Testimony of

Commissioner Joe Ponte,

New York City Department of Correction

before the

New York City Council committees on

Fire and Criminal Justice Services, Health and Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

regarding

Violence and the Provision of Mental Health and Medical Services in New York City Jails

June 12, 2014

Good afternoon Chairpersons Crowley, Johnson and Cohen and members of the Committees on Fire and Criminal Justice Services, Health and Mental Health. I am Joe Ponte, Commissioner of the New York City Department of Correction. Beside me are Chief of Department William Clemons and Deputy Commissioner for Strategic Planning and Programs Erik Berliner. Thank you for this opportunity to testify today.

I am pleased to be here in the company of my colleague, Dr. Mary Bassett, of the Department of Health and Mental Hygiene. As you know, New York City is one of the only jurisdictions in the United States that lodges responsibility for jail security and health services in two separate agencies. This approach provides independent oversight of the correctional healthcare program, but it also requires an extra level of inter-agency coordination. Our joint appearance today is evidence of our agencies' shared commitment to work together to address the serious issue on today's agenda, which is violence and the provision of mental health and medical services in New York City jails.

Just ten days ago, before the Committee on Fire and Criminal Justice Services, I presented my initial assessment of the Department of Correction after two months on the job. I described how assaults on staff, assaults on other inmates, and slashing and stabbing incidents, as well as uses of force by staff have all substantially increased over the past several years. These long-term trends, years in the making, are clearly unacceptable, and reversing them is my top priority. But as a correction professional with 40 years experience, I must assure you that the process will not be quick. And it will not be easy.

A key component will be recognizing that the Department of Correction's job is changing. Over the past decade, as our Average Daily Population declined from 13,751 in Fiscal Year 2004 to as low as 10,800 in recent months, the character of our inmate population has shifted. One of the most significant developments is the increasing rate of mental illness within our jails. In fiscal year 2007, 24 percent of our inmate population had a diagnosed mental illness. Today, nearly 40 percent have a mental illness diagnosis. Practically speaking, the population of inmates with mental illness at Rikers rivals some of the largest mental health facilities in the country.

I do not mean to equate mental illness with violent behavior. But I do want to stress that any comprehensive strategic plan to reduce violence in the jails must include significant reforms in the way we manage and treat inmates with mental illness.

The Task Force on Behavioral Health and the Criminal Justice System that Mayor De Blasio announced earlier this month will be a great help in this regard. It will be developing strategies to keep mentally ill people from entering the criminal justice system when they do not have to, and also improve in-custody and post-release treatment for those who do come into custody. Dr. Bassett and I are both part of the Task Force and I am sure she would agree that we are looking forward to participating in its deliberations and acting on its recommendations.

In the meantime, however, we are already collaborating to make facilities safer for staff and inmates alike, and to ensure that quality care is delivered to those in need. The need for better staff training and steady assignments is paramount, and the current class of recruit officers in the DOC academy will be receiving an additional eight hours of mental health training that we developed jointly, in addition to the established 38.5 hours. The new training includes an overview of mental illnesses and substance use disorders, introduces participants to risk factors and warning signs of mental health problems, and builds understanding of how mental illnesses may impact security staff efforts. It has also become apparent to us that security and mental health staff need to be able to share more information about the behaviors likely to be exhibited by the inmates in a particular unit. DOC is now providing officers and clinical staff with information about inmate's arrest charges. Conversely, clinical staff have begun sharing relevant behavioral information with housing area officers. Some medical information cannot be shared, of course. DOC staff cannot know inmates' diagnoses or medication details, for example. However, working together, DOC and DOHMH are determining a level of detail that is both necessary and appropriate to keep housing areas safe while still respecting inmates' medical privacy.

In recent months, much of the discussion on inmate mental health needs has focused on punitive segregation, even though this accounts for less than 6 percent of our total inmate population. As you know, punitive segregation is a corrections practice, common throughout the United States, in which inmates who misbehave, especially in ways that jeopardize the safety of other inmates and staff, are temporarily removed from the general population and confined to their cell most of the day. Over the past year and a half, significant changes have been made in how the jail-based disciplinary process responds to inmates with mental illnesses. DOC and DOHMH's long-standing housing response to inmates with mental illness who had been found guilty of an infraction was the Mental Health Assessment Unit for Infracted Inmates, commonly referred to as the MHAUII. While well intended at its creation in the late-1990s, the unit failed to provide adequate care and routinely saw some of the Department's highest rates of uses of force. In December 2013, the last MHAUII units were closed permanently after punitive segregation policies underwent some reform and inmates were transferred to two alternative housing units jointly developed by DOC and DOHMH, the Clinical Alternative to Punitive Segregation, or CAPS, and the Restricted Housing Unit, which goes by the acronym RHU.

The Clinical Alternative to Punitive Segregation provides a hospital-style, clinically-driven, treatment-focused environment for Seriously Mentally Ill inmates who have misbehaved that is completely non-punitive. Inmates in CAPS are not confined to their cells and are expected to participate in multiple treatment-oriented activities throughout the day.

CAPS, which to our knowledge is the only jail-based unit of its kind in the nation, is an unqualified success. Rates of use of force and inmate-on-inmate violence are extremely low compared to the former MHAUII or even current Mental Observation housing—the non-punitive housing option that the Department uses for inmates whose mental illness warrants special attention. This suggests that more treatment and more activity can reduce violence and misbehavior among all inmates with serious mental illnesses. We are working with DOHMH to determine whether the CAPS model, which is very

expensive, has a broader application in Mental Observation housing areas for those inmates who have not infracted.

Restricted Housing Units are punitive segregation with a progressive approach that includes a self-paced behavioral treatment program. RHUs offer inmates an opportunity to earn additional time out of their cells each day for good behavior and clinical engagement. The program is built around a step system: when inmates behave and participate, they progress through the steps and earn incentives including additional out-of-cell time. Rule violations usually result in a step backward and the loss of earned incentives rather than a new infraction with additional segregation time. Since bringing the RHUs to scale in December 2013, DOC and DOHMH jointly relocated the units from the facilities in which they were opened to an alternate site that is more conducive to programming and better management of the inmates. We have subsequently seen a steep decline in the number of splashing incidents and sizeable reductions in uses of force. We also know that inmates are participating in the programming much more than had been the case in either the former MHAUII or the early incarnations of the RHU. We are working with DOHMH to refine the RHU model and make it even more program-focused, building on the successes that we have had.

These programs—which, once again, apply to only a small fraction of our total inmate population—have demonstrated principles that can be applied to reduce violence in the general population, leading ultimately to a reduction in the use of punitive segregation as a disciplinary tool. The first is that steady staff committed to the mission of the unit makes a big difference. Consistency and familiarity provide the structure that the inmates seem to need. They also allow staff to anticipate and head off problems before force becomes necessary. The next principle is that training is crucial. While officers and captains are not permitted to know diagnostic or treatment information about the inmates in their custody, they are certainly able to learn behaviors, triggers and warning signs. For decades, our mental health training has focused on policy, and not the skill building necessary to manage the current needs of the jail population. New training in the CAPS and RHU settings that includes behavior recognition, trigger identification and avoidance techniques in addition to modern de-escalation approaches, has shown tangible benefits. The third principle is that punitive segregation time is not the only appropriate method to respond to misbehavior. It is one of many tools that DOC should be able to use to manage violence in the jails. The RHUs demonstrate the value of alternative inmate management techniques, such as incentives like extended lock out time for good behavior. It is important to understand, however, that these units were quickly implemented as the MHAUII was discontinued, and our management of the units has been continuously re-adjusted in the face of unacceptably high levels of violence. And there is more to learn. Just last night, an officer who works daily with the mentally ill population, is specially trained for this setting, and was following procedures, was assaulted as he uncuffed an inmate who had been progressing well through the RHU program and was about to participate in a group therapy session. Moreover, while incentives and informal, immediate sanctions such as the loss of outdoor recreation and locking in an inmate during lock out hours could be used to discourage misbehavior, they are largely prohibited by Board of Correction standards. We hope to work with the Board, which is engaged in rulemaking, to open up these options. DOC is focusing on the issue of punitive segregation and its effectiveness within the jail system in order to develop a thoughtful and effective approach going forward — one that can provide the possibility of separation of violent inmates from the population for the appropriate period of time while continuing to observe basic standards of care that comport with the science.

The Council has asked about our general approach to violence reduction. What I just described is intended for staff working directly with the mentally ill. However, it represents the underlying strategic

approach to the general issue of violence reduction. We need to better understand the risk and needs of an increasingly complex inmate population. We must make officers confident that they have the skills and tools necessary to control their housing areas and the inmates within them to prevent incidents and avoid uses of force. We must also provide constructive activities for the inmates, from increased recreation to programming in the housing areas and elsewhere in the jails. By reducing idle time and engaging the inmates productively we can make significant gains in reducing violence. This can only be done through systematic, cultural changes.

The long-standing trend toward increased violence cannot be resolved with memos and staff meetings or even a new program. System change, particularly in an organization of this size and scope, must be carefully planned and implemented and will include upgrading facilities, training staff, and recreating a culture. These significant changes will take time, but there are steps that we are taking now to make the jails safer. The first is communication. The new exchange of information between DOC and DOHMH staff will make everyone working in those housing areas more aware of potential dangers and help prevent violence. The second is training. Department-wide training reform will take time to undertake, but the process is beginning, as the next recruit class will receive new mental health training. Training reform includes a greater focus on field training. We will need field staff to develop officers' skills so they have the confidence to apply what they've learned in the classroom to real everyday situations. The third is the immediate responses to misbehavior. We hope to work with BOC to make these tools available.

I believe one way we can make everyone, from the City Council to the taxpayers of New York City to the inmates in our custody, confident that the work is ongoing and taking effect is to be transparent about it. We will continue to update you on our strategic plan implementation, especially regarding violence reduction initiatives and treatment for the mentally ill, and to work with the labor unions, oversight bodies, and advocacy organizations that have vested interests in the outcome of this important work.

Thank you again for the opportunity to testify today and for your support as we undertake these reforms.

NYC Health

Testimony
of

Commissioner Mary T. Bassett, MD, MPH
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on
Fire and Criminal Justice Services
Jointly with the Committee on Health
and the Committee on
Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

regarding

Oversight: Examination of Violence and the Provision of Mental Health and Medical Services in New York City Jails

June 12, 2014

250 Broadway
Committee Room, 16th Floor
New York City

Good afternoon Chairpersons Crowley, Cohen, Johnson and members of the committees. I am Dr. Mary Bassett, Commissioner of the New York City Department of Health and Mental Hygiene. I am joined by Dr. Amanda Parsons, Deputy Commissioner of the Department's Division of Health Care Access and Improvement, and Dr. Homer Venters, the Department's Assistant Commissioner for Correctional Health Services. Thank you for the opportunity to testify today on the topic of violence and the provision of mental health and medical services in New York City jails. This is an important and complicated issue for the Department and our City, and I thank you for focusing on it.

My testimony today will provide an overview of the role of the Health Department in New York City jails and some of the challenges that we face in providing health services to inmates. Commissioner Ponte and I have already met several times and I have had the opportunity to visit the Rikers Island complex. So today I will discuss some of the activities on which Commissioner Ponte and I, with our respective agencies, are currently collaborating on to address these challenges, as well as new initiatives aimed at reducing the violence that has no place in any healthcare setting.

Background

The Department is charged under the City Charter with providing health and mental health services in the City's correctional facilities. The City has 12 jail facilities, each with at least one health clinic. As Commissioner Ponte discussed, there are approximately 11,000 individuals in these jails daily, and most stay for only a short period of time. Over ninety percent of inmates are male, nearly all are African American or Latino, and many come from the poorest neighborhoods in the City. Educational attainment is low and unemployment is high. These inmates enter the jail system with a high burden of disease; rates of HIV, hepatitis C, asthma, hypertension and substance use are all significantly higher than they are among the general population.

The mission of the Department's Bureau of Correctional Health Services is to provide the best possible medical assessment and treatment during an inmate's detention and appropriate health-related discharge planning services. High quality correctional health services are critical for patient safety and health while they are in jail, but they are also important in safeguarding the health of communities to which individuals discharged from jail return. Each month, the Department provides over 63,000 health care visits in jail facilities, most of which occur at Rikers. These include approximately 5,300 comprehensive intake exams, 40,000 medical and dental visits, 2,300 specialty clinic visits and 20,000 mental health visits.

All inmates receive a full medical intake examination within their first 24 hours of entering custody. New York City is a national leader in this regard, as it takes most jurisdictions between one and two weeks to complete such initial exams. This intake exam allows us to screen patients and guides referral to a range of services they may need. It includes a comprehensive health assessment, sexually transmitted disease screening and initial mental health assessment. These help guide further treatment, discharge planning and entitlement applications.

Approximately 46 percent of inmates report that they are active substance users, although we believe the actual prevalence of substance use to be much higher. New arrivals are more likely to admit to substance use if their treatment records include medications like methadone, otherwise substance use may go unreported. The Department actively seeks to identify and assist individuals with a history of substance use in order to provide them with care while they are detained so they may return to their communities linked with appropriate assistance.

The New York City correctional health system is the only large correctional system to provide methadone treatment. Since 1987, we have provided methadone detoxification and methadone maintenance services to approximately 17,000 patients annually. Upon discharge, these inmates are referred to community-based methadone programs. Further expansion of addiction services would encourage more patients to report their substance use and enter treatment while in jail and after their return to the community.

In addition, since 2008, the Department has offered *A Road Not Taken,* a substance use treatment program which focuses on inmates who are potentially eligible for drug treatment as an alternative to continued incarceration. The program provides case management to connect patients to treatment in the community, liaises with drug courts, and coordinates care for eligible patients. Since 2008, over 6,300 individuals have been enrolled and treated in this program.

The Department is also a national leader in the adoption and use of prevention-oriented electronic health records in our jail facilities, allowing our health care workers to better coordinate care for their patients. These patient electronic health records can be shared with community providers via the Healthix Regional Health Information Organization.

Provision of Services

Although oversight of health services and discharge planning in City jails is the Department's responsibility, direct medical, mental health and dental care services are performed by vendor personnel from the health services providers Corizon Health Inc. ("Corizon") and Damian Family Care Centers ("Damian"). Hospital-level services are provided by the New York City Health and Hospitals Corporation. Corizon, the largest private for-profit correctional health services provider in the United States, manages the day-to-day medical and mental health services operation at Rikers and two other jail facilities. Damian Family Care Centers is a New York State-licensed Article 28 Diagnostic and Treatment Center and a non-profit Federally Qualified Health Center with a long history of providing high quality healthcare to the City's underserved. They provide services at the Vernon C. Baines Correctional Center.

The Department closely monitors these vendors through multiple lines of supervision. These include the credentialing of physicians and physician assistants, formulating all policies for medical, nursing, mental health and substance use care services, and ensuring compliance with those policies through a rigorous quality assurance process based on reporting of 40 performance measures. Through many weekly meetings between the Department and the vendors, we ensure that key issues are proactively identified and addressed early.

Mental Illness in NYC Jails

Identifying inmates with mental illness and helping them receive appropriate services is a core focus of our work. All arriving inmates receive a behavioral health screen and those determined to need a more in-depth mental health evaluation receive one within 72 hours. Our data show that approximately 25 percent of inmates are assessed to have some form of mental health diagnosis while in jail. A smaller group (4.5 percent) of the total inmate population is designated as seriously mentally ill, which includes psychotic illnesses, such as schizophrenia. Remaining mental health diagnoses include conditions such as depression, anxiety or adjustment disorders. It is worth noting that rates of diagnosis for both mental and serious mental illness in the jails are consistent with rates among the United States population overall.[1]

However, at any given time in the New York City correctional system, the overall burden of mental illness is 38 percent. This larger proportion results from the fact that inmates with mental illness diagnoses have, on average, longer lengths of incarceration. Because they are less likely to exit the system, they are overrepresented in the inmate population. While we do not know exactly why this occurs, it is an issue we are working to better understand, and I look forward to discussing it with Commissioner Ponte and other members of the Mayor's Behavioral Health and Criminal Justice System Task Force in the coming months.

The majority of patients assessed to have a serious mental illness are housed in the Mental Observation Units that Commissioner Ponte touched upon earlier, which are designed to meet these patients' health needs. The Department operates 19 Mental Observation Units, which currently house about 645 patients. These patients are provided services ranging from an outpatient level of care with talk-therapy to an inpatient level of care with coordination between social workers, psychologists, psychiatrists and pharmacists. We are currently in the process of completely reforming mental observation housing areas in the jails, which I will discuss in greater detail later in my testimony.

The care of patients in a correctional setting has complexities that arise from the joint aims of both maintaining security and promoting health and access to care. Our data show that mental health and violence in the jails are intertwined. Research conducted by the Department reveals that serious mental illness and placement in solitary confinement as punishment are predictive of acts of self-harm, including lethal self-harm. Independent of other factors, placement in solitary confinement as punishment increases the risk of self-harm. This risk is especially high among adolescents, whom we found to be nearly seven times more likely to engage in self-harming behavior. Mental Observation Units are among the most violent settings on Rikers, as was the recently closed MHAUII unit, which housed mentally ill inmates who were placed in solitary confinement as punishment.

Research published by the Department shows that half of adolescents arrive in jail with a history of both being struck on the head and suffering altered consciousness. These factors are associated with traumatic brain injury. Others sustain head injuries while in jail, due to injuries

[1] SAMSHSA data:
http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm

from inmate fights and as a result of reported "use of force" by correctional officers. In approximately 30 percent of violent interactions between correctional officers and inmates there is evidence of a blow to the head. We are in ongoing discussions with the DOC to determine how we can create a more therapeutic setting, as data show that standard practices in the correctional system, particularly solitary confinement as punishment and reliance on force, can be linked to outcomes that we all seek to prevent, including violence against self and others.

As a result of these discussions, in 2013, the Department and the DOC worked to eliminate solitary confinement as punishment for the seriously mentally ill, and opened the Clinical Alternatives to Punitive Segregation, or "CAPS" units. The three CAPS units, two for male and one for female inmates, offer better opportunities for inmates to engage with clinicians and receive mental health services. Initial experience shows that these approaches improve health outcomes and reduce inmate self-injury and violence. CAPS units consistently experience rates of violence and self-harm that are less than half of the rates of units where these patients had been housed previously. CAPS units report about 40 acts of self-harm per 100 patients, compared to 260 acts of self-harm per 100 patients in the restricted housing units, which combine solitary confinement as punishment with some mental health services.

During a recent visit to Rikers, I met a patient in a CAPS unit who had spent nearly two years in solitary confinement as punishment where he was involved in multiple violent encounters every month. When I saw him in the CAPS unit, he had spent approximately six months without any violent encounters or other problems. We have a total of 32 clinical staff in these units to ensure the provision of programming and mental health services for the seriously mentally ill men and women housed there.

In addition to CAPS, the Health Department and the DOC are working together to design new units for inmates with mental illness. This includes six Restrictive Housing Units across the jails; four for adult male inmates, one for adolescent male inmates and one for female inmates. These units are a work-in-progress as we strive to balance punishment and appropriate treatment.

