LVNs and RNs. Full-time psychologists were hired, as well as psychiatric nurses. Certainly there was not enough staff to cover the caseload, but it was a great improvement to have personnel with degrees on the unit. Prior to staffing infirmaries with civilian employees, most nursing and book-keeping chores were performed by prisoner nurses and prisoner book-keepers. The concept of patient confidentiality was not taken very seriously until the arrival of civilian employees in 1983-84.

There were several psychotic patients in Eastham who suffered with hallucinations and delusions daily. These men were housed together on the infamous A-Wing, which is a cell block with three tiers. There were no barriers to prevent the prisoners from going up to the third tier and jumping 25 feet to the concrete below, and this occurred with some frequency. In 1984, A-Wing was converted to a super-maximum security segregation block and this group of psychotic patients was split into smaller groups and housed in general population cell blocks. Bizarre behaviour and bedlam became even more commonplace.

Many of these men had committed heinous crimes and had come to prison after a stay in a secure state mental hospital. Most had been taking large doses of first generation anti-psychotic drugs for a long time and had developed tardive dyskinesia, a condition that causes involuntary movement of the jaw, lips, tongue and body. (In spite of the risk of serious side-effects, first generation anti-psychotic drugs are still widely used in the prison because they are less expensive than the newer, safer medications.)

Hundreds of other men in Eastham who suffered major mental disorders began to be prescribed medication and/or given opportunities to attend group therapy. A problem soon arose in that many medications used for treating psychiatric disorders indicate that a patient should avoid excessive heat and direct sunlight. On the Eastham Prison Farm where thousands of acres of cotton and feed corn are grown each year, the heat index reaches 100 degrees by 11:00 a.m. most mornings in the summer and early fall. By quitting time at 4:00 p.m., it is not unusual to have a heat index exceeding 110 degrees. Treating psychiatric patients with medication was going to interfere with agricultural production. Or so we thought. Ultimately, in the early 1980s, patients were given the choice: work in the sun **and** take medication or work in the sun and **not** take medication.

Throughout the 1980s at Eastham, several psychology and sociology classes were offered each semester by a nearby community college. As a symptom of my bipolar disorder, I tend to do things in spurts, and I have difficulty staying on task. But amidst the madness of prison life, the classroom offered a comfortable semblance of order and sanity. I took advantage of this and spent as much time as possible in classrooms trying to find the missing “parts” that would fix me so that I might someday live outside of an institution.

In 1985, I found a solution to the bipolar riddle in the text. But the recommended medication and talk therapy were not available at the time.

Life continued to be an endless series of manic highs and very low depressive states. I became paranoid and had frequent thoughts of violence and suicide, and I engaged in many high risk behaviours. The episodic manias eventually led me to commit an act of violence that landed me in a segregation cell for two years.

In 1988, I was released from administrative segregation and transferred to the O.B. Ellis Unit in Huntsville. I was no longer required to work in the fields nor in the direct sunlight, so I began taking a mood stabilizer (Lithium) and an anti-depressant (Elivil). My condition improved rapidly. I was able to perform work as a cabinet-maker, then as a pipe fitter and plumber at the meat-packing plant at the Mark W. Michaels Unit.

I stopped having explosive episodes and violent reactions to common setbacks. In fact, I was such an improved person by 1992 that I was made a trusty and allowed to do carpentry work on employee housing outside the fence.

RELEASE

In September, 1992, I was paroled to live in Dallas. I was not, however, referred to a health care provider or agency, nor was I given any medication when I left prison after a ten year stay.

I found a job quickly once released, and I went to a general practitioner who prescribed Lithium and Elivil on my word that these were the medications I took while in prison. I was able to attend classes at Hazelden Training Centre in Dallas, and then got a job as Assistant Director, Activities, at a private treatment facility in rural east Texas called Sundown Ranch. My job was to teach social skills to adolescents through sports and other experiential activities. This hospital, and my role there, were a world removed from the Eastham Prison Farm. It became obvious to me that, when my bipolar symptoms are held in remission with medication, I do well.