Finally, the Department provides discharge planning to eligible inmates with mental illness. These services, which are provided to approximately 20,000 individuals annually, include arranging for post-release medical and mental health care, applying for or reactivating Medicaid, applying for public assistance, providing a supply of and prescription for medications, arranging for transportation, and organizing post-release follow up.

Addressing Challenges

The success of health care delivery in our City jails depends on the safety of correctional health care workers. It is difficult to overstate how distressing the recent increases in assaults are to the Administration, the Department, and to me personally. Incidents of assaults against health care workers at Rikers spiked in December of 2013 and have continued, on average, to occur at a higher rate in 2014 than in years past. We are working to better understand the factors that have contributed to this rise in violence and our most urgent priority is to work with DOC and Corizon to protect our health care workers.

First, we are improving communication between health care workers and correctional staff. This includes ensuring health care and DOC staffs communicate about high-risk patients

after every tour of duty, allowing staff to target resources and treatment to these patients. Second, health care staff and jail wardens are meeting to address jail-specific safety concerns, resulting in improvements to staff workflows and additional security measures in the clinics. We have also revised our protocols so that high-risk patients receive services in clinic areas instead of their housing units, ensuring a safer setting for staff to administer care. Furthermore, the Department, DOC and Corizon are addressing environmental issues in jail facilities, which involve moving units in areas with unsafe features, such as narrow corridors, to areas that have a more secure layout.

Other efforts to increase safety and security include implementing an aggressive patient alert function in our Electronic Health Record system so that safety precautions are addressed prior to treating high-risk patients. We are also focusing our attention on locations where assaults are most frequent, such as mental health areas and high security settings. Although we do not believe staffing needs to be increased across the board, there are areas where we think additional staffing may improve safety, such as the Mental Observation Units, to better identify patients in crisis and provide them with services in order to prevent a violent encounter.

The Department is also working closely with the DOC to reassess the treatment of mentally ill and seriously mentally ill inmates, especially since a majority of recent assaults on staff and patient deaths have occurred in the Mental Observation Units. As I mentioned earlier, we are working together to redesign the workflows in these units to improve staff safety and patient health. Goals of this redesign include giving staff more say in how these units are run, enhancing support to our social workers, and instilling routine, patient-centered communication between health and security staff that covers basic elements of each patient's status. The Mental Observation Unit redesign process is expected to take several months and we look forward to sharing more information about these changes in the future.

Finally, I want to reiterate what Commissioner Ponte said earlier, that he and I communicate regularly, not just on jail safety and inmate health issues, but also on broader reforms to the criminal justice system as we work together on the Mayor's Behavioral Health and Criminal Justice System Task Force. The Task Force, chaired by Deputy Mayor Barrios-Paoli and the City's Director of the Office of Criminal Justice, Elizabeth Glazer, is charged with developing and implementing strategies to ensure the appropriate diversion of mentally ill people away from the criminal justice system. I look forward to future collaboration with Commissioner Ponte and his agency as we move forward, together, to improve the health and safety of staff and inmates in our City's jails.

Thank you for the opportunity to testify. My colleagues and I are happy to answer any questions.

Testimony of the Children's Defense Fund – New York

Beth Powers

Senior Juvenile Justice Policy Associate

Examination of Violence and the Provision of

Mental Health and Medical Services in New York City Jails

New York City Council

Committee on Fire and Criminal Justice

Committee on Health

Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

June 12, 2014

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My name is Beth Powers and I am the Senior Juvenile Justice Policy Associate at The Children's Defense Fund New York. I thank the Committee on Fire and Criminal Justice, Committee on Health, and Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services for holding a hearing on this very important topic.

The Children's Defense Fund (CDF) Leave No Child Behind® mission is to ensure every child a Healthy Start, a Head Start, a Fair Start, a Safe Start and a Moral Start in life and successful passage to adulthood with the help of caring families and communities. CDF provides a strong, effective voice for all the children of America who cannot vote, lobby or speak for themselves. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, into trouble, drop out of school or suffer family breakdown. As part of our advocacy efforts, CDF launched the Cradle to Prison Pipeline® Campaign, a national call to action to stop the funneling of thousands of children, especially poor children and children of color, down life paths that often lead to arrest, conviction, incarceration and even death.

New York is one of only two states in the nation that automatically treats all youth ages 16 and over as adults in the criminal justice system. This practice is harmful to young people and bad for public safety, in that young people tried in adult criminal justice system have significantly higher rates of recidivism than youth tried in juvenile systems. There are about 700 adolescents (ages 16 to 18) incarcerated on Rikers Island on any given day. Although New York State criminal law currently treats 16- and 17-year-olds as adults, we know that youth are developmentally different than adults.

Violence is a very serious concern in city jails. Our purpose in testifying is to express our concern with short sighted efforts, namely the use of isolation, to deal with problematic behavior through means that are harmful and often exasperate the very problems they are attempting to address. High quality age appropriate programming is necessary to address the complex needs of adolescents and accomplish genuine behavioral change. An investment in such programming is much more likely to go further than any existing effort to safeguard not only the adolescents and adults being held at Rikers, but also the corrections officers and other staff responsible for their supervision.

Just as punitively prosecuting adolescents as adults does not accomplish the desired effect of decreasing future criminal behavior, the use of solitary confinement does not result in a more controlled jail environment. From 2007 to 2013 the number of punitive segregation beds at

Rikers has increased 61%. Despite this dramatic increase, the jail has not seen a decrease in violence. In the same time period as Rikers instituted a sharp increase in punitive segregation beds, the jail experienced a tripling of use of force incidents despite having a decrease in census. Ultimately, isolation is an unacceptable means of control used by the Department of Corrections in lieu of comprehensive services that have been shown most effective in addressing both the needs of adolescents and the call for public safety.

Adolescents housed in adult jails are at risk of harm

There is extensive research outlining the harmful impact to youth of housing them in adult jails. Youth have the highest suicide rates of all inmates in jails. Young people have the highest rates of sexual victimization of all prisoners. Studies show that youth in adult prisons are twice as likely to report being beaten by staff, and 50% more likely to be attacked with a weapon than young people placed in youth facilities.

Harm of isolation

Young people in solitary are denied basic elements necessary for positive development: an adequate education, adequate and age appropriate services, appropriate mental health care, contact with family, appropriate nutrition, and adequate physical activity.

The harms of isolation for people of all ages are well documented. The United Nations Committee on Torture and the European Court of Human Rights have both deemed solitary confinement to be forms of torture and a violation of human rights. As a result of a lawsuit brought by the New York Civil Liberties Union (NYCLU), the New York State Department of Corrections and Community Supervision (DOCCS) recently agreed to remove adolescents, pregnant women, and inmates with developmental disabilities from extreme isolation in New York state prisons. In their 2011 report, *Growing up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States*, the American Civil Liberties Union (ACLU) and Human Rights Watch (HRW) examined the detrimental effect isolation has on adolescents and ultimately recommended prohibiting the use of solitary confinement for youth. Adolescents subjected to solitary confinement risk even further damage than the already horrendous effects to adults given their active development. Solitary confinement can hinder the ability of a young person to rehabilitate, can force the emergence of or

exacerbate existing mental health concerns, and can be physically harmful due to the denial of necessary physical exercise. According to the ACLU/HRW report, 14 percent of all adolescents were housed in isolation at some point during their detainment at Rikers with an average length of stay of 43 days. In their Report to the New York City Board of Corrections, Drs. James Gilligan M.D. of New York University and Bandy Lee M.D., M.Div. of Yale University report that at the time of their investigation in July of 2013 there were 6 inmates on a punitive segregation until for mentally ill inmates that had been in isolation over 1,000 days and one inmate with a stay of over 3,000 days – roughly 3 and 8 years.

Mental Health

According to the ACLU and HRW, more than 48 percent of adolescents at Rikers have diagnosed mental health problems. Adolescents with mental health concerns are disproportionately impacted by the practice of punitive segregation. Drs. Gilligan and Lee cite in their report to the Board of Correction that in July 2013, 73% of adolescents in punitive segregation were diagnosed as either seriously or moderately mentally ill. This is nearly double the percentage of inmates jail-wide diagnosed as such.

Growing up Locked Down makes clear the damage done to adolescents held in isolation, particularly those with pre-existing mental health concerns. In addition to causing significant harm to those with mental health concerns, the torturous practice of punitive segregation can cause new psychiatric symptoms to occur in previously unaffected individuals. Just as the number of punitive segregation beds dramatically increased from 2007-2012, instances of self mutilation and suicide attempts increased nearly 75%.

Drs. Gilligan and Lee, cite multiple examples of the excessively unsafe and harmful conditions they observed young people exposed to at Rikers Island. The inadequacy of staff to appropriately respond to mental health concerns is portrayed below in an excerpt from Drs. Gilligan and Lee, detailing an incident they observed last summer:

"One incident we observed while visiting the adolescent Restrictive Housing Unit (RHU) was a youth banging on the door of his cell, which grew increasingly louder over twenty minutes or so. One could hear that he was initially using his arms and legs but later his whole body, while personnel walked by him, ignoring him. When he failed to gain attention, we observed him tearing his sheet into strips, wrapping it around his arms and legs, and then his neck (as if preparing to hang himself). When we told the staff what he was doing, they did not call the mental health staff (even though this was supposedly occurring in a mental health-oriented RHU) but security. The security staff's first response was to arrive as a group and to tell us to

step back, as they were going to spray him, and they proceeded to pull out a can of Mace. We insisted that this was not necessary and requested that they call mental health staff, at which time the inmate was asked if he wished to see the psychologist, to which he nodded "yes."

Lack of Educational Opportunities

Adolescents in solitary confinement have exceptionally limited educational opportunities consisting of workbook pages to be completed on their own with minimal access to teachers via a phone brought to their cell, if any. When one considers the fact that the DOC reports that more than 50% of the students at Rikers read below a 6th grade reading level, it is impossible to imagine adolescents who are so far behind academically already making any educational strides while confined in isolation 23 hours a day and given work sheets to complete on their own without any in-person instruction – in many instances for periods of time that stretch beyond six full weeks.

Appropriate and Sufficient Staffing

While New York State continues to classify adolescents as adults when it comes to criminal responsibility, the reality is that the 700 adolescents who are present at Rikers on any given day are not adults. Neuroscience supports that development continues until around age 25. Teens are different from adults and must be treated as such. We should not limit the needed conversation to increasing the number of Corrections Officers. The quality of staffing is of utmost importance. Appropriate training to work with this complex and high needs population is vital to ensure Corrections Officers are equipped to handle the special needs of detained teens.

There is an urgent need for comprehensive evidence-based and/or proven programming and services to actually address the academic, social, health and mental health needs of these teens and not simply contain them in dangerous and demoralizing environments that exacerbate their special needs. The DOC describes the existing Institute for Inner Development as staffed by specially trained Corrections Officers. We are encouraged by the acknowledgement of the need for specialized training in order for Corrections Officers to better be able to competently address the needs of teens in custody. We support the ABLE Project for Incarcerated Youth, however we urge the development of comprehensive programming that extends beyond the school day and week and beyond serving only the school-attending teen population at Rikers.

Recommendations:

In conclusion, we strongly suggest the following:

- No adolescents or young adults under age 25 should be housed in isolation.
- The DOC should be required to make data public on a regular basis regarding the use of isolation. This data should include frequency of occurrence, duration of stay, and infraction. This should be disaggregated by age to make transparent the impact on adolescent inmates.
- All DOC staff working directly with teens detained in city jails should receive on-going training including but not limited to adolescent development and best practices for working with detained youth.
- The DOC should fund and implement robust developmentally appropriate interventions to reduce violence and decrease the need for punitive measures. In addition, the DOC should identify alternative punitive strategies that do not include the detrimental and excessively harmful effects of isolation.
- As long as youth remain detained in isolated confinement, The DOC should ensure that youth are no longer denied appropriate educational access
- The DOC should expand programming for adolescents to include all teens, not just those in school programs, and include after school and weekends.
- Once discharged from NYC jails, no one should continue to carry a debt of time owed in solitary confinement to be paid should they return to a NYC jail in the future.

New York City must much more appropriately deal with the adolescents in the care of the criminal justice system. Research shows conclusively what common sense also tells us - adolescents fare better when they are treated with developmentally appropriate programs. Investing in positive alternatives to punitive segregation and in rehabilitation is certainly the best way forward when it comes to ensuring the safety of all parties.

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Written Comments of The Bronx Defenders
New York City Council
Joint Meeting of the Committee on Fire and Criminal Justice Services and the Committee on Mental Health, Development Disability, Alcoholism, Substance Abuse, and Disability Services
June 12, 2014

Good afternoon. My name is Skylar Albertson, and I am the Assistant to the Executive Director at The Bronx Defenders. In this capacity, I have been conducting interviews since January with clients of The Bronx Defenders currently or formerly held in solitary confinement at Rikers Island. I would like to thank the Council for the opportunity to testify on this matter.

One year ago, I graduated from college excited to begin my first full-time job at The Bronx Defenders. Having interned at a public defender office as an undergraduate student, I assumed that not much would shock me. For several months, this expectation held true. Then, in January, I began meeting with clients of The Bronx Defenders held in solitary confinement at Rikers Island.

Nothing could have prepared me for what I would hear. The treatment of individuals placed in solitary confinement at Rikers goes far beyond what I ever imagined could be possible in the United States, let alone in the city where I have lived for nearly my entire life. It is horrifying and it is shameful.

Roughly three months ago, I sat across a table from Lacquan Berkley in a cramped interview room at Rikers. Lacquan was hunched over with one arm handcuffed to a wall; the fear in his eyes was painfully clear. In a word, he looked broken. Just weeks earlier, Lacquan had spent his twentieth birthday in solitary confinement.

At the time of our interview, Lacquan had been in solitary for approximately six months. Prior to arriving at Rikers, he had been diagnosed with multiple mental illnesses and learning

disabilities. At school, Lacquan had been placed in a special education program. Yet once Lacquan entered solitary confinement, he found it incredibly difficult to access even the most basic services, such as medical care, phone calls, and showers. On more than one occasion, Lacquan resorted to hanging himself so that he could see a mental health professional. In response, the correctional officers responsible for Lacquan would taunt him, telling him to "hang it up real good" and to call them when he was "about to die." The officers would return an hour or two later to mock Lacquan, asking him if he was dead yet. When Lacquan was receiving mental health therapy, he was kicked out for poor behavior, despite the fact that his actions were clearly symptomatic of his illnesses.

I wish I could say that Lacquan's situation is unique, but based on the interviews I have conducted over the past six months, many aspects of his experience are all too common among our clients held at Rikers. Inexplicably, solitary confinement is the *only* form of punishment used for most infractions at Rikers. There is no range of penalties. Once a person faces allegations and appears at an internal hearing for which there is no right to counsel, the only question remaining is just how long he or she will be locked away in solitary confinement.

The overwhelming majority of our clients who are held in solitary confinement are young men between the ages of 17 and 22. The median age for our male clients interviewed this year about their experiences in solitary is only 20 years old. Once our clients enter solitary confinement, it becomes shockingly easy for correctional officers to pile on tickets for alleged infractions. The median amount of solitary time for our male clients interviewed this year is 105 days. The average amount of time is an astonishingly high 357 days on account of the fact that at least five of our clients have received tickets totaling several hundreds of days in solitary confinement and two of our clients have received tickets totaling approximately 1,400 days.

While some of our clients are released from Rikers before completing their solitary time, the clients we have interviewed so far this year had spent an average of over 150 days in solitary confinement by the time we met with them. Even worse, those clients are at risk of being placed directly in solitary if they ever return to Rikers in the future.

The proposal at hand is crucial for developing meaningful changes to the use of solitary confinement at Rikers. It is inexcusable that arguably the most severe punishment that the government inflicts upon individuals in this city is shrouded in secrecy. Making data concerning the use solitary confinement publicly available will enable organizations like us not only to advocate for policy changes but also to see whether those policies are being implemented.

Unfortunately, transparency is just the first of many changes that must be made. It is unacceptably difficult for our clients in solitary confinement to receive basic services. Despite the fact that the Minimum Standards guarantee our clients one phone call per day, our clients have been denied access to phones on several occasions. Particularly for our younger clients, the inability to contact family members while held in solitary confinement can be devastating. Similarly, some of our clients have gone multiple days in solitary confinement without being able to take a shower. When our clients force open the slots in their doors in order to demand these services, they receive infraction tickets which carry more days in solitary confinement.

Perhaps most egregious are our clients' experiences with recreation time. Since our clients in solitary confinement are locked in their cells for nearly 24 hours each day, it is absolutely essential that they are able to spend some sort of meaningful time outside. Unfortunately, this is usually not the case. In order to go outside, our clients must first be awake and at the front of their cells as early as five-thirty in the morning to be added to the list of people allowed outside each day. Correctional officers generally make little or no attempt to

make sure that everyone who would like to go outside is able to do so, and it is easy for officers to pass by the cells of individuals who have fallen out of their favor. As a result, some of our clients have gone months without being able to venture outside. When our clients do go outside, they discover that recreation time consists of standing in cages that are roughly the same size as their cells. In fact, some of our clients refuse to go outside because they find the experience of standing in a cage even more dehumanizing than sitting in their cells.

The one service that our clients do receive every day – three meals – also falls short of their needs. Unlike in general population, our clients in solitary confinement are unable to obtain additional food in between meals. Most of our clients in solitary confinement – many of them in their late teens –describe their experiences as the hungriest that they have ever been.

Shockingly, our clients' inability to access important services also extends to medical care. A common complaint among our clients held in solitary is that they are only able to receive prompt medical attention if they are bleeding. Otherwise, it usually takes hours for them to see a doctor – even for serious injuries and illnesses.

Our clients face similar obstacles to receiving mental health services, a fact that should be considered absolutely unacceptable given the mental damage that solitary confinement causes. Nearly all of our clients in solitary confinement are diagnosed with mental illnesses prior to entering solitary. The few that do not have prior mental health issues usually experience deteriorations of their mental health not long after being placed in solitary confinement. Group therapy and other services such as academic classes that would undoubtedly go a long way towards improving our clients' mental health are next to impossible to access in solitary confinement.

Even in the Restricted Housing Unit, which purportedly exists specifically for clients with severe mental illnesses, mental health services consist of minimal group therapy and an hour or two of television each week. None of these services comes even close to making up for the daily mental trauma that our clients endure in solitary, let alone treating the mental health issues that plagued them before they arrived at Rikers. It is akin to giving someone a Band-Aid and aspirin each day after breaking his bones.

Solitary confinement as it is practiced at Rikers Island is cruel, unusual, and inflicts both severe mental and physical harm on individuals who are already in the custody of the city. There is no place in modern society for the duration and conditions of solitary confinement that are imposed on our clients. It will take much more than monthly reports to check the overuse and abuse of solitary confinement at Rikers Island, but without knowing the full scope of the problem and without being able to monitor any progress that we achieve, we have nowhere to begin.

Norman Seabrook

President

Testimony before Committee on Fire and Criminal Justice Services

Council Member Elizabeth Crowley, Chair

Date: Thursday, June 12, 2014

Norman Seabrook Testimony Before NYC Council
Committee on Public Safety

June 12, 2014

The events of the past couple of months have thrust Correction Officers into the public consciousness. The tragic death of Jerome Murdough, a series of assaults on Correction Officers, the arrest of Correction Officers, questions about punitive segregation and mental illness are in the news, as they have been in the past. With a new Mayor comes a new New York City Department of Correction (DOC) Commissioner intent on making sweeping changes to the way that we are allowed to do our jobs. These proposed changes range from the "process" that an inmate is "due" before he or she is infracted, to the protection to be afforded – and medical treatment – of the alleged 40% that are mentally ill, how punitive segregation can be used, how violent 18 year olds are treated, and even whether 24 year olds are to be treated as if they were in their mid-teens.

New York City Correction Officers are sworn peace officers in the State of New York. They have a very tough job, and they do the job very well under the circumstances, 24 hours a day, 7 days a week. What's become very alarming is that Correction Officers are now faced with dealing with some of the most psychologically challenged individuals in society, the mentally ill detainees. They're also charged with dealing with a growing number of homeless individuals. Has Riker's Island become the dumping ground?

Riker's Island is part of a penal system that was established to detain individuals who have been accused of committing crimes. It appears now that we are in the business of housing inmates that need mental health assistance, we are in the

business of housing the homeless, we are now charged with three different types of individuals that are in our care, custody, and control. Things are going wrong. The City Council, the City of New York, and government in the city are responsible for providing services to the citizens of this city that need services. Riker's Island is not a mental institution where Correction Officers can be made responsible for medicating those in our charge, to insure that they're receiving the proper treatment that they so rightfully deserve and that the City of New York has a fiduciary responsibility to provide. Riker's Island is for individuals who have allegedly committed crimes. Mentally challenged individuals did not commit a crime. The only crime that people want to accuse them of committing is not receiving their help or medication.

We don't have Solitary confinement on Rikers Island and NYC Jails. We are a jail system and not a prison system. We have Punitive Segregation and there's a difference.
Terms like the "Box", The Hole" or Solitary Confinement doesn't apply to Rikers Island and NYC Jails. Punitive segregation has been an effective tool in controlling criminal/violent behavior and enforcing rules and regulation within the jail system.

It is a non-violent way of affecting a punitive action on offenders after a due process hearing is conducted. Punitive segregation is like a jail within a jail. Punitive segregation is the most non-violent/non-adversarial tool in DOC for enforcing rules and regulations. Limiting the use of punitive segregation is already having a negative effect on Rikers Island. The increase in violence by inmates who when they break the rules are not punished and continue to commit infractions. The managers of New York City Department of Correction have decided to house gangs separate

from each other (Bloods in one house and Crips in another house and Latin Kings in another house) rather than doing what is done in the state prisons. That is inmates should be housed according to their classification and not gang affiliations. THERE IS AN 800 BED BACK UP of inmates waiting to go into punitive segregation because of crimes and infractions committed by inmates since being incarcerated.

In 2013 there were a total of 3285 use of force incidents. Of these 3285 use of force incidents, [illegible] inmate-on-inmate slashing and stabbings, [illegible] serious injuries from inmate-on inmate incidents, [illegible] class "A" use of force incidents where inmates and/or Correction Officers were injured, and 196 incidents with Correction Officers receiving serious injuries (Broken bones, sutures, fractures etc.)

There is an increase in violence but a decrease in the amount of arrests. How is that possible? Correction Officers are not opposed to change. We are not opposed to pursuing a multifaceted approach to handling inmates. We're opposed to being subjected to violence by inmates who become unpunishable or untouchable behind the mentally ill label. We are opposed to not being able to punish inmates who commit crimes and violate the rules while in jail.

Riker's Island continues to deal with the inmates who commit crimes against the public. Riker's Island also has to deal with a huge gang population, and they continue to stab, slash, and attempt to murder each other within the confines of the jail. While doing all this, Correction Officers are very short staffed. We don't have the staffing levels we need to combat the problems, we don't have the equipment we need to combat the

problems, yet everyone continues to say "what are we gong to do about it"? Well the answer is simple. The money that's allocated to provide services to the homeless, let that money go to the homeless, and provide housing for the homeless. The money that's allocated to treat mentally ill individuals, let that money go to those individuals, so that they can be treated in institutions that have the equipment to treat them, like Bellevue Hospital, like Creedmoor, like upstate New York where they have institutions that have already been set up to deal with the problems we face every day in the City of New York.

Direct the Department of Mental health to concern themselves with their business and stop dumping their responsibilities on New York City Correction Officers. They continue to neglect the individuals that need service in this city and just rubber stamp the paper work until something goes terribly wrong. They then begin to backpedal, blaming others for their shortcomings.

According to the statistics of the DOC mentally ill inmates make up 37.5% of the population in NYC jails but are responsible for 61.30% of the use of force and assaults. Why is this? According to the experts this is a direct response to being placed in punitive segregation. Nothing could be further from the truth. Part of the reason for this spike is that a small group of inmates have learned how to play the system, and the Correction Officers are no longer in charge of the jails. Inmates know they just have to request to see a mental health worker to be classified as an inmate with mental health issues and they can't be housed in punitive segregation.

It is a fact that we have inmates in our system that are mentally ill. Correction Officers are conscious of this, but we're also conscious of the fact that mentally ill inmates are not members and leaders of gangs. Correction Officers believe that programs such as Clinical Alternative to Punitive Segregation (CAPS) and Restricted Housing Units (RHU) are progressive and if provided to the inmates who are truly mentally ill without a doubt can be successful. But inside the CAPS and RHU programs are inmates who are gang members and inmates who are guilty of crimes of assault against other inmates, civilians and Correction Officers.

The reality is inmates who have mental problems should not be housed on Rikers Island. They should be housed in a mental institution and/or Bellevue Hospital Prison Ward. They should be in custody of mental health professional and not Correction Officers.
A newly appointed Correction Officer receives a total 21.5 hours of mental health training while assigned to the Correction Academy. Thereafter Correction Officers receive a one day refresher course. COBA isn't opposed to our members receiving additional training in mental health to better handle inmates who are truly mentally ill.

New Yorkers are a unique group of people. We're made up of individuals from all walks of life. All walks of life suffer mental illness, it's not just the minority community. All walks of life suffer homelessness, it's not just the minority community. Yet when you look at Riker's Island you would look at it as a dumping ground for individuals that come out of these same communities where gentrification is taking place. We have to do a little bit more, we have to work a little bit harder, and we have to give Correction Officers and Correction staff the equipment they need to combat these problems.

The Rikers Island Dilemma is that the focus of the department has shifted from running an efficient organization to numerical results. It's more concerned with, and afraid of inmate advocacy groups than running a proper detention facility

On Rikers Island violence among inmates and toward Correction Officers is considered normal and the blame is placed on the Correction Officer charged with patrolling this beat. What did the City or the Department do about the crimes of assault that took place last year? What does the department or the city do for the victims of these crimes? What does the city and the department do about the crimes committed inside the jails?

In March at the City Council budget hearing for the DOC there was no money in the budget for hiring additional Correction Officers although the previous Commissioner testified that the DOC was under its staffing level by more than 900 Correction Officers. There was no money for additional mental health training for Correction Officers. There was no money to hire additional Correction Officers to work in the gang intel unit to deal with gang activity and gang violence.

We welcome the new Correction Commissioner that has come to the City of New York, Joseph Ponte. We are going to work diligently together. Give Joe the power to dismiss all that have been a part of the problem under previous Commissioners, and let us do our job. As President of the Correction Officer's Benevolent Association I want to make this an environment where not only can inmates, the Correction Officers, and the civilians be safe, but its important that the public be kept safe as well. If the individuals are not secure in these facilities and they begin to escape into the City of New York they will continue to commit more crimes.

Correction Officers have been the stepkids of law enforcement. A police officer interacts with these individuals for approximately 60 minutes. We have them every day for 60 days.

We had Dr. Dora Schriro who failed the system, we had Martin Horn, who failed the system. We now have to work diligently and be able to tell the Mayor of the City of New York, no, Riker's Island is not a dumping ground for mental health inmates, Riker's Island is not a dumping ground for the homeless. Riker's Island is a penal system established for those individuals who have committed infractions against the law, and have been placed there pending the outcome of their trial and/or until a judge decides he or she can go home.

The Riker's Island Dilemma is simple. Will the professionalism of those responsible for the Care, Custody, and Control of 12,000 detainees continue to be questioned? Or will all the stakeholders in the City's jail system start to act in a more collaborative fashion for the betterment of all?

DOCTORS DC COUNCIL
a national affiliate of SEIU

A United Voice for Doctors, Our Patients, & the Communities We Serve

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Testimony of Frank Proscia, M.D.,
President of Doctors Council SEIU
Before the New York City Council Health Committee

June 12, 2014

Good afternoon Chair Johnson, Chair Crowley and members of the City Council. I am Dr. Frank Proscia, President of Doctors Council SEIU. We are a union for doctors and voice for patients. Thank you for the opportunity to speak. We represent doctors throughout the country, including those that work in HHC hospitals and facilities; DOHMH; and Rikers Island and other City Agencies.

Today's oversight hearing comes at a volatile time for healthcare workers and other professionals who have been faced with a marked increase in violent assaults while providing care at Rikers Island. Rikers saw eight assaults on healthcare staff in 2011, 22 assaults in 2012 and 32 assaults in 2013, according to DOHMH. It is worth noting that the uptick in violence has coincided with the increasing numbers of mentally ill offenders in our jails. Thirty seven percent of inmates at Rikers on any given day had a mental health diagnosis, according to the New York City IBO.

We support Intro 292 which aims to track and assess punitive segregation especially with respect to those inmates with mental health issues. These statistics may help the various agencies involved make informed decisions on how to better address certain volatile behavior in the prison setting and enhance safety for everyone at Rikers.

Through working with the Board of Corrections and through our contract with Corizon, Doctors Council has advocated for immediate changes that can improve the work environment for all staff. Steps are being taken in the right direction, but recent incidents show that this continues to be a serious issue that requires all parties to work together.

First, we are calling for more training of staff across all agencies. Specifically, we encourage in-person safety trainings of medical staff and COs for a team approach to reducing violence. We call on Corizon and the City agencies to make trainings on safety protocols more of a priority. Furthermore, we believe that COs would benefit from more in-depth training at the Academy level, specifically on mental health issues. Currently, a CO has three hours of mental health training which is not nearly enough when almost half the population at Rikers has a mental behavioral problem.

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Sufficient staffing of doctors and COs is also a critical issue. Inmate wait times in medical clinics are excessive, causing overcrowding and agitation and putting inmates, corrections officers and healthcare professionals at risk. In 2013, almost half of the 65,000 inmates scheduled to be seen for important medical follow-ups and care were not seen and instead were cancelled upon due to understaffing. People have a right to timely access to care and wait times, as described in the Board of Corrections Minimum Health Standards.

With respect to CO staffing, more individuals are clearly needed to provide a safer environment in the clinics. In some clinics, inmates can walk around unescorted and in other clinics areas, there are no COs at all.

Another critical area is the physical set-up of the health clinics. Clear site lines so that corrections officers can see doctors is important. We would like more input into how clinics are physically set-up and maximized for security. We were pleased to see that panic buttons have been added to several clinics recently, something we have long advocated for, and we thank DOC for that progress. But that is just a first step. Our doctors have called for on-person panic buttons, cuff bars in all clinics, and emergency egress for medical staff in treatment areas.

Working with the Board of Corrections and DOHMH, Doctors Council has helped convene and taken part in two interagency working group meetings in recent months at Rikers and we will continue to take a leadership role and collaborate with various parties to ensure stronger workplace safety standards and quality care at Rikers Island.

We would like to thank the Mayoral administration and various City agencies for reaching out to us in recent phone calls on the issue of workplace safety at Rikers. It is this type of inclusive dialogue that will help affect change on this difficult issue. Doctors Council SEIU also welcomes the administration's news on the formation of the Task Force on Behavioral Health and the Criminal Justice System. Our doctors understand the many challenges involved with providing comprehensive and lasting care for those with mental illness, especially in the safety net hospital system. I hope the administration and the City Council will continue to think of us as a sounding board on this matter.

Thank you for your time today.

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About Doctors Council SEIU

Doctors Council SEIU, a professional organization for doctors, is the nation's oldest and largest union of attending physicians and dentists in the United States, with members in New York City, and in states across the country. Formed in 1973, Doctors Council SEIU is a union for doctors and a voice for patients, and represents attending physicians and dentists at Health and Hospitals Corporation (HHC) facilities and hospitals, including doctors employed by the affiliates New York University School of Medicine, the Mount Sinai School of Medicine and the Physician Affiliate Group of New York (PAGNY). HHC is the largest public hospital system in the nation. Doctors Council SEIU also represents doctors in the New York City Mayoral agencies including the Department of Health and Mental Hygiene (DOHMH) as well as doctors working at Rikers Island, the largest correctional facility in the nation. Affiliated with SEIU, Doctors Council SEIU is a national union representing doctors employed in the public and private sectors.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

June 12, 2014
New York City Council Hearing, Committee on Health
Examination of Violence and the Provisions of Mental Health and Medical Services in NYC Jails
Testimony from Maya Escalona, NP

My name is Maya Escalona. I'm a Psychiatric Nurse Practitioner working at Rikers Island and a member of the New York State Nurses Association.

Our union is in ongoing constructive dialogue with the mayor's office and with city officials regarding the assaults on caregivers at Rikers and we appreciate both the city council's and the mayor's commitment to addressing the situation. We look forward to working with all parties to find a long term solution. The city council resolution being considered today will create more transparency which is an essential first step, but we need to go further to address these issues at their root, to create a safe environment for workers and inmates at Rikers.

For going on 3 years I've worked mostly full-time and in the Mental Observation units. These are the areas where mentally ill inmates with higher treatment needs are housed. I enjoy working with these patients, for the most part. Of course it's not without its challenges. But it's an opportunity to help some of the people in our community who are in great need. Many of them have serious chronic mental illness and the jail is one of few places where they have access to treatment.

But some of these inmates can be violent as we all know. In the last year, assaults against civilian medical staff have spiked. Most of these attacks have occurred in the Mental Observation or the MO units as their called. One intern was punched in the face, unprovoked, and she sustained multiple fractures-broken jaw, nose and orbit. Another intern was sexually assaulted. And assaults against officers have also risen. Sadly I've seen few changes to improve the safety of these areas in the last year despite the worsening violence. As a result, I've refused to visit MO patients in the housing areas. Many of my colleagues who continue to work in the MOs, are in constant fear. Being escorted by an officer does not guarantee safety as some of the most recent attacks have shown--these clinicians were attacked, unprovoked, with officers next to them.

I recommend that until conditions improve, clinical staff should not visit patients in their housing areas. This is a high risk interaction--for the caregivers, officers and patients. Instead, the patients should be brought to staff in secure clinic offices. I understand that the city wants to increase programming and offer more treatment to the patients in MOs. As a mental health professional, I certainly understand the value of this. But this would require more clinical presence in the housing areas. If Rikers or part of Rikers is to operate like a psychiatric facility, then reforms need to be made so that we can treat patients in a safe environment.

I chose to reduce my hours, work part-time, and with patients in General population rather than in mental observation to avoid becoming a statistic. We understand we work in a potentially dangerous place, but we don't have to be in danger.

I urge the agencies on Rikers to increase their efforts at collaboration and to develop solutions to this very serious problem. We need safe levels of staffing of all staff at all times – that includes both healthcare workers and officers. We need better protocols for how healthcare is handled on the Island. Our safety concerns need to be addressed in a responsible and timely manner. Thank you.

FOR THE RECORD

New York City Council
Committee on Fire and Criminal Justice Services
Committee on Health
Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Thursday, June 12, 2014
250 Broadway, 16th Floor Committee Room

Testimony of Five Mualimm-Ak
Incarcerated Nation / New York Jails Action Coalition

My name is Five Mualimm-Ak.

For 9 long months, I was held inside solitary confinement in the CPSU unit 1 South in the lock box cell. This incarceration was first in a pre-hearing detention format in which I was held in my cell for 24 hours a day for the total of 5 days, after which I was then held even longer for receiving a book that wasn't allowed in the facility due to it having being written by a Black Panther. During my stay I received another ticket for not being ready to leave the shower when my time was up. This time I needed because I was injured in a fight that broke out in the day room which led to everyone on that tier being held in pre-hearing detention, but instead of receiving medical attention I was additionally punished because of my inability to move fast enough. I was eventually removed to another facility when I spoke up about the cage fights that were organized by the facility guards that also denied other people held there to have their hour recreation. I suffer from bipolar disorder and to be held in a concrete box literally drove me insane and my actions from that only led to further punishment. Why is that an issue? Because the DOC does not do assessment and my medical records could not be accessed due to the private hospitals policy of information.

City Council Member Dromm has introduced Int. 0292-2014, a local law to amend the administrative code of the city of New York in relation to requiring the commissioner of the Department of Correction to post a monthly report on its website regarding punitive segregation including statistics for city jails. This important legislation will provide oversight for monitoring punishment in the New York City jails that has been ignored. This local law will allow the information of events like mine and others to be examined and used to better the conditions of the thousands that are held there each year. This monthly report is what is needed to prevent further damage to our citizens that are being held there. With no oversight this location has grown to become a site of torture and abuse that knows no end. People have died, been killed, and suffer every moment of the day there instead of just being held for court reasons. I have seen people including myself assaulted, bitten by dogs, and denied their so-needed recreation. We as New York have to be better in the way we treat our prisoners because the nation is watching, and being that we have unique facilities like Rikers that hold the greatest amount of people incarcerated, we have to be an example for the nation in itself.

Committee on Fire and Criminal Justice Services

Committee on Health

Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse, and Disability Services

Oversight Hearing – Examination of Violence and the Provision of Mental Health and Medical Services in New York City Jails

Thursday June 12, 2014
250 Broadway, 16th Floor Committee Room

Testimony of Elizabeth Mayers
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Thank you for this opportunity to testify concerning the brutality and violence that are endemic throughout the jails at Rikers Island and which foster an environment that is extremely destructive for all who are confined there.

I am a new member of the Jails Action Coalition. JAC includes formerly and currently incarcerated people, family members and other community members working to promote human rights, dignity and safety for people in New York City jails. I am pleased to be active with this dedicated group about the devastating problems that are part of life on Rikers Island, a place I could not have imagined before my visits there.

I have been a visitor at Rikers for two and one half years, accompanying the mother of a young man now 20 years old, who has been held in the Bing, aka solitary confinement, for much of this time. We have never understood why he has been in the Bing so frequently and long. What we do know is that he has a mental illness and has been taking medication since he was eight years old. Presently he is in protective custody which is solitary confinement with a TV.

Those of us on the outside have very little knowledge of what goes on inside. This opacity is profoundly troubling but seems to be the modus operandi at Rikers. For this reason I am grateful for what we have learned from recent information obtained through the Freedom of Information Law, information which would not otherwise have been available to those outside the Department and Board of Corrections. These documents shed some light on the secret activities in the jails that flourish like mushrooms in a dark and damp environment.