I managed to stay out of prison for five years, from 1992 to 1997. In my third year of freedom, however, the illness overcame the amount of medication I was taking. I began boasting of success. I had the job at the hospital and had started a furniture manufacturing business. I also had entered into a partnership in a small marketing firm. I had a wife who worked as a charge nurse on a major trauma unit in Fort Worth, Texas. I had a stepson and a home. But I became symptomatic with mania and began sleeping very little. I was so on the run that I began leaving Post-It

notes on the bathroom mirror trying to arrange to cross paths with my wife once or twice a week. Poor judgement caused me to quit taking medication altogether when I became to believe that it was not doing me any good. Grandiosity told me that I was now a success and did not need medication.

In a manic episode, I did the things bipolar people do. I made a split second decision to quit the job at the hospital. I could not stay on task long enough to complete any projects in the furniture shop, and my business partner in the marketing business was avoiding me. I spent money foolishly and made trip after trip to Louisiana and to cities in north Texas. My wife left, and after my refusal to change things in my life, divorced me.

I have since learned that bipolar disorders often disguise themselves as drug and alcohol addiction. Although I had not used these substances in some time, I started self-medicating with marijuana and then with heroin. After 18 months of the ups and downs of drug use and an un-medicated bipolar disorder, in September, 1997, I was arrested by Texas Rangers in Athens, Texas, for a robbery I had committed in an adjoining county. I have been incarcerated since that time.

That five year stay on the other side of the prison fence was the longest period of time I had been on that side of the fence since I was 15 years old. Trying to place blame for my incarceration and the documented mental disorder that went untreated for so long would not be productive. As previously described, the Texas prison system has made many changes in the way persons with mental disorders are treated. My experience, as a patient, convinces me that the need for comprehensive treatment of mentally ill prisoners is of the utmost importance. It would benefit the patient, it would benefit public safety, and it would lower the cost of imprisonment because effective mental health treatment will ultimately reduce recidivism.

MANAGED HEALTH CARE

By mid-1996, all of the Texas prison medical and psychiatric services were contracted out. Texas Tech University (TTU) and the University of Texas Medical Branch (UTMB) have the contracts. UTMB serves prisons in south, east and central Texas; TTU serves north and west Texas prisons.

Recent reports state that Texas spent \$330 million on prisoner medical services during 2004 for more than 154,000 state prisoners. While this expenditure puts Texas 40th in the nation in per prisoner expenditures, the situation may be even worse. The Texas Managed Health Care Committee

of the Department of Corrections, which oversees expenditures, has not required the two service providers to keep records. Prisoners, attorneys, advocates and taxpayers are kept in the dark, with growing suspicions as to how much of the \$2,100 per prisoner actually goes to prisoner care and how much to administrative overhead (*Coalition for Prisoner Rights Newsletter*, 2005).

From early 1999 through much of 2000, I was housed again at the O.B. Ellis maximum security unit in the southern region of Texas where I was under the care of UTMB. Treatment for mental disorders in Texas prisons had changed once again. Many things were better. Appointments with psychiatrists and psychiatric nurse practitioners occurred on a regular basis. Medication blood levels were closely monitored through lab work. Patient compliance in taking medication was also monitored. Many patients were allowed to participate in group therapy, and others, such as me, were routinely seen by their case managers in brief one-on-one sessions.

PATIENT CARE

In August, 2000, I was transferred to the Nathaniel J. Neal Unit in Amarillo, Texas. Neal houses approximately 1,640 prisoners, with 425 (26%) on out-patient status for psychiatric disorders. Approximately 300 of these patients are on some sort of medication therapy. These patients are mainstreamed with the rest of the population and get no special consideration from administrators or security staff. Distressed psychiatric patients are “dealt with” by security personnel in the same manner as non-patient prisoners.