For example, because of information contained in an email sent by the Executive Director of the Board of Corrections to members of the Board on November 13, 2013, we know about the plight of Jose Bautista who was admitted to the Otis Bantum Correctional Center on January 10, 2013. Quoting the email: after admission Mr. Bautista was "subject to a new admission medical exam, after which he was sent to an intake pen. In the pen, he attempted to commit suicide by tying himself up by his neck on the bars of the cell. A video shows inmates taking him down, officers entering the cell, and then a use of force and rear-cuffing of the inmate on the ground. The inmate appears to jump up to his feet at one point, and is then subjected to more force. He and the officers move out of the camera's view, and then come back into view where the officers are seen repeatedly punching the inmate on the floor. The inmate sustained potentially life-threatening injuries requiring emergency surgery for a perforated colon, and hospitalization.

Although this email contains descriptions of three deaths, two by suicide, and acts of use of force on four other incarcerated persons, I chose this particular case to highlight because it includes issues of mental health, brutality, and lack of transparency. A man with mental illness attempts suicide, and corrections officers'

response is to use significant force against him – including while he is on the floor and handcuffed. A portion of the incident cannot be seen on video because the video line of sight is only partial. But we know the truth of what happened because it was captured on video. Unfortunately these brutal acts are often committed outside the camera's range.

In April, 2013, The Legal Aid Society's Prisoners' Rights Project gave testimony about violence in New York City Jails to the Committee on Fire and Criminal Justice Services. This thorough report covered many aspects of the violence endemic in New York City jails. The report lists twenty-six incidents of head and face injuries in 2012 resulting from the use of force by Department of Corrections uniformed staff. It notes that the 'frequency and severity of injuries, confirmed by medical records, was astounding".

Still pending is the case Nunez vs the City of New York, a class action suit brought by The Legal Aid Society in April, 2012. It "seeks to end the pattern and practice of unnecessary and excessive force inflicted upon inmates of New York City jails by the Department of Correction uniformed staff and knowingly permitted and encouraged by Department supervisors." It pertains, for the first time, to all New York City jails. I pray that by shedding light on past abuses, and punishing them, it will have a very positive impact on the brutality and violence that define the Rikers jail system.

Thank you for this opportunity to speak to you today.

New York City Council
Committee on Fire and Criminal Justice Services jointly with the Committee on Health and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services
Oversight – Examination of Violence and the Provision of Mental Health and Medical Services in New York City Jails.

Thursday, June 12, 2014
250 Broadway, 16th Floor Committee Room

Testimony of Deborah R. Hertz, Esq.
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The NYC Jails Action Coalition is made up of formerly and currently incarcerated people, their family members, and other community members working to promote the human rights, dignity and safety of people incarcerated in New York City Jails. Among our goals are: putting an end to the use of solitary confinement and increasing transparency and accountability in the NYC Department of Correction policies and practices.

Along with this written testimony, I am submitting copies of "Voices from the Box," a collection of seven direct accounts from men, women, and young people sentenced to solitary confinement at Rikers Island. Its pages decry the torture that IS solitary confinement. Echoing their accounts, Juan E. Mendez, United Nation Special Rapporteur on torture said, "Considering the severe mental pain or suffering solitary confinement may cause, it can amount to torture or cruel, inhuman or degrading treatment or punishment when used as a punishment."[1] He went on to say that it should be used only in "very exceptional circumstances for as short a time as possible," and stressed the need for procedural safeguards.

This is NOT the case in New York City jails. Solitary confinement is meted out as punishment, not only for serious or violent infractions, but for non-violent, rule-breaking. It is used at the whim of correction officers and used arbitrarily and capriciously. There are rarely any procedural safeguards in place if any at all. There is no mechanism in place for the DOC to report on solitary confinement statistics. The public has the right to know

[1] United Nations General Assembly, Sixty-sixth session Item 69 (b) of the provisional agenda, interim report prepared by the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, in accordance with General Assembly resolution 65/205.

about the human rights violations being committed in its jails and prisons. The public must have access to information of those in solitary confinement such as: the number of people confined, the number of mentally ill confined, the number that commit suicide or attempt suicide, the number that caused injury to themselves, and other pertinent data.

It is for these reasons that the Jails Action Coalition strongly supports the local law being proposed by City Council Member Dromm. Councilman Dromm introduced Int. 0292-2014, a local law to amend the administrative code of the city of New York in relation to requiring the commissioner of the department of correction to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement. This important legislation will provide much-needed oversight and transparency. The veil of secrecy must be lifted. The citizens of New York City have a right to know.

THE LEGAL AID SOCIETY

TESTIMONY

The Council of the City of New York

Committee on Fire and Criminal Justice Services
Jointly with the Committee on Health and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Oversight: Examination of Violence and the Provision of Mental Health and Medical Services in New York City Jails.

AND

Int 0292-2014 A Local Law to amend the administrative code of the city of New York in relation to requiring the commissioner of the department of correction to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement.

June 12, 2014
New York, New York

Prepared by
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Testimony of the Legal Aid Society

Before The New York City Council
Committee on Fire and Criminal Justice Services Jointly with the Committee on Health and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

June 12, 2014

Thank you for the opportunity to testify today concerning the serious risk to New Yorkers posed by inadequate medical and mental health care and violence in the New York City jails. In addition, we testify in support of the pending legislation to amend the administrative code of the City of New York in relation to requiring the Commissioner of the Department Of Correction ("DOC") to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement. We submit this testimony on behalf of The Legal Aid Society, and thank Chairs Elizabeth S. Crowley, Corey D. Johnson and Andrew Cohen, and the Committee on Fire and Criminal Justice Services, Committee on Health, and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services for inviting our thoughts on the subject. We applaud the Council for tackling these important topics and considering this legislation, which will increase accountability and transparency in the City Jails.

Since its inception over 40 years ago, the Prisoners' Rights Project of the Legal Aid Society has addressed the problems of inadequate medical and mental health services and of violence in the New York City jails. Through advocacy with the Department of Correction ("DOC") and individual and class action lawsuits, we have sought to improve medical and mental health care and to reform the systems for oversight of the use of force and violence in the jails. Each week we receive and investigate numerous requests for assistance from individuals incarcerated in the City jails who are not receiving adequate medical and mental health care and from others who are victims of violence in the jails. We interview inmates and carefully review their medical records. Years of experience, including daily contact with inmates and their families, has given our office a firsthand view of the problems with the delivery of medical and mental health services and the effects of jail violence. It is on this basis that we offer these comments to legislators and all New Yorkers.

Tragic Consequences: Neglect and the Lack of Mental Health Treatment in the NYC Jails

The death of Bradley Ballard: Bradley Ballard, a Legal Aid Society client, died on September 11, 2013 at Elmhurst Hospital when clinical and uniformed staff at the AMKC Mental Health Center on Rikers Island left him locked in a cell and did nothing as they watched him deteriorate. Mr. Ballard was remanded to jail as a parole violator, where he died, for *failing to report a change of address.*

Clinical staff neglected Mr. Ballard despite knowledge of his serious mental health needs and ignored his clearly evident psychiatric deterioration over his last week. Mr. Ballard came to AMKC from the Bellevue Hospital prison psychiatric ward. He was hospitalized on July 1, 2013, in a psychotic and uncooperative state. He remained on the Bellevue prison ward until he was discharged on July 31. Mr. Ballard had scarred wrists from prior suicide attempts. He had a

known and reported history of schizoaffective disorder, including prior hospitalizations. He was placed into the AMKC Mental Health Center, the Unit on Rikers Island that is for individuals identified as needing enhanced mental health treatment services while in the jails.

On September 4, after it was reported that he made a lewd gesture to a female correction officer, he was locked in his cell for seven days and not let out at all. During this period he was not provided prescribed medication and was not always provided food; he clogged his toilet so that it overflowed, stripped off his clothes, and tied a rubber band around his genitals. This prolonged in-cell confinement was a direct violation of the NYC Board of Correction Minimum Standards, which require 14 hours a day out-of-cell time for everyone but prisoners in punitive segregation or medical isolation (quarantine). Mr. Ballard was not locked in his cell based on any disciplinary process – no procedural protections of the disciplinary process were afforded to him – yet he was isolated and ignored in his cell by DOC and clinical staff. His deteriorated condition was obvious: a video from September 10, shows an inmate on the unit delivering a food tray to the cell, and covering his nose with his shirt because of the smell emanating from the cell.

After seven days of unauthorized isolation, lack of medications and complete neglect, Mr. Ballard was found naked and unresponsive in the cell. He was covered in feces, his genitals swollen and badly infected. On his last day alive, no clinical staff conducted the required twice daily rounds of the specialized mental health unit. He was taken by ambulance to Elmhurst Hospital, where he was pronounced dead shortly after he arrived.

The failure to provide treatment for Mr. Ballard, when his need for it was well known, rises to criminal neglect and amply demonstrates the abysmal lack of mental health treatment services in our City Jails. A state investigation found clinical staff missed multiple opportunities to treat Mr. Ballard; as a result, a unit chief was transferred to another facility and mental staff were re-trained on how to conduct rounds and other required procedures. But this is not enough because, unfortunately, his is not the only appalling and tragic example of neglect.

The death of Horsone Moore: The Division of Parole and DOC knew that Mr. Moore suffered from serious mental illness. When he missed two parole appointments he was arrested by his parole officer and taken to the Bronx Court pens and placed in DOC custody. Horsone Moore tried to kill himself at the Bronx Court pens on October 11, 2013. This suicide attempt was thwarted by DOC staff through force. Mr. Moore was sprayed with chemical agents and DOC staff removed the string that he was tying to the bars of the cell. There was a suicide screen filled out by DOC staff including notations that he was thinking about killing himself, was incoherent and believed that others were trying to kill him. Yet, no suicide watch was ordered or begun.

Although screening was done and notations made by correctional staff, Mr. Moore was not actually seen by mental health staff until a day and a half later. On October 13, during medical intake, clinical staff did order that he was to be placed on suicide watch. This order, which stated that Mr. Moore was actively suicidal and required a suicide watch, was never implemented. Mr. Moore was placed into the decontamination room of the AMKC receiving room. He was taken back to the clinic for a psychiatric evaluation. While waiting for the evaluation he ran out of the holding area and engaged in disruptive behavior including aiming a fire extinguisher at an officer and then banging it on the fire door to get out, and attempting to call 911 from the phone at the nurse's station stating "help" repeatedly into the phone. He was

cuffed and removed from the mental health clinic by a DOC probe team and was taken back to the decontamination room.

While in the decontamination room, Mr. Moore attempted suicide again. The video tape of the decontamination room reveals that Mr. Moore was rear cuffed when he was left in the room. When he tried to leave the room, a DOC Captain grabbed his arms and flung him into the room causing him to fall. This use of force was not reported. Mr. Moore was able to bring his cuffs to the front and then spent much of the afternoon preparing a ligature out of his shirt. He tied it around his neck and tied it to the shower pipe. At this point, DOC staff entered the room and stopped him. This second suicide attempt was not reported by DOC staff as required by regulations. Nor was Mr. Moore taken to medical or mental health staff for treatment after the attempt. Mr. Moore then removed his underwear and began to rip it up to fashion another ligature. Mr. Moore successfully hanged himself from the shower frame on October 14 after spending 15 hours alone in the decontamination room with no one watching. Why was an actively suicidal Mr. Moore left by himself for 15 hours? To date there is no answer.

The death of Gilbert Pagan: On September 29, 2013, Gilbert Pagan hanged himself by a ligature attached to his bed frame in a protective custody housing area in GMDC. Mr. Pagan was discovered hanging after correction staff noticed a sheet covering his cell window and opened his cell when he did not respond to the staff. Mr. Pagan had placed his bed in an upright position in order to provide something from which to hang himself. Due to a prior suicide at GMDC in May of 2012 using a bed frame in that manner, DOC responded with a plan to weld all unattached bed frames in all facilities to the floor, but it did not follow through. After the suicide of Mr. Pagan, the NYC Board of Correction learned that 14 out of 32 housing areas in GMDC (where both deaths occurred) remained with unbolted beds and with no timeline for completion of the welding project.

The death of Jerome Murdough: On February 15, 2014, Mr. Murdough, a 56-year-old homeless veteran who suffered from bipolar disorder and schizophrenia, was left alone in a mental health observation area in AMKC when he was supposed to be on a constant suicide watch. At Mr. Murdough's intake on February 8, the screening for suicide prevention found that he was on psychotropic medications, feeling hopeless, and was depressed and suicidal. A supervisor was notified and "constant supervision" should have been ordered as is required by regulations. On February 9, Mr. Murdough's mental health intake was completed and his expression of suicidal ideation was noted along with the fact that he had previously attempted suicide. No enhanced supervision was ever instituted for Mr. Murdough.[1]

Mr. Murdough was housed in mental observation housing – like Mr. Ballard's placement – a housing assignment that demonstrates knowledge of his serious mental health treatment needs. On February 15, DOC staff left Mr. Murdough alone in his cell in an area of the jail that had a malfunctioning heater. DOC logbooks falsely claim that there were tours of the area at thirty minute intervals. The DOC staff member responsible for the area abandoned her post in the mental health observation unit and Mr. Murdough was left alone for at least four hours. The homeless ex-Marine, taking psychotropic medications that can make one more vulnerable to heat-related illness, died alone and neglected in his overheated cell.

[1] Reply Declaration to Plaintiffs' Motion for Enforcement, Exhibit 29, e-mail from Office of Compliance Consultants to Department of Correction, Benjamin v. Ponte, 75 Civ. 3073 (S.D.N.Y., April 14, 2014).

The Scope of the Problem and Use of Isolated Confinement in City Jails

The prior City administration was aware that even as crime in NYC had declined, individuals with mental illness comprised an increasing percentage of the City's jail population. In March 2011, NYC sought assistance for a study concerning individuals with mental illness in the NYC jails from The Justice Center of The Council of State Governments (CSG). The report, *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems*, was completed in December 2012.[2] The CSG Report findings included that individuals with mental illness stayed in jail roughly twice as long and were less likely to make bail than individuals with no mental illness. It identified 1300 individuals who were in jail even though they were eligible for community based treatment and supervision and had a low risk of failure to appear for their court dates. It identified failures in linking individuals with mental illness to alternatives to incarceration, and a lack of sufficient community alternatives willing to serve people involved in the criminal justice system.

Information gathered by DOHMH at the time of the CSG report demonstrated that incarcerated individuals with mental illness were more likely than others to be injured while in custody and were more likely to end up in punitive segregation.[3] Yet, in total disregard of reforms implemented in the New York State prisons for individuals with serious mental illness, as well as reforms around the country reducing reliance on isolated confinement, under the Bloomberg Administration, the NYC DOC increased its use of isolated confinement (punitive segregation). The percentage of the New York City jail population in punitive segregation increased from 2.7% in 2004 to 7.5% in 2013. The number of solitary confinement beds increased in number from 614 in 2007 to 998 in 2013.[4] At the same time, approximately 40% of the individuals incarcerated in the City jails were reported to have a psychiatric diagnosis with many of that number suffering from major mental illness.[5]

Not surprisingly, the prior City Administration failed to solve, or even make progress towards solving, the long-standing problem of inhumanely housing individuals with mental illness in punitive solitary confinement settings in the City jails. Instead, DOC increased reliance on solitary confinement.[6] In response, on April 9, 2013, the NYC Jails Action Coalition petitioned[7] the City Board of Correction to implement new rules regarding solitary confinement to be made part of the jail Minimum Standards.[8] After the JAC petition was filed, the NYC DOC took some minimal steps towards reform, discussed below; the Board of Correction, its experts

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[2] The report is available at: http://www.nyc.gov/html/doc/html/events/FINAL_NYC_Report_12_22_2012.pdf.

[3] Andrea Lewis to Homer Venters, Memorandum, March 14, 2012, "Medical Informatics, New York City Department of Health and Mental Hygiene and Correctional Health Services." This independent analysis conducted by DOHMH is cited in endnote 9 of the CSG Report.

[4] Gilligan, Lee, *Report to the New York Board of Correction* (Sept. 2013) at p. 3.

[5] *Id.*

[6] Because of this failure advocates in New York including the Prisoners' Rights Project of The Legal Aid Society formed a community organization/umbrella group called the NYC Jails Action Coalition (JAC).

[7] The JAC Petition for Rule-Making is available at: http://www.nycjac.org/storage/JAC%20Petition%20to%20BOC.pdf.

[8] The Board of Correction establishes and ensures compliance with minimum standards regulating conditions of confinement and correctional health and mental health care in all City correctional facilities.

and its staff have investigated and agreed to initiate rule-making to address harmful, dangerous, and abusive use of solitary confinement in the jails; and a study of solitary confinement and the risk of self-harm was conducted and published by employees of NYC DOHMH.[9] All of the investigations, reports and studies identify alarming failures by the prior Bloomberg Administration to end abusive and dangerous conditions in the City jails.

In September 2013, a report to the New York City Board of Correction by their mental health experts, Drs. James Gilligan and Bandy Lee, reported on the large numbers of individuals with mental illness in solitary confinement in the City jails and the failure to provide treatment in accordance with the current Minimum Standards.[10] Based on what they observed in the jails, Drs. Gilligan and Lee recommended that no individuals with mental illness should be placed in solitary confinement, that no individuals *at all* should be subjected to the prolonged solitary confinement in use in the City jails because *"it is inherently pathogenic – it is a form of causing mental illness."*[11] They reported negatively on the reforms implemented by NYC DOC: the creation of a Clinical Alternative to Punitive Segregation (CAPS) unit for individuals with serious mental illness and the Restricted Housing Units (RHU) for individuals with "non-serious" mental illness. The doctors reported that CAPS was far too small for the population that would need a therapeutic alternative placement and should be expanded, and that the RHU was a complete failure and non-therapeutic. The report recommended elimination of the RHU model because it remains punitive in nature and does not grant any relief from the use of solitary confinement. The report detailed the lack of access to treatment (even in the purportedly therapeutic RHU), the lack of an appropriate range of available treatment modalities, and the utter lack of a physical environment conducive to providing confidential treatment in a clean and private space.

Drs. Gilligan and Lee chillingly detailed the violent culture in the NYC jails: "[a]ll too many of the officers that we observed appeared to us to make it clear that they were quite willing to accept an invitation to a fight, or to regard it as a normal response within the cultural norms of the jail."[12] During their investigation they witnessed an adolescent in the RHU becoming increasingly agitated in his cell – first banging his arms and legs on his cell door then his whole body, ripping up a sheet, wrapping his arms, legs and then neck as if preparing to hang himself. No NYC DOC staff responded until Drs. Gilligan and Lee intervened. Shockingly (since the RHU is supposed to be a therapeutic alternative to solitary confinement for individuals with mental illness), the officer staff's first response was to pull out a can of chemical agent (mace). The doctors had to intervene and insist that this was not necessary and that mental health staff should be notified. The violent response of staff to the individuals in their care, followed by severe punishment with solitary confinement, was identified by Drs. Gilligan and Lee as "the mutually self-defeating vicious cycle that develops between inmates and correction officers, in which the more violently an inmate behaves, the more seriously he is punished, and the more seriously he is punished, the more violent he becomes." It is a perpetual vicious cycle that fuels

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[9] Kaba, Lewis, Glowa-Kollisch, Hadler, Lee, Alper, Selling, MacDonald, Solimo, Parsons and Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM.J. PUBLIC HEALTH 442, 445 (2014) available at: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742.

[10] Gilligan, Lee, *supra* note 3.

[11] *Id.* at p. 6.

[12] *Id.* at p. 16.

continued violent conduct. In the face of overwhelming lack of appropriate care and treatment, the doctors' report calls for significant changes in policy, culture and training of staff.

Two additional reports prepared by and for the Board of Correction concern the adolescent population of the New York City jails.[13] *Three Adolescents with Mental Illness in Punitive Segregation at Rikers Island* was written by members of the Board of Correction staff and details the poor quality of mental health treatment and delivery of treatment services for three young people with mental illness while held in solitary confinement settings in the NYC jails.[14] *Rethinking Rikers: Moving from a Correctional to a Therapeutic Model for Youth* was prepared by Professor Ellen Yaroshefsky with assistance from students at Cardozo Law School and provides examples from New York State and other states to use as a basis for eliminating the use of solitary confinement for youth and to shift to a therapeutic approach with practices that are specialized for and dedicated to youth rehabilitation.[15] Like the findings in the report of Drs. Gilligan and Lee, *Rethinking Rikers* reports on the failed policy and over-utilization of solitary confinement and calls for a "much-needed cultural transformation on Rikers Island."[16]

Solitary Confinement and Risk of Self-Harm Among Jail Inmates reports on a study conducted by employees of NYC DOHMH.[17] The report makes numerous findings that illustrate that solitary confinement is a dangerous and self-defeating practice:

- The risk of self-harm and potentially fatal self-harm in solitary confinement was higher than outside solitary, independent of prisoners' mental illness status and age group.
- Self-harm is used as a means to avoid the rigors of solitary confinement – inmates reported a willingness to do anything to escape solitary confinement.
- Patients with mental illness become trapped in solitary confinement, earning new infractions resulting in more time in solitary.[18]

The report indicates a need to reconsider the use of solitary confinement as punishment in jails "especially for those with SMI [serious mental illness] and for adolescents," and cites the American Psychiatric Association and American Academy of Child Adolescent Psychiatry as professional societies that recommend against the use of solitary confinement for adolescents and individuals with serious mental illness.[19] It then goes on to describe the creation of CAPS and RHU as reforms that will "provide an opportunity to evaluate the effect of increased clinical

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[13] New York is one of only two states in the country to treat 16 and 17-year olds as adults in its courts.

[14] *Staff Report: Three Adolescents with Mental Illness in Punitive Segregation at Rikers Island,* CITY OF NEW YORK BD. OF CORRECTION (Oct. 2013), available at http://www.nyc.gov/html/boc/downloads/pdf/reports/Three_Adolescents_BOC_staff_report.pdf.

[15] *See* Yaroshefsky, *Rethinking Rikers*, *supra* note 3.

[16] *Id.* at p. 48.

[17] See Kaba, Lewis, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, *supra* note 3.

[18] The study includes the "extreme" example of a patient breaking a sprinkler head to use to self-harm and receiving an institutional infraction as well as a new criminal charge for the destruction of government property. *Id.* at p. 446.

[19] *Id.* at p. 447.

management and decreased reliance on solitary confinement as a means to reduce self-harm and other behaviors among inmates with mental illness."

Ongoing Problems with Medical Care in the City Jails

In addition to the problems with the care and treatment of individuals with mental illness in the jails, the Prisoners' Rights Project regularly receives complaints about medical care. Many categories of medical complaints are received with alarming frequency: DOC staff interfere with medical orders such as by confiscating medically authorized therapeutic adjuncts, orthopedic shoes and supportive footwear, canes, walkers, wheelchairs and braces. We receive many complaints that medical staff fail to dispense or fill orders for medication and fail to provide medically ordered special diets (*e.g.*, diets for heart problems, diabetes, and allergies). Medications are reported discontinued without reason or explanation, including medications for pain, psychiatric treatment, diabetes, seizures, and HIV disease. Individuals complain of retaliation through discharge from medical housing for making complaints. There are also reports of verbal abuse from PHS health care workers. There are regular problems reported due to the lack of accessible facilities for individuals with disabilities, including the lack of adequate wheelchairs and/or needed assistance with daily living activities. There are reported long waits at the clinic to be seen and even longer delays to receive specialty care after it is ordered including lack of access to hospital care, especially for surgical procedures and follow-up. The Doctors Council reported to the Board of Correction that a lack of escort officers causes long wait times for patients to see medical staff – sometimes resulting in loss of patience followed by a refusal to see medical staff. The Doctors Council also reported that follow-up medical appointments are not attended due to the lack of available escorts.[20]

Violence Against Inmates in the City Jails

Excessive force by correction staff is tolerated, and indeed encouraged, in the City jails. DOC staff frequently inflict serious injury on prisoners, and force is often used in response to perceived disrespect or other minor misconduct. And, as described above in the death of Mr. Horsone Moore and by Drs. Gilligan and Lee, who had to intervene to stop the use of chemical agents against a young person, force is used by uniformed staff when interacting with individuals who are exhibiting serious mental health needs. Commissioner Ponte reported at the beginning of this month that from fiscal year 2010 to fiscal year 2013, uses of force increased by 59 percent (1,871 to 2,977).[21]

The deficiencies in use of force investigations, discipline, monitoring and supervision, and the practice of ignoring staff members' use of force history in making promotions are all issues raised in Legal Aid's pending class action *Nunez v. City of New York, No.* 11-cv-5845 (S.D.N.Y. 2012). Since *Nunez* was filed in May of 2012, events continue to validate its charges. Last summer, ten correction staff, including a former assistant chief for security and two

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[20] See New York City Board of Correction Minutes, September 9, 2013.

[21] Statement of Joseph Ponte, Commissioner, NYC Department of Correction to New York City Council Committee on Fire and Criminal Justice Services, June 2, 2014. Commissioner Ponte reported on other increases over the same time period: slashing and stabbing incidents increased by 30% (34 to 68), assaults on staff increased by 30% (500 to 646).

captains, were indicted for savagely beating an incarcerated person.[22] In late November the correctional staff conducted an illegal job action that stopped individuals incarcerated at Rikers from attending their court appearances. The bus stoppage was intended to disrupt – and did disrupt – the prosecution of two correction officers who allegedly attacked an incarcerated person and attempted to cover up their brutality.[23]

The New York City jails have long been tremendously violent. Incarcerated individuals, staff and sometimes visitors are often seriously injured as a result. The misuse of force by uniformed staff in the City jails has been the subject of a series of class action lawsuits brought by our office. In each case reforms were implemented that reduced the incidence of use of force and the severity of resulting injuries. Yet the progress achieved has not been sustained. Proven reforms are abandoned when the pressure and spotlight of plaintiff and expert monitoring of the settlement agreements end. We testified about the persistent brutality and history of past litigation before the Committee on Fire and Criminal Justice Services on April 4, 2013. We have attached a copy of that testimony for your information and provide a 2013/2014 update herein.

In 2013 and 2014, the Prisoners' Rights Project interviewed, and wrote to DOC seeking investigations, on behalf of over 300 incarcerated individuals injured in violent, and often unprovoked, encounters with uniform staff. The frequency and severity of injuries confirmed by medical records continues to be astounding and inexcusable. Prevalence of injuries to faces and heads continues unabated, indicating that the practice of using blows to the face and head as a first resort by staff, persists even though it is contrary to DOC's own written policy. Examples of injuries confirmed in 2013 and the first few months of 2014 in use of force incidents with DOC uniformed staff are set out in the Table below.

Table: Examples of confirmed injuries in 2013 and first four months of 2014

Initials	Location	Injury after Use of Force by DOC Staff
A.J.	Intake pen	Injury face/orbital area/jaw/nose, nasal bone tenderness, right zygoma- tender to touch, overlying soft tissue contusion, right mandible-tenderness, soft tissue contusion over right jaw, injury to both elbows. Dermabond on face.
C.J.	Main Clinic inside pen	Contusion of eyelids. Elbow, forearm, wrist injury (no fracture). Superficial abrasion, left periorbital ecchymosis (ruptured blood vessels) with mild subconjunctival hemorrhage, redness of skin under eye, left cheek abrasions.
W.R.	Queens Supreme Court	Back pain, blood in urine, spinal tenderness.
D.R.	OBCC	Multiple abrasions of head and face, swelling over left eye, multiple contusions of face, head, arm, shoulder. Injury of shoulder and upper arm and lower arm. Arm put in sling, rotator cuff sprain.
R.D.	Bronx Hall of	Nasal cavity, x-ray shows minimal displaced bone fracture. Back muscle spasm.

[22] See "Rikers Island Security Chief Is Charged with Ordering Brutal Assault on Inmate," *New York Times*, June 26, 2013.

[23] See "Bus Stoppage Said to Target Rikers Inmate," *New York Times*, November 20, 2013.

Table: Examples of confirmed injuries in 2013 and first four months of 2014		
Initials	**Location**	**Injury after Use of Force by DOC Staff**
	Justice	Right wrist tender to palpation, decreased ROM. Right knee tender to palpation.
H.A.	GMDC	Closed head injury with concussion. Contusion to forehead, abrasion to knee, small hematoma on forehead. Swelling, redness, tenderness right forehead.
J.M.	OBCC Annex	Bruise on forehead, left jaw swelling.
P.C.	MHAUII	CAT scan for head injury. 6 staples right posterior scalp laceration, scalp swelling, mild levoscoliosis of upper dorsal spine. Scalp profusely bleeding from lacerations.
T.L.	OBCC	Lip laceration, left facial bruises, right shoulder tenderness with limited ROM, right knee tenderness, right hip tenderness. Sling ordered for right shoulder.
A.J.	GRVC	Minor abrasions and contusion to right side of face. Right scalp laceration.
F.R.	GMDC	Laceration left temple treated with dermabond. Contusion left face. Closed fracture of zygoma.
T.J.	AMKC	Left eye subconjuntival hemorrhage, contusions - multiple sites. Large frontal scalp hematoma, rib and spine tenderness. Laceration left side of mouth.
R.K.	OBCC	Closed fracture of mandible, jaw tenderness bloodied lower frontal gums.
G.T.	AMKC	Right wrist injury of left ulnar styloid, forearm splint, no fracture or dislocation.
S.E.	RNDC	Multiple contusions left lower jaw, left facial area, left ribcage.
P.D.	RNDC	Right scalp swelling, right eyebrow swelling and bleeding. Unable to open right eye fully. Ambulance report: bruises and swelling to back of head on both sides, bruises and swelling to right eye and left side of lips, lower back pain.
R.L.	GRVC	Left mandible fracture. Blood in left ear. Facial swelling. Multiple abrasions/contusions to face, closed fracture zygoma. Surgery to wire jaw.
M.T.	GMDC	Laceration left scalp, multiple hematomas and erythema over multiple surfaces of scalp. Hematoma forehead. Swelling left elbow. Swelling both ankles.
W.M.	RNDC	Multiple bruises and swelling to forehead. Facial contusions. Swelling to left eye and right ankle. Injury to neck and right knee.
H.R.	GMDC	Fracture right nasal bone. Right periorbital and facial soft tissue swelling. Multiple contusions and edema to face, head, orbital area, scalp, mandible, left shoulder, left upper arm, left rib, lower back. Right eye swollen shut with ecchymosis. Left eye subconjunctival hemmorrhage. Superficial cut to inner right upper lip.
G.J.	RNDC	1 cm laceration to upper lip. Sutured. Bruises left face and right side of head. Chipped upper incisor tooth. Cuffmarks on wrists.

Table: Examples of confirmed injuries in 2013 and first four months of 2014		
Initials	**Location**	**Injury after Use of Force by DOC Staff**
Z.R.	RNDC	Nasal fracture, superficial bruising to bilateral shoulder. Abrasion and tenderness left orbital. Ear redness and tenderness.
F.A.	GMDC	Nasal fracture, back contusion and abrasions.
H.E.	RNDC	Scalp laceration, dermabonded.
A.P.	EMTC	Deviated nasal septum, redness over nasal bridge. Lacerations on upper and lower lip, sutures.
C.V.	GRVC	Contusion face/scalp/neck. Contusion mandibular joint. Broken tooth. Back contusion and contusion chest wall. Fracture confirmed. Hematuria.
M.C.	AMKC	Swelling, contusion, and laceration above left eyebrow. Left shoulder swelling and contusion.
B.J.	OBCC	Right forehead laceration, abrasion and swelling of posterior head, abrasion left upper back.
E.V.	AMKC	Ankle sprain. Back contusion. Scalp contusion. Spinal tenderness.
D.K.	OBCC	Closed nasal fracture. Laceration on left eyebrow. Sutures.
B.D.	GMDC	Deep laceration below chin. Sutures. Contusion right eyelid.
W.N.	OBCC	Laceration to right frontal scalp, mild redness over left knee with tenderness. Redness and hematoma to left lower frontal area of head, tenderness c-spine area.
M.B.	AMKC	Fracture left maxilla. Fracture medial orbital wall. Edema of eyelid, contusion of eyeball. Sub-cutaneous emphysema from trauma.
G.C.	OBCC	Right scalp swelling, facial swelling. Multiple facial abrasions/ecchymoses, abrasion over bridge of nose. Right upper lip swollen with hematoma. Abrasion inner left lower lip. Left forearm tenderness and ecchymosis.
M.A.	GMDC	Upper lip contusion. Bilateral wrist contusion. Fracture navicular bone.
B.A.	GRVC	Swelling of nose, contusion of eyelids and periocular area. Contusion of face, scalp, neck. Closed fracture nasal bone. Two chipped teeth.
R.A.	MDC	Closed fracture orbital bone. Closed fracture nasal bone. Closed fracture of navicular bone of wrist. Laceration left upper lip.
G.S.	AMKC	Orbital fracture. Persistent vision impairment reported 3 weeks later. Left periorbital swelling/tenderness with 1 cm laceration. Right eye mild swelling and tenderness.
C.A.	RNDC	Mild infraorbital swelling. 8-9 cm superficial laceration left side of face. 6-7 cm deep laceration right side of face. 1.5 cm thumb laceration. Abrasion of right

Table: Examples of confirmed injuries in 2013 and first four months of 2014		
Initials	**Location**	**Injury after Use of Force by DOC Staff**
		hand. Tenderness right wrist and forearm. Ecchymosis, bruises, tenderness on back of both shoulders.
P.V.	GRVC	Laceration right eyebrow, repaired with sutures. Laceration left eyebrow, repaired with 1 suture. Right shoulder, right forearm, wrist, hand, ankle tenderness.
R.A.	Bronx Central Booking	Abrasion, contusion to face. Left tympanic membrane perforated. Acute left-sided hearing loss.
F.J.	OBCC	Multiple head and scalp contusions/abrasions. Lip laceration.
W.A.	OBCC	2 cm eyebrow laceration, abrasion right temporal area of head.
B.E.	OBCC	Slightly deviated nasal septum with large right-sided nasal septal spur contacting the inferior turbinate. Bruises on face, diffuse facial tenderness.
B.T.	Bronx Central Booking	Perforation of tympanic membrane. Facial and scalp contusions.
R.I.	GMDC	Left periborital ecchymosis. Zygoma fracture. Rib tenderness. Chest and back bruises.
A.J.	GMDC	Laceration right eyebrow. Dermabonded. Nasal bleeding.
R.C.	Bronx Court Pens	Nasal fracture. Maxillary sinus posterior fracture. Tenderness and swelling left side of face/jaw. Tenderness left side of ribs and chest. Tranfer to Hospital.
W.T.	GRVC	Swelling right forehead with erythematous bruises, right suborbital and intraorbital ecchymosis with swelling and tenderness, right eye subconjunctival hemorrhage, periocular eccyhymosis and swelling, photosensitivity, dried blood at left ear from small laceration at left ear lobe, lower lip swelling. Nasal fracture.
L.K.	MDC	Periorbital soft tissue swelling around the left eye, subjunctival hemorrhage lateral to left cornea.
H.T.	AMKC	Fractures of 6th, 7th, and 8th ribs.
R.J.	Queens County Criminal Court	Forehead contusion, two broken incisors, abrasion lower lip, neck scratches.
L.R.	NIC	Profuse bleeding from nose. Swollen and tender right side of face. Bruise on lower lip.
G.C.	AMKC	Closed head injury. Perforation left tympanic membrane. Back and chest pain.
C.R.	OBCC	Subconjunctival hemmorhage left eye.

Table: Examples of confirmed injuries in 2013 and first four months of 2014		
Initials	**Location**	**Injury after Use of Force by DOC Staff**
A.E.	RNDC	Positive for right nasal bone fracture. Facial ecchymosis, swelling across nasal bridge. Abrasion across mid-thoracic spine.
J.D.	RNDC	Multiple swelling on skull and forehead. Left knee bruises, right arm swollen and tender.
C.J.	RNDC	Abrasions to face and upper body. Facial swelling. Cannot flex left elbow.
G.K.	RNDC	Multiple facial contusions with tenderness. Rib and chest tenderness. Tenderness, palpable spasm, thoracic region with swelling.
R.S.	Queens Court pens	Bruising noted under right eye, on scalp and behind right ear.
V.L.	GRVC	8 inch laceration to forehead, swelling left upper eyelid, abrasion on lip.
T.A.	GRVC	Left eye suborbital swelling. Bilateral nasal bridge swelling and tenderness. Left nasal bleeding.
M.M.	GRVC	Bilateral eyebrow tenderness, mild contusion. Right zygomatic process contusion tender, erythema, ecchymosis. Right nostril with dry blood. Right ankle, right foot tenderness. Left shoulder tenderness, mild swelling, ecchymosis. Left arm large ecchymosis, very tender. Bilateral upper ribs, erythema, ecchymosis, tenderness. Multiple abrasions to temporal area, small bruises to both rib cages. Contusion chest all, multiple sites shoulder and upper arm, knee, wrist. Abrasion to right eyelid, Closed head injury, Shoulder pain. Swelling, abrasions to right periorbital area, ecchymosis left arm.
W.M.	GRVC	Scalp laceration. 3 staples placed in scalp. 2-3 cm superficial abrasions noted on left deltoid.
P.T.	GMDC	Large hematoma on left forehead above left eyebrow, positive tenderness in left jaw unable to open mouth and bite. Tenderness on nose and swelling on bridge deviated septum, no active bleeding.
B.S	RNDC 2013	Closed fracture of left wrist.
B.L.	EMTC	Left eye infraorbital swelling, notable swelling of left side of face, one cm laceration, dermabond.
M.R.	GRVC 2013	Contusion face/scalp/neck, gross swelling of upper and lower lip. Fractured jaw requiring surgery.
S.N.	GMDC	1.5 cm and 1 cm laceration right eyelid, infraorbital swelling & facial erythema and swelling at left zygomatic region. Swelling and tenderness at right nasal bridge. Facial lacerations sutured.
K.C.	OBCC	Left jaw swelling, severe tenderness, unable to open mouth.
R.F.	OBCC 2013	Fractured finger, refused surgery.