It is a common practice of security officers on this unit to escalate rather than try to de-escalate a confrontational situation. TDCJ-CID security policy on management of aggressive behaviour is similar to the Prevention and Management of Aggressive Behaviour (PMAB) used in private psychiatric hospitals across the state. It calls for physical restraint as a last resort. In the years I have been a patient at this facility, I have seen only one instance where the officer in charge during a confrontational situation took steps to de-escalate the situation. He did this by removing the officer with whom the patient was angry from the scene. It worked! The patient became compliant with movement orders and calmed down.

What is more common is for a distressed patient to be ordered to “assume the position” on the wall. Then two or more security officers will crowd him, yelling threats and sometimes cursing him. Often, these tactics

provoke the patient, which results in justification for the use of physical force. Many times, patients are slammed to the pavement, handcuffed, and sprayed with mace. This type of response by security officers often goes unchecked by supervisors and administrators. Patients tend to view security officers as bullies who use the colours of the state to shield themselves from the lawful consequences of unlawful conduct. Many patients are terrified by the security officers. They feel that they are being controlled through fear of unlawful violence in the same way that inmate guards brutalized them at the behest of corrupt administrators and security personnel in the past.

A glaring example of the brutal methods used on psychiatric patients is a case from the Neal Unit which was examined by U.S. District Judge Mary Lou Robinson in the U.S. District Court for the Northern District of Texas, Amarillo Division (Cause No. 2:04 – CV – 0150).

The plaintiff in this action is a patient I will call “Johnny”. His on-record medical problem list states that Johnny suffers from upper extremity surgical procedure, chronic injury, schizophrenia, paranoid type aging mental disorder due to medical condition, psychotic disorder due to medical condition, and borderline intellectual functioning. Johnny was 47 years old at the time of the incident. He is 5’3” tall and weighs 150 pounds. His attackers were a prison sergeant, who is 6’5” tall and weighs in excess of 300 pounds, and a lieutenant, 5’10” tall weighing 275 pounds. The records of Judge Robinson’s Memorandum Opinion and Order of Dismissal indicate:

Specifically, plaintiff alleges that after a disciplinary hearing, defendant (Lieutenant) told him to leave the office and then told him to “assume the position” against the wall. Plaintiff says he couldn’t raise his right arm because of surgery “so (Lieutenant) kicked plaintiff’s right foot from under plaintiff making plaintiff collide with the wall”. Plaintiff says (Sergeant) then grabbed him by the neck and slammed him into the wall, scratching his neck. Plaintiff says that while being escorted and in handcuffs, defendant (Sergeant) pinched his arm and stepped on his toes, trying to crush them. Plaintiff also claims (Lieutenant) and (Sergeant) refused him medical treatment until the next day. (Plaintiff alleges that his injuries were diagnosed as bruises, scratches, bumps, and general soreness for which he was prescribed a soak for swelling, pain medication, and tetanus shot.)

In her Judicial Review of the case, Judge Robinson wrote: "Unprofessional as these acts described by plaintiff may have been, the Court finds no repugnant use of force is evident here." In the Law and Analysis section, Judge Robinson wrote:

The malicious and sadistic use of force to cause harm violates contemporary standards of decency; however, not every malevolent touch, push, or shove by a prison guard gives rise to a federal cause of action. (Citations omitted) A use of force which is not 'repugnant to the conscience of mankind', is excluded from the Eighth Amendment's prohibition of cruel and unusual punishment and is considered to be *de minimis*.

It is ironic that in the weeks when Johnny's civil rights' claim was being reviewed (and dismissed) by Judge Robinson in Amarillo, at Fort Hood, Texas, the U.S. Army was beginning to prosecute U.S. soldiers for prisoner abuses alleged to have occurred at Abu Ghraib prison (Huckelbury, 2006). Some of the abuses there were strikingly similar to abuses Johnny suffered at the Neal Unit in Amarillo. Specifically, at the court martial of Army Specialist Charles Graner, a government witness, Specialist Matthew Wisdom, told the military jury of what he described as sickening abuse upon entering the prison section where Graner worked. He alleged that abuses by Sergeant Jarval Davis were particularly disturbing. "I distinctly remember Sgt. Davis walking around a pile of prisoners and stomping on their toes", said Wisdom, who added that he thought the guard could have easily broken the prisoner's toes (Smith, 2005).