Table: Examples of confirmed injuries in 2013 and first four months of 2014		
Initials	**Location**	**Injury after Use of Force by DOC Staff**
B.A.	GMDC	Swelling and erythema in outer left ear, nose deviation to the right, swelling of left side of face.
A.C.	RNDC	Left orbit fracture, bilateral jaw fracture, surgical intervention.
E.V.	GMDC	Multiple kicks to face and head, laceration to face, left jaw pain, multiple bruises on chest, shoulder and upper back.
D.K.	OBCC	3.5 cm laceration to face, swelling to scalp and face, dermabond.
R.Q.	Judicial Center	Multiple facial bruises, head injury.
F.E.	GRVC	Right elbow dislocation. Reduced under procedural sedation with orthopedics and splinted.
M.M.	GRVC	Left scalp area with bleeding. Right cheek swollen, Fracture of C6 spinous process.
M.P.	GRVC	Patient hospitalized at Elmhurst with 'Blunt trauma to abdomen." Underwent surgery. Grade 4 liver laceration, multiple rib fractures.
R.J.	EMTC	Several facial bruises to forehead, cheeks, right orbit. Right orbital bruising/swelling. Tender to palpation. Dried blood in nose; tenderness to palpation of bridge/tip of nose, swelling. Pain/swelling of lips on right with abrasions. Pain with opening of jaw on right.
T.W.	GMDC	Left frontal scalp laceration and hematoma. No skull fracture. 3-4 cm V-shaped laceration over left eye. Repaired with 7 sutures.
S.R.	Judicial Center	Nasal bone fracture, nose bridge swollen, tender.

Because so many individuals in our jails continue to suffer needless injury at the hands of uniformed staff, and because the problem of uniformed staff brutality is widespread throughout the system, we believe a system-wide reform of policy and practice is necessary to bring an end to this violence. Our litigation, *Nunez v. City of New York*, S.D.N.Y., 11 Civ. 5485 (LTS), seeks to stop the systemic excessive use of force by corrections staff against individuals in our jails.

Past litigation experience demonstrates that controlling violence in the jails is a function of municipal leadership. Only when top officials actively intervene to make clear to correction staff that violence will not be tolerated, does brutality cease. We now have a new City administration including a new Commissioner of Correction. The administration and Commissioner Ponte must not disregard or condone misconduct. Supervision must include oversight of those involved in questionable incidents and discipline for those involved in misuse of force. Staff must be held accountable for excessive force, and investigations must be thorough and speedy. It must be made clear to line staff that brutality will not be tolerated.

The Need for Increased Transparency, Communication and Reporting

Int 0292-2014 A Local Law to amend the administrative code of the city of New York in relation to requiring the commissioner of the department of correction to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement.

This legislation should not be controversial. It proposes that DOC should be responsible for collecting vital data about solitary confinement in our jails and should post that information publicly on its website. Collecting and sharing the information will permit the community to understand the utilization and consequences of use of punitive segregation in our jails. The collection and dissemination of the proposed data on the use of punitive segregation will provide essential information on the lengths of stays in solitary and their human and fiscal costs. This data must be collected by DOC in order to inform itself regarding the consequences and effects of its policies. The data should be public so that the proposals made by DOC can be subject to rational and informed input from the community. Valid data about lengths of stay, transfers from mental observation housing, uses of force, self-harm and suicide will enhance the development of appropriate reforms and policy initiatives for safe management of the incarcerated population. The disaggregation of data by facility and program will assist the DOC in identifying specific programs or jails where there are training needs, additional staffing needs or needs for other remedies for identified problems. The legislation should be passed.

Additional data points could be added to the legislation to further improve the collection and dissemination of information. For example, data about the new alternatives to solitary confinement – RHU and CAPS – are appropriate. DOHMH staff described CAPS and RHU as reforms that will "provide an opportunity to evaluate the effect of increased clinical management and decreased reliance on solitary confinement as a means to reduce self-harm and other behaviors among inmates with mental illness."[24] We have shown above and below that their implementation is inadequate. Data collection about self-harm and other behaviors is essential to ensure that valid evidence-based rehabilitation programs are identified and may then be replicated. The addition of such outcome data from correction policies that limit the use of solitary confinement will assist in encouraging rule changes that will create humane, safe and cost-effective corrections policies.

Separate from the need for passage of Int 0292-2014, there may be a need for additional legislation that requires across-the-board collection and publication of information about the City jails. Unfortunately, the NYC DOC has *decreased* the statistical information on its website instead of improving its accountability to the public by posting the information that it collects about our jails. When we began to draft this testimony we discovered that the statistical reports about uses of force that *used to* be reported on the DOC website are no longer available on line. In fact there is no longer any statistical or demographic information available on the DOC website. This lack of transparency should not be tolerated and appears to be contrary to the intent of the City's Open Data Law passed in March of 2012.

Next Steps

NYC DOC has taken some minimal steps toward reform of isolated confinement and Commissioner Ponte, the new Commissioner, has expressed his support for additional reform

[24] See Kaba, Lewis, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates* at 445.

and for increased training of DOC staff.[25] At least one prior reform, the CAPS unit, does provide a therapeutic setting far different than punitive segregation for individuals with serious mental illness. However, admissions to the CAPS unit remain extremely low despite the large population of individuals with mental illness in need of its therapeutic programming and relief from the harmful environment in punitive segregation. In contrast, the RHUs continue to be extremely punitive in nature and are not providing a treatment or respite from isolation for the individuals with mental illness housed in them. In conjunction with implementation of the RHUs, changes were made to the sentence structure for disciplinary sentences. Although there was a brief period of reduced sentences, those changes were short-lived; sentences are increasing and very harsh sentences continue to be meted out. Thus, reforms that were presented as highly significant by the previous administration have proven much less significant in their actual implementation, most likely because elements of the staff do not fully support the reforms and seek to continue old practices.

Further, even these limited reforms can be defeated when they are not supported by other elements of the system. For example, one of our clients with mental illness was recently transferred repeatedly between jails and programs. Finally, he was placed into CAPS, where he reported doing well despite the runaround (that included several lengthy stays in intake areas) that preceded his CAPS placement. But he was then removed from CAPS because it was found that he owed "old bing time" from a prior incarceration. This old punitive segregation time should not have impacted his CAPS placement – no one is in CAPS who is not serving punitive segregation time. Yet he was transferred to the GRVC RHU, which did not provide sufficient clinical interventions for his mental health treatment needs. Our attempts to get him back into the CAPS program were not heeded despite our expressed concerns about prior acts of self-harm. Our concerns were well placed: at this time, this client remains hospitalized in the Bellevue Hospital Prison Ward after committing another act of self-harm while in the RHU. When an individual is determined to be clinically appropriate for placement in CAPS, he should stay there. Other agendas within the agency should not be allowed to interfere with that placement.

The implementation of CAPS and RHU and the changes to disciplinary sentencing simply do not comprise the needed comprehensive reforms that address the root problems of far too many individuals with mental illness ending up in the criminal justice system or the failure to respond to their needs in the jails in a non-punitive manner. The existing reforms also do not reflect the substantial and comprehensive reform to the use of solitary confinement needed in the NYC jails and now repeatedly identified in the described reports and studies. In his testimony on June 2, Commissioner Ponte acknowledged that the tactics of the prior administration "ultimately failed to make a significant impact because they failed to address the underlying problems;"[26] he also acknowledged an inadequate staff training program, the need to provide treatment to individuals with mental illness *before* they break prison rules, and the need for a comprehensive approach to the management of young people "while tending to their necessary developmental and educational needs."[27] Commissioner Ponte appropriately emphasized the

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[25] Statement of Joseph Ponte, Commissioner, NYC Department of Correction to New York City Council Committee on Fire and Criminal Justice Services, June 2, 2014.

[26] Statement of Joseph Ponte, Commissioner, NYC Department of Correction to New York City Council Committee on Fire and Criminal Justice Services, June 2, 2014, at p. 2.

[27] *Id.* at p. 3.

need to reduce violence in the City Jails, and indicated that "[s]uccess will come with collaboration – and not just with DOHMH and our union partners."[28]

We are in agreement that necessary reforms include training DOC staff to work with individuals with mental illness in an appropriate and humane manner rather than in a punitive (and all too commonly violent) manner; changing police and bail policies to reduce the number of individuals with mental illness committed to the City jails; and sufficient alternatives to incarceration to move individuals with mental health needs out of the criminal justice system, since the need is for medical and social service interventions. We also agree that the improved treatment and education of young people and individuals with mental illness in our jails must be a priority. Likewise, DOC must prioritize reducing violence in our jails, including the all too frequent staff brutality. Stories like those of the tragic deaths by suicide and neglect by clinical and security staff, set out at the outset of this testimony, must end.

We urge Commissioner Ponte, and the newly formed Task Force on Behavioral Health and the Criminal Justice System (The Task Force), to include in their collaborative efforts advice and comment from advocates, formerly incarcerated individuals and family members of incarcerated individuals. We urge the Commissioner to consider the NYC Jails Action Coalition Petition for Rule-Making as a model for comprehensive reform of prison and jail policies and elimination of harmful long-term isolation[29] and to work with the NYC Board of Correction's current rule-making initiative on punitive segregation. Most of all, we urge the Commissioner to keep a close watch on all the reforms that are instituted to ensure that they are operating as planned and are not undermined by old bureaucratic habits and staff resistance to change.

Conclusion and Recommendations

We are hopeful that Commissioner Ponte and The Task Force will institute substantial and comprehensive reforms of the failed policies of the prior Bloomberg Administration and that they will have the support of City Council in those endeavors. We are hopeful that part of that process will include supporting the rule-making initiative of the Board of Correction and will result in implementation of reforms recommended in the JAC Petition: putting an end to the overly punitive response to *all* individuals in the NYC Jails, and ending the use of isolated confinement for individuals with disabilities and for individuals under the age of 25. Improved medical care and mental health care in our jails must also be a priority. Improved medical and mental health care in the City jails creates better public health throughout the City. The opportunities and services available in jail directly affect the skills, problems and needs prisoners will have at the time of their release. For individuals with medical or mental health needs, this includes their willingness to accept and participate in treatment; if medical or mental health programs are unavailable, ineffective or unpleasant in jail, the individual may be less likely to seek and participate in necessary treatment after release. The City must also change police and bail policies to reduce the number of individuals with mental illness who are relegated to the City

[28] *Id.* at p. 3.

[29] The JAC Petition proposes significant limits on the use of solitary confinement, places a 15 day limit on each sentence with no more than 60 consecutive days permitted, provides for 4 hours out-of-cell in solitary confinement, excludes vulnerable populations (under 25 years old, and individuals with mental, physical or medical disabilities), provides for alternative safety restrictions for vulnerable populations which require 8 hours out-of-cell daily and a program of positive incentives, enhanced due process requirements at disciplinary and other hearings, and public reporting on the use of solitary confinement and alternative safety restrictions. The JAC Petition for Rule-Making is available at: http://www.nycjac.org/storage/JAC%20Petition %20to%20BOC.pdf.

jails. In addition, the City must provide sufficient alternatives to incarceration to move individuals with mental health needs out of the criminal justice system and provide the medical and social service interventions that they need and that will better serve society than locking them up in institutions that are not designed to address their problems.

The reduction of violence in our jails must be a priority. The City Council can play an essential role in that process by continuing to monitor violence in the jails, insist that the facts be publicized, and provide oversight and support so that Commissioner Ponte is able to implement long-lasting reforms and end the inappropriately high level of violence in the jails.

The collection and dissemination of data on the use of solitary confinement will provide essential information on the harmful lengths of stays in solitary and their human and fiscal costs; data collection on alternatives to solitary confinement will ensure that valid evidence-based rehabilitation programs are identified and may then be replicated; and outcome data from correction policies that limit the use of solitary confinement will assist in encouraging rule changes that will create humane, safe and cost-effective corrections policies. The NYC DOC should be encouraged to collect and analyze, *and make public* data on additional areas of concern as well. For example, the formerly available data on uses of force should be publicly available. Additional data should be available on demographics of the jail population, transfers to medical and psychiatric hospitals, transfers from isolated confinement to the street. The Council should consider whether additional legislation is needed or whether the need is simply to push DOC for compliance with the Open Data Law.

We thank the Committees for this public forum to discuss vital areas of concern about the management of our City jails. The City Council should continue to provide public forums so that the important issues of medical and mental health care and violence in the City jails continue to be the subject of informed public discourse. The City Council plays and must continue to play an important role in understanding, monitoring and tracking the conditions of confinement for individuals incarcerated in the City jail system.

We appreciate the opportunity to provide this testimony.

Dated: June, 12, 2014

TESTIMONY

The Council of the City of New York

Committee on Fire and Criminal Justice Services
Elizabeth S. Crowley, Chair

Examining Violence in New York City Jails

April 4, 2013
New York, New York

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Thank you for the opportunity to testify concerning the serious risk to New Yorkers posed by violence in the New York City jails. We submit this testimony on behalf of The Legal Aid Society, and thank Chair Crowley and the Committee on Fire and Criminal Justice Services for inviting our thoughts on the subject. We applaud the Council for tackling this important topic.

Since its inception over 40 years ago, the Prisoners' Rights Project of The Legal Aid Society has addressed the problem of violence in the New York City jails. Through advocacy with the Department of Correction ("DOC") and individual and class action lawsuits, we have sought to reform the systems for oversight of use of force and violence in the jails. Each week we receive and investigate numerous requests for assistance from City jail inmates who have been victims of violence in the jails. We interview inmates injured in violent encounters, and carefully review their medical records. Years of experience, including daily contact with inmates and their families, has given our office a firsthand view of the effects of jail violence, and it is on this basis that we offer these comments to legislators and all New Yorkers.

From our experience, we have seen that controlling violence in jails is a function of leadership by municipal officials: when top officials actively intervene to make clear to correction staff–by actions as well as words–that it will not tolerate management-by-violence, brutality ceases. When the leadership turns a blind eye towards misconduct—by failing to hold staff accountable for excessive force, conducting sham investigations, failing to supervise more closely those involved in questionable incidents and failing to discipline those who misuse force—it sends a signal to line staff that they can control troublesome, or defiant, or merely disrespectful prisoners by beating them.

Violence Against Inmates Is Epidemic in the City Jails

The New York City jails have long been tremendously violent. Inmates, staff, and sometimes visitors are seriously injured as a result. In the last year alone, we have settled a lawsuit in which a teenager suffered a lacerated kidney, bruised spleen and traumatic brain injury in a beating by other inmates, with the collusion of staff, at the adolescent jail, the Robert N. Davoren Center (RNDC), for which the City paid $850,000 in compensation (*John v. City of New York,* 11-cv-5610 (RPP)); advocated on behalf of several prisoners

suffering broken mandibles when attacked by other inmates; and filed another lawsuit on behalf of an inmate who has suffered permanent brain injury and multiple jaw fractures in a "program" beating. At the same time, as described below, we are counsel in law reform litigation seeking to stop the systemic excessive use of force by corrections staff against inmates. *Nunez v. City of New York,* S.D.N.Y., 11 Civ. 5485 (LTS).

While the Department frequently announces new measures and metrics to address violence by inmates, the serious safety threat posed by *staff* violence receives remarkably little discernible attention in comparison. Yet hundreds of New Yorkers are suffering preventable, serious injuries each year at the hands of uniformed correction staff, with drastic consequences for their safety and health and the security of the jails. In many cases, the force is wholly unjustified, and is used as "off the books" punishment for minor misconduct, complaints by inmates, or perceived disrespect. And while some use of force will be part of any correctional setting, in New York City, DOC staff often resort to highly injurious force under circumstances where, at most, some minimal, non-injurious restraint was justified to control an inmate.

The problem of brutality by New York City DOC staff against inmates in their custody has persisted for years, but the recent trends are alarming. In each of the last three fiscal years (FY 2010, 2011 and 2012), the Department has reported ever higher numbers of "class A" use of force incidents—incidents the Department deems most injurious to staff or prisoner. DOC statistics report:

Use of Force Incidents Class A (resulting in injury)

FY 2012 - 147

FY 2011 - 142

FY 2010 - 128

FY 2009—109

FY 2008—88

FY 2007—113

FY 2006—89

FY 2005—72

FY 2004—86

FY 2003—95

FY 2002 - 101

FY 2001 - 106

(Source: http://www.nyc.gov/html/doc/html/stats/doc_stats.shtml)

These numbers actually under-report serious incidents, because in our experience, DOC has chronically miscategorized use of force incidents and failed to designate as class "A" many incidents which, by their own directives, should be so designated. Moreover, this increase has occurred while the jail population has been declining. (www.nyc.gov/html/doc/html/stats/doc_stats.shtml).

In 2012 alone, the Prisoners' Rights Project interviewed, and wrote to DOC seeking investigations, on behalf of over 140 inmates injured in violent, and often unprovoked, encounters with uniformed staff. The frequency and severity of injuries, confirmed by medical records, was astounding, with the prevalence of injuries to inmates' faces and heads being most disturbing and notable. For example, the head and face injuries which we confirmed in 2012 alone, in use of force incidents with DOC uniformed staff, include:

- Inmate K.B., GRVC, fractured orbital bone, fractured nose, chin laceration
- Inmate T.M., AMKC, head injury, right subconjunctival hemorrhage, eye swollen shut, decreased vision in eye, abrasions to lip and face
- Inmate D.M., GRVC, 1.5 cm laceration above left eyebrow closed with dermabond, left orbital swelling, laceration on bridge of nose
- Inmate T.M., RNDC, multiple contusions to face, neck and scalp
- Inmate C.S., Queens court pen, contusion of right eye, contusion of face, laceration on face
- Inmate A.M., OBCC, black eye, severe swelling to face
- Inmate H.S., OBCC, 6 x 6cm echymosis on right forehead, 3 cm bruise under right eye
- Inmate S.V., OBCC, facial abrasions, eyebrow laceration closed with dermabond
- Inmate M.C., OBCC/GRVC, right perforated eardrum, left face swollen near eyes, closed fracture of malar bones and maxillary bones.
- Inmate J.S., RNDC, nasal bone fracture, bruises on face

- Inmate U.A., GRVC, multiple contusions to face, closed head injury, blood in urine
- Inmate O.R., OBCC, swelling and large hematoma to right side of head, right traumatic iritis
- Inmate T.N., AMKC, bruising and swelling right side of face, hearing loss, traumatic iritis.
- Inmate W.H., RNDC, transversal laceration in right eyebrow closed by 10 sutures
- Inmate T.R., Queens court pen, bruise and erythema right side of face, temporal swelling
- Inmate M.S., AMKC, nasal bone fracture
- Inmate A.S., RNDC, head injury, depressed fracture of skull, sutures over right eye, lip laceration
- Inmate R.W., OBCC, laceration to eyelid, multiple scalp bruises.
- Inmate J.L., GRVC, closed fracture of orbital floor, closed fracture of malar and maxillary bones, closed fracture to skull, open wound to lip.
- Inmate L.F., RNDC, closed fracture to the nose.
- Inmate Q.H., GRVC, swelling to left forehead, right eye swollen shut, blood in nasal passages.
- Inmate E.I., GMDC, nasal bone fracture, orbital fracture with hematoma
- Inmate M.H., AMKC, multiple facial fractures, right orbital contusion.
- Inmate D.L., EMTC, laceration of lower eyelid, nasal fracture, orbital fracture
- Inmate J.F., OBCC, perforated eardrum, facial contusions
- Inmate D.W., CPSU, 6 cm laceration to right eyebrow repaired with sutures, laceration below nose, abrasions to occipital area.

Shockingly, this is not even a comprehensive list of head and face injuries incurred—let alone other very serious injuries—but reflects merely injuries suffered by those individuals who reached out to our office for assistance, and for whom we could obtain medical records.

In the last few years we have represented numerous individual victims of staff brutality. These clients suffered a constellation of severe injuries such as a fractured orbital wall; facial bruising; severe bruising all over the body; a facial laceration requiring many sutures; a broken nose; and a skull laceration requiring many staples. These assaults by Department staff cost the City tremendous amounts of money. In 2009-2011, the City paid over $3.95 million to settle cases by victims of excessive force by uniformed staff simply in cases of which we are aware—and there are many more cases than that. Because such judgments are paid by the City, and not out of the DOC budget, the DOC is effectively outsourcing the costs of its failure—or unwillingness—to rein in its rogue staff.

Because so many detainees and sentenced inmates are suffering needless injury at the hands of uniformed staff, and because the problem of uniformed staff brutality is widespread throughout the system, we believe a systemwide reform of policy and practice is necessary to bring an end to this reign of violence. To achieve that end, on May 24, 2012, the Prisoners' Rights Project, together with the law firms of Ropes & Gray and Emery Celli Brinckerhoff and Abady, filed a class action lawsuit, *Nunez v. City of New York,* S.D.N.Y., 11 Civ. 5485 (LTS), on behalf of all New York City inmates held in commands not subject to court orders. The lawsuit seeks to end the pattern and practice of unnecessary and excessive force in the City jails. Defendants include the City of New York as well as the officers and captains who have inflicted brutal beatings on our clients, and have lied and coerced false statements to prevent those beatings from coming to light. It also includes the supervisors at these jails who have allowed staff to use unlawful violence with impunity. We have attached a copy of the Amended Complaint for your information.

A Case Study: Perforated Eardrums

The persistence of perforated eardrum injuries in the jails is stark illustration of the Department's continuing failure to end longstanding problems of brutality. A perforated eardrum is an injury associated with the infliction of torture. See Istanbul Protocol, *The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (2004) ("Trauma to the ears, and

especially rupture of the tympanic membrane, is a frequent consequence of harsh beatings.") Perforated eardrums are generally caused by blows with cupped hands to the ear. Medical experts have told us that it is almost impossible to inflict that injury inadvertently. The inexcusable prevalence of perforated eardrum injuries following applications of force by uniformed staff in the New York City jails is not news to DOC. In *Sheppard v. Phoenix*, litigation brought in the 1990s to address excessive force in the Central Punitive Segregation Unit ("CPSU"), former Commissioner Michael Jacobson described the injury as one "associated with" use of force in the CPSU. When he was interviewed by the New York *Times* after the *Sheppard* case settled, Commissioner Kerik, referring to the infliction of perforated eardrums, stated, "[t]hat kind of thing doesn't happen here anymore." *Rikers Island Guards Made "House of Pain" for Inmates*, New York Times, August 16, 1998. (http://www.nytimes.com/1998/08/16/nyregion/rikers-island-guards-made-house-of-pain-for-inmates.html?pagewanted=all&src=pm). Prior to the resolution of *Sheppard* in 1998, approximately 35 prisoners sustained perforated eardrums in the CPSU over a period of seven years.

The issue of perforated eardrums was again addressed in detail in the subsequent litigation about brutality in the jails, *Ingles v. Toro*, which was settled in 2006, and monitored extensively though 2009. Towards the end of our monitoring, at least four inmates suffered perforated eardrums in use of force incidents in a few months' time span towards the end of 2008. We filed lawsuits on their behalf, all of which were settled in 2010 for substantial damages.

Despite repeated litigation and significant cost to the City, the incidence of perforated eardrums in the jails was not curbed. Yet again in 2011, our client Mr. Muniz suffered a perforated eardrum in a savage beating caught on videotape, and the City bore the costs of compensating his loss too. And even since that suit was filed, we have received complaints from yet two more inmates who have suffered perforated eardrums.

There is simply no excuse or reason why this form of torture continues to be seen in the City jails. The fact that these incidents recur, despite being well known to the DOC and senior City officials points to a serious failure in supervision and oversight of the use of force by uniformed staff in the City jails.

"Those Who Do Not Learn From History:" The Department Has Known of the Brutality Problem For Decades

The misuse of force by uniformed staff in the City jails has been the subject of a series of class action lawsuits before *Nunez*.. The remedies implemented in those cases have shown that brutality is not inherent in the correctional mission, and that the City jails can be safely and securely operated without resort to excessive force—when the Department chooses to do so. The lessons learned from those successful reforms that reduced the incidence of use of force and the severity of the resulting injuries *should* be guiding policy today. Yet the frequency, severity and nature of brutality by staff that we are seeing at present reflects little of the progress we witnessed and expected to continue. There is one vital exception: in our view, the increased use of video cameras in the jails, which was required by our most recent class action settlement, has been a singularly effective means of deterring excessive force in the areas under surveillance, permitting the Department to hold staff and inmates accountable. But the other consequence is that staff have learned to engage in excessive force in areas which are off camera, and in some cases have taken prisoners into those areas to beat them. Expanding video surveillance throughout the jails should be a top priority, for the safety of both staff and inmates.

In a challenge to excessive force in the prison wards of New York City hospitals, a consent judgment provided for, *inter alia,* screening measures for correction officers to ensure that those with disciplinary records connected to use of force were assigned elsewhere. *Reynolds v. Sielaff,* 81 Civ. 101 (PNL), Order and Consent Judgment Approving Class Settlement at ¶¶ 43-48 (S.D.N.Y., Oct. 1, 1990). Complaints of use of force dropped significantly, providing an important lesson: active supervision of staff, and careful screening and assignments to marginalize those officers whose conduct is more suspect than others, will yield results. The DOC central office must exercise leadership in staff assignments and promotions, and send the message that an officers' *entire* use of force history will be scrutinized in all promotion decisions.

Later litigation challenged excessive force and inmate on inmate violence at the jail for sentenced misdemeanants on Rikers Island. The court found that DOC uniformed staff engaged in a pattern that sounds familiar today: "1) use of force out of frustration in response to offensive but non-dangerous inmate goading; 2) officers' use of excessive

force as a means of obtaining obedience and keeping order; 3) force as a *first* resort in reaction to any inmate behavior that might possibly be interpreted as aggressive; and 4) serious examples of excessive force by emergency response teams." *Fisher v. Koehler,* 692 F. Supp. 1519, 1538 (S.D.N.Y. 1988), *aff'd*, 902 F.2d 2 (2d Cir. 1990). The court found that DOC's "failure to monitor, investigate and discipline misuse of force has allowed—*indeed even made inevitable*—an unacceptably high risk of misuse of force by staff on inmates." *Id.* at 1558 (emphasis supplied). After the court ordered significant changes in the investigation of use of force and discipline of staff members, the use of force in that jail declined precipitously.

Concurrently, a suit about excessive force at the Brooklyn House of Detention yielded a settlement with similar terms, with the added requirement of installation of video cameras in areas where brutality was prevalent. *Jackson v. Freckleton,* CV 85-2384 (AS), Order Approving Stipulation of Settlement and Entry as Consent Judgment (E.D.N.Y., Nov. 27, 1991). This early experiment in the utility of cameras, long before the current digital technology was available, had dramatic results, as the complaints of misuse of force diminished sharply.

In 1998, in *Sheppard v. Phoenix,* the City and Legal Aid negotiated a comprehensive settlement addressing the horrific brutality by uniformed staff at the CPSU, which houses teenagers and adults who have committed disciplinary offenses. The warden of the CPSU testified at his deposition that that brutality was "ingrained in the culture" of the Department. *Sheppard,* Declaration of Plaintiffs' Counsel, June 26, 1998. To address this culture at its core, the City agreed to blanket the CPSU with recording videocameras, and to weed out the "bad apples," or officers whose use of force histories were troublesome. Two expert joint consultants in security, including a former head of the Federal Bureau of Prisons, provided technical assistance in transforming the "culture of violence" in the CPSU, with remarkable success. For example, from 1997 (the last year before the settlement) to 2001, the number of serious and injurious use of force incidents in the CPSU dropped from 177 to 15—an over 90% decline.

Even though these remedies proved that DOC *could* reduce the injuries suffered by inmates if it chose to do so, those reforms were not rolled out systemwide. Instead, the excessive force against inmates continued unabated in the other City jails. Legal Aid then

filed its first system-wide brutality case, *Ingles v. Toro*, to address excessive force in all of the remaining jails which had not been under Court order. *Ingles* settled in 2006. Central to the settlement were requirements for significantly more camera coverage in the jails, and the development and promulgation of new procedures to govern the Investigation Division, which had a history of merely whitewashing investigations of use of force incidents, rather than functioning as a genuinely investigative body. That settlement agreement terminated on November 1, 2009.

We observed some significant improvements in the Department's management of use of force while the *Ingles* settlement was in effect and permitted us to monitor systematically. However, the Department did not maintain its efforts once the spotlight was off, and the number of complaints of serious, injurious, and unjustified use of force again began to increase. We saw that we had to renew our systemic litigation efforts.

When we filed the *Nunez* class action, we were thus not writing on a blank slate. The Department knew steps that could work to curb violence in the jails, and refused to implement or sustain them systemwide. The incidents that have occurred within the last year—both the circumstances in which they have occurred (i.e., staff retaliation for inmate complaints or verbal annoyance) and the highly injurious nature of force used—are simply inexcusable in a system that has had ample opportunities to reform.

"The Program": Inmate-Inmate Violence with Staff Collusion or Encouragement

We are deeply concerned by another source of violence in the jails: assaults by inmates on other inmates, with the acquiescence or collusion of uniformed staff. This practice has become so entrenched at the adolescent jail, RNDC, that it is widely known simply as "the program." Under "the program," staff effectively deputize certain inmates (often a specific gang) to run a given housing area, ceding to these inmates authority to control access to telephones and meals and extort goods from other inmates and pay them with contraband or privileges. Youth who are not "with it" or "down with the program"—that is, those who do not acquiesce to the demands made by the inmate-controllers to turn over goods purchased at the commissary or telephone PIN numbers, or to beat other inmates—are beaten, often with full knowledge of the officers.

The "program" is no secret. The Bronx District Attorney ("DA") has explained that RNDC is run like an organized-crime family, where correction officers, under "the Program," give "favored prisoners free reign to beat, rob and extort whomever they please"—to quote an outraged *Daily News* editorial. RNDC was an "incubator for violent criminal activity sanctioned by adults in positions of authority," according to the DA. Bronx District Attorney, Press Release, *Two Correction Officers Plead Guilty to Charges in Connection to a Four Month Investigation of Assaults on Rikers Island,*(http://bronxda.nyc.gov/information/2011/case43.htm). In a January 29, 2009 editorial, the New York *Times* described this as a "horror story." Editorial, *Rikers Horror Story*, N.Y. Times, Jan. 29, 2009 at A26 (http://www.nytimes.com/2009/01/29/opinion/29thu2.html). The *Times* demanded that "the entire culture" of RNDC "needs to be changed" and laid the blame squarely on the City for failing to properly train and supervise correction officers. *Id.* As part of "the Program," the officers would conceal evidence of these crimes by "failing to intervene or stop the inmate assaults, making false reports about the assaults or directing inmate victims to make false reports regarding the assaults or acts of extortion, and by using violence or the threat of violence to ensure the victims' continued participation in the Program." Bronx District Attorney, Press Release, *The Death of an 18-Year-Old Inmate on Rikers Island Last October Leads to Numerous Criminal Charges Against Three Correction Officers and Twelve Teenage Inmates*, Jan. 22, 2009 (http://bronxda.nyc.gov/information/2009/case3.htm).

For years, and preceding the above mentioned criminal prosecutions, The Legal Aid Society has forwarded complaints about the "program" to DOC officials. We also testified about the "program" in detail before this Committee on November 24, 2008, long before it hit the headlines, and would happily provide copies of that testimony. Yet the practices continued, leading to the horrible "program" beating of inmate Kadeem John in RNDC in June 2010, and two beatings of our client Mr. Dwaine Taylor in May and November, 2011.

The consistency of the complaints coming out of RNDC about "the program," and the severity of injury that youth are suffering while in the City's care, raises very serious questions about the degree to which central management controls staff misconduct in the

jail. The Department has the ability to identify which staff repeatedly are present in locations where inmates are suffering serious injuries at the hands of other inmates, and to supervise those areas and staff closely. The Department should not be permitted to take refuge in the fact that teen inmates are often very reluctant to request a housing area change or to lodge complaints about their treatment. The adolescents' fear of retribution within the Department is entirely reasonable. Moreover, in free society, we do not depend upon 16 year olds' assessments of their personal safety in potentially dangerous situations, but rather expect their adult caretakers to be vigilant and protective. So too in jail, the Department absolutely must take responsibility for the violent culture created by "the program." This would include actively investigating indications or reports that staff have engaged in such misconduct; detailing and bolstering the measures taken to prevent staff from bringing into the jail contraband that facilitates this operation; taking seriously the complaints of inmates who are brave enough to report their overseers; and holding staff accountable to their supervisors for the inmate-inmate violence that occurs on their watch.

Meaningful Investigation, Supervision and Discipline

The Department already has extensive written policies governing use of force; an Investigation Division tasked with investigating and reporting on staff misconduct; overlapping systems for tracking which officers have been involved in use of force incidents; and a disciplinary system leading to formal charges against officers who break the rules. But these systems serve only to whitewash misconduct if they lack integrity, and if there is no ongoing vigilance by correctional leadership to ensure integrity.

In our experience, the Investigation Division of the Department has not been held accountable for its longstanding failures to conduct unbiased, even-handed investigations of use of force incidents. The default mode seems to be that the task of the investigation is to exonerate staff of wrongdoing, unless there is video evidence that precludes such a finding. This should not be, as ID has an excellent manual, created by the Department itself pursuant to the *Ingles* settlement, that, if followed, would guide investigations and evaluation of conflicting testimony and evidence. But in our experience, these requirement are not being followed in many cases. Key eyewitnesses are not interviewed; critical forensic medical evidence is not, as required, discussed with the Office of the Medical

Examiner, but rather is examined simply by jail clinicians not trained in the interpretation of such evidence; and inmate accounts are more or less automatically dismissed when they conflict with officers' accounts of disputed facts. It is imperative that the Investigation Division conduct its investigations meaningfully, thoroughly, and even-handedly if staff misconduct is truly to be discovered and addressed, and that end can only be accomplished through strong leadership and supervision from above in order to overcome an entrenched culture of bias and lack of thoroughness and professionalism.

There must also be an effective staff disciplinary system to enforce compliance with Departmental policies and ensure staff professionalism. The Department's disciplinary system necessarily depends on the investigative system to identify cases calling for disciplinary prosecution, and the above described deficiencies in the investigative system severely compromise internal staff discipline. Even in those cases that are identified for prosecution, the disciplinary system seems to move extraordinarily slowly in use of force incidents, and thus the deterrent value—or message sent—by discipline is so temporally removed from the misconduct itself that it is often meaningless. We encourage the Department to identify the obstacles to speedy yet just resolution of the charges it brings against officers it believes have violated the rules.

Even effective investigative and disciplinary systems cannot by themselves create a culture of professionalism in the jails. Active and effective daily supervision of staff is also essential. Departmental managers—especially wardens and supervisors in specific jails—can and should learn their staff's use of force histories, *not* to impose discipline, but rather to assess whether a staff member is properly assigned; whether he or she has repeatedly been involved in the same questionable scenarios; and whether his or her involvements with inmates should be more actively supervised. In our experience, the identity of the "head beaters" or "bad apples" in a jail is usually an open secret. Providing staff with impunity for their misconduct not only perpetuates the occurrence of serious injury, but also encourages other staff, such as new recruits, to join the company of rogue actors. The leadership from top to bottom must make clear that use of force histories will not be swept under the rug, but rather staff will be held accountable.

Mental Illness in the Jails

We are extremely concerned that many detainees and inmates with serious mental illness and serious mental health needs are frequent victims of violence and brutality in our City jails. The results are well known and harmful to this vulnerable population. Individuals with inadequately treated mental illness who cannot conform their behavior to jail rules due to untreated symptoms or who are punished for symptomatic behavior, end up injured due to unwarranted and overly aggressive confrontations with inadequately trained uniformed staff and are punished by placement into isolated punitive segregation where their mental condition worsens and they may accumulate additional disciplinary infractions and sentences to harmful isolated punitive segregation. The City does not adequately train its uniformed jail staff to recognize and accommodate mental illness and mental disability so that incidents of violent confrontations are minimized and does not appropriately refrain from the use of harmful isolated confinement despite the national trend to change policies and limit the known harmful use of isolated confinement in jails and prisons.

The recent Council of State Government Report on the New York City Jails that is the result of a Mayor's Task Force on Mental Illness in the Jails, *Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Corrections Systems*,[1] indicates that 33% of the jail inmates in New York City suffer from mental illness; jail inmates with mental illness are held in pretrial detention for significantly longer periods of time than inmates without mental illness; and the disproportionate length of their detention is not due to severity of criminal charge or risk of rearrest. The findings reflect that jail inmates with mental illness are more likely to be injured during their stay in custody and that DOC managers reported they were more likely to be involved in jail incidents. These findings reflect severe shortcomings by the City in providing appropriate accommodations so that individuals subject to arrest in New York are not discriminated against based on mental disability. The Report suggests that thousands of pretrial detainees with mental illness each year should not have been subject

[1] The report is available online at: http://consensusproject.org/jc_publications/improving-outcomes-nyc-criminal-justice-mental-health/FINAL_NYC_Report_12_22_2012.pdf.

to pretrial confinement and the resultant incidents of violence and injury that they experience in the jails. Changes to bail policies, improved training for uniformed staff and increased availability of Alternatives to Incarceration (ATI) and Alternatives to Detention (ATD) cannot be delayed.

Recommendations

A. Greatly expand the videocamera surveillance in the jails.

B. Exercise municipal and correctional leadership, and hold staff members who misuse force accountable for their misconduct through meaningful discipline.

C. Revise the Department of Correction's management and promotion policies so that staff members' use of force is addressed in assignment and promotion of staff.

D. Overhaul the Department's Investigation Division to ensure that it complies with the Investigation Manual and conducts bona fide, competent investigations.

E. Review the Department of Correction's systems for maintaining and utilizing information about violence against inmates, and for holding accountable staff who foster inmate violence.

F. End the use of solitary confinement of mentally ill prisoners.

G. Train department staff to recognize and accommodate mental illness so as to reduce the number of violent encounters with mentally ill inmates.

Thank you for the opportunity to speak about this important topic.

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URBAN JUSTICE CENTER

New York City Council
Committee on Fire and Criminal Justice Services
Committee on Health
Committee on Mental Health, Developmental Disability, Alcoholism,
Substance Abuse and Disability Services

Oversight Hearing – Examination of Violence and the Provision of Mental Health and Medical Services in New York City Jails

Int. No. 292-2014 – A Local Law to amend the administrative code of the city of New York in relation to requiring the commissioner of the department of correction to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement.