The message seems clear; if a prison guard has a sadistic streak and enjoys abusing prisoners, detainees, or psychiatric patients, he ought not to do it on the world stage and at the embarrassment of the Secretary of the U.S. Army, the Secretary of State, or the President of the United States. Such actions will likely result in highly publicized prosecutions and prison sentences. But the same type of abuses can be committed against prisoners, the mentally ill, and the mentally handicapped in any number of Texas prisons. The perpetrators of abuse in TDCJ-CID very often risk only short suspensions or the possibility of being labeled "unprofessional".

A huge obstacle in stopping the abuses of mentally ill prisoners in Texas is that the word of even several witnesses will not stand against the word of an officer. Investigators who look into claims of abuse by the mentally ill often

take the mirrors and blue smoke approach to clear officers of wrongdoing: they administer a polygraph test. Polygraph results are deemed to be so unreliable that they are not admissible evidence in any court in the state of Texas. But it is often the result of a polygraph test that determines whether a perpetrator of violence and/or sexual abuse is prosecuted or is allowed to continue to wield the colours of state. Many psychiatric patients have been reluctant to report abuses by prison staff for fear that they will not be believed and that officers will only be emboldened in their abusiveness by surviving an investigation.

THE MONEY CRUNCH

In 2003, the comptroller of Texas informed the Governor and legislature that due to overspending in the previous legislative session, there was currently a \$10 billion shortfall in the state budget. This over-committing of monies had occurred in the legislative session that began in January, 2001. This, incidentally, was the time when George W. Bush was vacating the office of Governor of Texas to take up residence in Washington, D.C.

Due in part to new Governor Rick Perry's vow not to raise taxes, the scramble was on to find places to make budget cuts. The prison system took several hits, ranging from small items such as serving desserts with only two meals a week, to major things such as the cutting of all funds for substance abuse treatment programs and counselors on the Institutional Division units (major prisons). Other cuts resulted in lay-offs for several academic and vocational teachers, as well as the elimination of some of those classes. The complete list of cutbacks in prison spending is not available to me, nor am I able to explain why Managed Health Care providers took this opportunity to make cost-saving changes in the services provided at the Neal Unit.

In the early months of 2003, patients were informed that all group therapy would stop and that individual therapy sessions would be very limited. The explanation for this decision was that the focus of "treatment" was to be "stabilization" through medication therapy. The bar was being lowered. Rather than trying to assist patients in getting "well" (as defined as the target of treatment in the TDCJ-CID Handbook), the goal now is merely to stabilize the patient during his incarceration. This cost-saving approach to treating psychiatric disorders is referred to as "psychopharmacology", which is the practice of using only medication to treat complex mental illnesses.

A rise in the practice of psychopharmacology has been spurred in part by the explosion of medicines for treating psychiatric conditions, and in part by the rise in managed health care, which encourages prescription drugs as a less expensive alternative to extended talk sessions (Soloman, 2005). It is estimated that nationally up to 30 per cent of out-patients see their doctors just for medication. But psychopharmacology is not without its critics. "Fragmenting [the profession] into brain specialists and mind specialists ... is a perversion of good psychiatric care", says Barry F. Chaitin, Chairman of the Counsel on Healthcare Systems and Financing for the *American Psychiatric Association* in Arlington, Virginia. Such an emphasis on medicine, Dr. Chaitin says, "is really the devolution of managed care" (Solomon, 2005, p. 1). One problem here is that prisoners/patients cannot learn coping skills, or process trauma, by taking pills. Also, one would assume that prison psychologists would want to keep closer tabs on their patients.

Also in 2003, patients were being told that they were not eligible for dormitory housing if they were "taking psych medications". Dormitories offer more freedom of movement and more outdoor recreation. These are strong inducements in prison. Many patients got off their medications against medical advice to get moved to dormitories. Some managed well enough, and some did not. In late 2004, the allure of dormitory living was enough of an inducement to coax me into giving up my medication. I was moved to a dorm but soon became manic and agitated. I returned to the doctor and got back the medication. It was several months before the classification committee realized that I was taking psychiatric medication and living in a dorm, but when it was discovered, I was immediately moved into a cell block that was rife with incidents of violence and periodic lock-downs. I felt that I was being punished for seeking treatment, and I started searching for the official policy that had been quoted to me by classification committee members for three years. I could find no such policy. I then complained through an editorial that the administrators here were offering inducements to psychiatric patients to get them off their medications. The editorial was published and circulated. Representatives from the *National Alliance of the Mentally Ill* then joined our struggle. After approximately one year, the situation has changed and this discriminatory practice has ended. I do not know if the health care provider was involved in implementing the unwritten policy that resulted in patients abandoning treatment against medical advice. One employee, who has asked not to be identified, has said of his health care provider employers: "They certainly knew about

it, and they never objected to it.” Because this situation involved patients with diagnosed mental disorders stopping their medication, it appears that if anyone stood to prosper, it was the health care provider who paid the pharmaceutical bills.

CRISIS MANAGEMENT

When patients at Neal Unit find themselves in a psychiatric crisis, their condition is evaluated by the staff on duty or the on-call personnel. If it is determined that the patient is unsuited for continued out-patient care, he is transferred to the Crisis Management Section of the William P. Clements maximum security prison unit nearby. There, as a matter of routine, the patient is placed naked inside a suicide watch cell and held for 72 hours of “evaluation”. All reports are that the temperature is kept very low in this cell and that it is extremely dirty. Some patients have stated that dried feces and mucus are often on the walls and toilet. TDCJ-CID security guards keep watch over these cells, and it is up to the guard on duty as to whether the patient is issued toilet paper. Patients are fed “Johnny sacks”, which consist of two sandwiches in a brown paper sack, three times a day. Very often, this paper sack has to double as toilet paper. With all the reports of unsanitary conditions, the chief complaint is the temperature and how cold the cell is. All indications are that this “suicide cell” is the latest replacement for the legendary tubs of ice water formerly used to control mental patients.

After 72 hours of observation, the patient is evaluated by a psychiatrist. At that time, he may be returned to out-patient status at Neal Unit, transferred to in-patient status at the Montford Unit in Lubbock, Texas, or he may be given a blanket and returned to the suicide watch cell. A psychology department employee revealed that many patients who go to crisis management are delusional and meet the criteria for in-patient placement. Most are returned to the Neal Unit for out-patient care, however, due to a lack of bed space.

CONCLUSION

Mental health treatment in Texas prisons has improved since my first encounter in 1976. While treatment standards were on the rise until 2003, since that time we seem to be experiencing a decline. It would be easy to lay blame on the suspected greed of a profit-motivated managed health care system for the shortcomings in mental health treatment. But to lay all blame for all shortcomings in one place is taking the short-sighted view.

Consider that any service provider who enters the prison system is largely viewed as an outsider, and regardless of profession, education or salary, many prison employees see them as being untrustworthy and just a small cut above the prisoners. It is difficult, and sometimes impossible, for service providers to do their job due to a lack of co-operation and/or interference from security staff and prison administrators.

For persons suffering with a mental illness and not receiving adequate counseling and support, often the push and shove of prison life drives them over the edge, and they lash out violently. It is a common occurrence and it makes no difference that the man is mentally ill, is not receiving adequate treatment, or was provoked by the unprofessional conduct of an officer. Chances are he is going for an indefinite term into administrative segregation, which means being locked inside a cell 23 hours a day. (Texas has one of the largest segregation systems in the nation, and some estimates are that at least one-third of these prisoners suffer from a major mental illness.)

The characteristics of the antebellum South are so deeply engrained in this prison culture that anyone or anything that does not fit the mold is held in disdain. The system is, therefore, geared to produce mindless and submissive convicts rather than good citizens.

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