Thursday, June 12, 2014
250 Broadway, 16th Floor Committee Room

Testimony of Jennifer J. Parish
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As director of criminal justice advocacy at the Urban Justice Center Mental Health Project and a member of the New York City Jails Action Coalition, I am pleased to submit this written testimony in support of Introduction No. 292-2014 (Int. No. 292) and to share our concerns regarding the quality of mental health services in the City jails.

The Urban Justice Center Mental Health Project has focused on the needs of people with mental illness in the criminal justice system for more than a decade. We are deeply familiar with the difficulties people with mental illness have within correctional facilities and in accessing essential mental health services, housing, and benefits upon release.

The New York City Jails Action Coalition (JAC) is a coalition of activists that includes formerly incarcerated and currently incarcerated people, family members, and other community members working to promote human rights, dignity, and safety for people in the City jails.

Introduction

We commend the City Council for convening this hearing. It is critical that the Council provide oversight of the management and functioning of the jails.

We are hopeful that the de Blasio Administration and new Department of Correction (DOC) leadership will radically redefine their approach to the matters that are the subject of today's

hearing – violence and mental health services. For far too long, correction staff violence and a culture of disrespect for the people incarcerated in jails have flourished. The use of solitary confinement contributes to this problem. We ask the Council to support the comprehensive approach that JAC has proposed for limiting the use of isolation in the City jails.

Requiring regular reporting on the use of solitary confinement (what DOC calls "punitive segregation"), as Int. No. 292 does, is a step in the right direction. We encourage you to pass this crucial legislation.

The Administration has taken an important first step in addressing the over-incarceration of people with mental illness by forming the Task Force on Behavioral Health and the Criminal Justice System (Task Force). Realigning policies of policing, prosecution, and incarceration of people with mental illness so that Rikers Island is not the primary provider of mental health treatment in the City is critical. We hope that the work of this Task Force also results in significant improvement in the mental health and substance abuse treatment provided in the jails.

We are extremely disappointed that the City has not embraced an opportunity – provided by the recent court order in *Brad H. v. City of New York*[1] – to pursue a new course in the way discharge planning services for people with mental illness are provided. Rather than recognizing the systemic failures that result in people with mental illness leaving the jails without connections to services and benefits, the City's initial response to the court's decision was to engage in further litigation. We hope that the City will rethink this approach and instead develop a method for ensuring real results for people with mental illness released from jail. We ask the Council to convene a hearing in the fall on the status of discharge planning as well as the progress of the Task Force generally.

Introduction No. 292-2014

We strongly support Int. No. 292, legislation to require the DOC to report monthly on the number and characteristics of the people in solitary confinement in the City jails. Information about how solitary confinement is used in New York City should be made available to the public. In the past this information was not reported and a drastic expansion occurred.

From 2007 through the end of Fiscal Year 2013, the Department of Correction increased its solitary confinement capacity by 61.5%, from 614 beds to 998 beds.[2] On January 1, 2004, 2.7% of the incarcerated population in the City jails was in solitary confinement, but by June 30, 2013,

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[1] In August 1999, the Urban Justice Center, New York Lawyers for the Public Interest, and Debevoise & Plimpton, LLP, filed *Brad H. v. City of New York*, a class action lawsuit challenging the City's failure to provide discharge planning for people with mental illness in the City jails. On January 8, 2003, the parties settled the case with an agreement that the City would provide class members with discharge planning services, including continued mental health care, case management, and assistance in accessing public benefits and housing. Unfortunately the City has failed to comply with the settlement agreement. On April 18, 2014, the court extended the settlement agreement for an additional two years and ordered the City to modify its failed policies which have prevented the City from complying with its obligations.

[2] Gilligan and Lee, *Report to the New York City Board of Correction* (Sept. 2013).

the percentage in solitary had almost tripled to 7.5% of the population.[3] This increase happened gradually and was not widely reported.

It is critical for the public to be informed about the use of this dangerous and inhumane practice in the City jails. The United Nations Special Rapporteur on Torture has found that "solitary confinement, when used for the purpose of punishment, cannot be justified for any reason, precisely because it imposes severe mental pain and suffering beyond any reasonable retribution for criminal behaviour" and has called for "an absolute prohibition on solitary confinement exceeding 15 consecutive days."[4] Research conducted in the City jails reveals that individuals sentenced to solitary confinement are almost seven times more likely to attempt to hurt or kill themselves than other incarcerated people.[5] The harm caused by placing people in solitary confinement could not be more evident.

As evidenced by the support that JAC received in its efforts to call attention to this problem, when the public learns about the widespread use of solitary confinement, they oppose it. In April 2013 thirty-nine JAC members presented the Board of Correction with proposed rules for transforming the use of solitary confinement. Thirty-eight organizations and thirty-five individuals, including eleven City Council Members, declared their support for humane treatment of people incarcerated in the City jails and for rules to limit the use of punitive segregation.

What goes on in the City jails is hidden from the public. The City Council has the capacity to require transparency and accountability from the DOC. We encourage the Council to pass this legislation without delay.

Reducing the Number of People with Mental Illness Subjected to the Criminal Justice System

There are too many people with mental illness in the City jails. The Independent Budget Office recently released data comparing the number of people with mental illness in the City jails (4,376 on any given day) with the capacity of the City's psychiatric facilities (4,518 beds).

The concentration of people with mental illness in the City jails is in large part the result of punitive public policy responses to individuals in need of assistance. The incarceration of Jerome Murdough, who died in DOC custody in February 2014, is a tragic example.[6] He was arrested for trespassing because he was allegedly sleeping in a stairwell on the roof of a public housing project. The police arrested him, the Manhattan District Attorney prosecuted him, and a

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[3] *Id.* at p. 3.

[4] *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, A/66/268, August 5, 2011, pp. 20-21 available at http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf.

[5] *See* Kaba, Lewis, Glowa-Kollisch, Hadler, Lee, Alper, Selling, MacDonald, Solimo, Parsons, and Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUBLIC HEALTH 442 (Mar. 2014) (hereinafter "Venters et al.") available at http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742.

[6] Pearson, *NYC Inmate 'Baked to Death' in Cell*, Associated Press, Mar. 19, 2014, available at http://bigstory.ap.org/article/apnewsbreak-nyc-inmate-baked-death-cell.

criminal court judge set $2,500 bail – resulting in his imprisonment while his case was pending in criminal court. Mr. Murdough's incarceration was unnecessary. In a society that values human life, the response to Mr. Murdough's behavior – sleeping in a stairwell – should have been to help him to find housing, not subject him to arrest, prosecution, and incarceration. Mr. Murdough's situation is not unique. Thousands of people with mental illness are incarcerated for being poor and disconnected to basic human services.

Large-scale reform is needed. We commend Mayor de Blasio for convening the Task Force and for appointing to the executive committee the Commissioners of the Police Department, Human Resources Administration (HRA), and Department of Homeless Services – agencies which must be part of any move to prevent people with mental illness from entering the criminal justice system. The executive committee should also include representation of family members and formerly incarcerated individuals with mental illness. People with lived expertise in the intersection of these two systems must be included in efforts to change it.

We are pleased that the Task Force includes a working group on "Street to Court." The front door to the criminal justice system needs to be closed to people with mental illness whose need is treatment, and another door – for housing, resources, and treatment – needs to be opened. The Task Force should promote the creation of community crisis intervention teams – a combined response of trained police officers and mental health peer support – and new policing policies that lead to a drastic reduction in the number of people who are incarcerated for being in need.

We also hope that the work of the Task Force will lead to expanded opportunities for people with mental illness to receive treatment and support in lieu of further incarceration. Unfortunately the District Attorneys are frequently gatekeepers that prevent people with mental illness who have some history of involvement in the criminal justice system from receiving alternatives to incarceration. Prosecutors must recognize the negative effects of incarceration on people with mental illness and also recognize that the more humane approach of addressing the underlying service needs of people with mental illness promotes public safety.

Appropriate Mental Health Treatment to People in DOC Custody

The City has a constitutional obligation to provide mental health treatment to the people it incarcerates. The recent deaths of people with mental illness who were in jail mental health units suggest that the fundamental needs of people with mental illness are neglected and that the City currently lacks the capacity to provide adequate treatment.

Mr. Murdough's death illustrates this inadequacy. He was placed in a mental observation unit in Anna M. Kross Center (AMKC), the jail at Rikers Island with the most intensive mental health resources, yet his needs were not met. He was reportedly placed on suicide watch, but he was not monitored every 15 minutes as required because there was apparently no one assigned to do this monitoring. The correction officer who was required to check on him every half hour reportedly did not do so for at least four hours. This unit, which houses people on psychotropic medication, was allowed to become exceedingly hot; the temperature in Mr. Murdough's cell was more than 100 degrees. Psychotropic medications can create extreme sensitivity to heat; thus people on such medications must be maintained in housing that takes this sensitivity into

account. The City's neglect of this climate control issue in Mr. Murdough's housing area illustrates a disregard for people with the most severe mental health needs.

Mr. Murdough's is not the only recent death in a mental observation unit at AMKC. Bradley Ballard died there as well.[7] Correction officers confined him to his cell in violation of the Minimum Standards that require 14 hours of out-of-cell time daily and did so without a hearing to determine whether he merited confinement.[8] Correction staff unilaterally imposed that punishment, and no one stopped them. Mr. Ballard deteriorated before their eyes, yet not one of the uniformed staff, captains, or assistant deputy wardens who observed Mr. Ballard intervened. In fact, when his cell was finally opened after seven days of continuous confinement, it was not correction officers who took him out of the cell. Other people incarcerated on the unit were sent in to pull out his lifeless body.

Not only did correction staff fail Mr. Ballard, mental health staff did as well. Mental health staff are required to conduct rounds in the housing area twice daily. Yet no mental health staff intervened to evaluate or treat Mr. Ballard. Moreover, he was not provided with his prescribed psychiatric medication during most of the seven days he was locked in his cell. Mr. Ballard's need for treatment should have been apparent given that he was hospitalized at the Bellevue Hospital psychiatric prison ward for 38 days immediately before he was transferred to the mental health unit at AMKC.

In addition to the basic disregard for human life that these tragedies suggest, there appear to be systemic problems in providing mental health treatment in the jails. According to the Executive Director of the Board of Correction, only one of the 53 officers who worked on the mental health unit during the time Mr. Ballard was incarcerated there was a steady officer and none of the 11 captains were steady – even though the Mental Health Minimum Standards require that only steady correction officers be assigned to the mental health units. None of the uniformed staff had received the annual mental health training enhancement required by the Mental Health Minimum Standards.

We also have concerns that mental health staff does not have a greater presence on the units and that significant monitoring responsibilities are delegated to correction staff and incarcerated suicide prevention aides. Interactions between mental health staff and the people they treat seem to be quite limited, raising concerns about the adequacy of staffing. We also question whether there is sufficient capacity in the psychiatric prison wards at Bellevue and Elmhurst Hospitals to treat all of the people who require that level of care.

To gain a better understanding of the mental health treatment provided in the jails, we gathered information from people receiving mental health treatment at AMKC as well as the jails where adolescents and women are confined. With the help of students in Lori McNeil's Advanced

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[7] Pearson, *Inmate Died After 7 Days in NYC Cell*, Associated Press, May 22, 2014, available at http://news.msn.com/crime-justice/ap-exclusive-inmate-died-after-7-days-in-nyc-cell.

[8] The sanctioned policy of punitive segregation is to lock individuals alone in their cell for 23 hours a day, but to do so, there must be an administrative hearing to determine whether a rule violation has occurred and the length of the sentence.

Advocacy class at Columbia University School of Social Work, we surveyed people receiving treatment and learned the following:

• More individual therapy was the single most common suggestion for improving the quality of mental health services, with 70% of respondents indicating that this was important.

• The cursory nature of the mental health encounters is cause for concern. Over 60% of individuals stated that their sessions lasted from five to 15 minutes. One person commented: "*Sometimes they rush me out and don't listen carefully.*" Another individual highlighted the importance of quality services to prevent recidivism. *"Staff members should have more concern regarding treatment, rather than just providing a patient medication, asking the patient 3 to 5 standard questions and rushing them out the session to see the next patient. Mental health needs change in the jail system and should be treated as priority to assist people with their problems to refrain from coming back to jail, to correct as implied not punish as the system operates now."*

• The overuse of medication as treatment was an important concern. Most respondents (64%) were taking medication for their mental health condition prior to entering jail; 79% were on medication prescribed while in jail. Although part of the increase in these numbers may represent increased access to needed services, 27% said the only service they received was medication. Of those taking medication, only 62% reported seeing a counselor or therapist, 7% attended a substance abuse treatment group, and 20% attended a therapy group led by a counselor. This shows a very significant gap in the services provided, as it indicates that the only treatment some individuals are receiving is medication, and for those who also see a counselor, as noted above, these sessions tend to be too short to accomplish any therapeutic goals. One respondent explained, "*Often times mental health staff believe the correct way to treat a patient is by increasing the medication. Due to the lack of experienced treatment I have stopped taking my medication and refuse the services because [of] the fast food atmosphere and lack of therapy.*"

• The vast majority, 71%, of respondents, did not have or did not know they had a treatment plan. Only 8% reported having a lot of input into the development of their treatment plan and 54% reported having a little or no input at all. The experience was similar for discharge planning, where 59% reported not having or not knowing if they had a discharge plan.

• The importance of comprehensive discharge planning was highlighted by several respondents. One person said: "*I am terrified of leaving prison. I don't think I can remain free. Don't know how to assimilate. I've spent ½ of my life in prison.*" Lack of housing upon release was a particularly common concern for many, 59% citing it in their top three most important discharge services.

<u>Need for Connections to Treatment and Benefits for People Released from Jail</u>

As a provider of mental health treatment in the jails, the City is obligated to provide discharge planning services to those who are released from jail. Discharge planning is universally recognized as an essential part of adequate mental health care.

The *Brad H.* litigation is about ensuring that the City provides discharge planning to individuals who receive mental health treatment in jail so that they have appropriate treatment and services

when they are released. On several occasions we have testified before the Council about the status of the implementation of the *Brad H.* settlement agreement.

We are disappointed to report that more than a decade after the case was settled the City remains out of compliance with its obligations to provide discharge planning services to people who receive mental health treatment in the City jails. In fact, the most recent report on the City's compliance shows no improvement in the provisions of services, and for measures related to Medicaid, medication and prescriptions on release, appointments and referrals for continued treatment, and public assistance and supportive housing applications, the City's performance is at an all-time low.

On April 18, 2014, the court extended the settlement agreement for another two years and ordered the City to take actions that will hopefully result in its coming into compliance, including making "the necessary administrative changes to fully staff all clinical and non-clinical discharge positions" and "reorganiz[ing] the provision of discharge planning services to eliminate the fragmented dichotomy between clinical and discharge planning positions."

We had hoped that the new Administration would embrace this opportunity to make significant changes to the ineffective way that discharge planning services have been organized. Unfortunately the City has instead chosen to litigate these issues, filing a motion to reargue the Court's decision and a notice of appeal.

We believe that there are fundamental obstacles to providing quality services and that the leadership at Department of Health and Mental Hygiene, DOC, and HRA should address these issues and not continue the same practices which have proven ineffective in the past.

Conclusion

Thank you for convening this hearing and inviting our office to testify. We appreciate your oversight efforts and encourage you to continue to bring to light conditions of concern in the City jails.

TESTIMONY OF
THE FORTUNE SOCIETY

The New York City Council

Committee on Fire and Criminal Justice Services

Jointly with the Committee on Health and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

RE: Int 0292-2014 A Local Law to amend the administrative code of the city of New York in relation to requiring the commissioner of the department of correction to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement.

June 12, 2014

Presented by: Dr. Kirk A. James

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Good Afternoon. My name is Dr. Kirk Anthony James. I am testifying today on behalf of the Fortune Society, but I would like to first start by thanking the various Councilmembers and the Committee for convening this important hearing in an attempt to create greater transparency regarding the utilization of solitary confinement in New York City jails. I would especially like to thank the Committee for allowing The Fortune Society ("Fortune") an opportunity to testify.

First, I'd like to share with you a bit about Fortune's history. In 1967, David Rothenberg produced the off-Broadway play "*Fortune and Men's Eyes*." Written by John Herbert, a formerly incarcerated playwright, the play captured the experience of people living in prison. It told the story with such honesty that audiences were mesmerized; it also generated a great deal of public discussion outside of the theatre. People could not believe many of the stories; how could they? Who would think that such "inhumane" atrocities took place in an advanced society; especially in a place that was designed to "reform", a place designed to help people reclaim their lives.

Since its founding shortly after the off-Broadway play, Fortune has served as a primary resource for New Yorkers released from jails and prisons seeking to build constructive lives in their communities; it now serves some 4000 men and women with criminal justice histories annually. All of our programs are designed and implemented to meet the unique needs of this population through skilled, holistic and culturally competent assessments, and appropriate service provision. We build an initial relationship with clients that fosters trust and safety to begin the healing; often a crucial prerequisite to providing service for people with justice involvement; this is further reinforced by the degree to which our staff reflects many shared life experience of our clients. 70% of our staff are themselves either formerly incarcerated and/or in recovery. We believe in the importance of this cultural competency; however, it is this same cultural competency, specifically, the narratives told by our staff and clients regarding their experience within solitary confinement units across New York City and State, that allows us a deeper understanding of the degradation and inhumanity experienced in such settings. As such, we started the David Rothenberg Center for Public Policy (DRCPP) seven years ago to "officially" utilize this unique understanding of the criminal justice system to shape and inform humane policy and practices.

It is with this backdrop complete, that I now take the time to share a personal story with you:

In December of 1999, on the eve of a new century I was sentenced to do time in in the "box." I was already in prison. I was "inmate # 94A6325. I was approximately 5 years into a "7 years to life" sentence that I received at 18 years old. The crime was: criminal possession of a controlled substance in the 2nd. It was my first time going to the "box"; I had almost 5 years in some of New York State's finest establishments, but had been fortunate enough to avoid the "prison within a prison"; however, I was sent there after a "random" search determined I was in possession of contraband:

Inside of my cell I had a legal document with another person's name. I worked in the library and was making a copy for the individual whose name was on this legal document. He was filing an appeal and did not have access to the copy machines. I told this to the officer during my Tier 3 (highest level infraction) Hearing. He was not convinced! I was found to be in violation of some

correctional law that forbade "inmates" from possessing the legal documents of other "inmates". I was given a few weeks in "solitary". I had no tickets in my 5 years in prison until that moment, but none of that mattered. I was led out of the hearing room in handcuffs. I was being handcuffed so that I could be transported to the "prison within prison".

Can you imagine what that feels like? I was already in prison, which was bad enough; I had to now experience this dark, isolated and desolate place called the "box". And it literally was exactly that, it was an empty box within a box. Decorated with only a stainless steel concoction that somehow managed to contain, a toilet, a sink, and a washbasin all in one. Decorations also included an unmovable steel cot less than 3 feet from the head of the toilet bowl, which had no cover.

After the handcuffs were removed, and the cell doors slammed shut behind me, I looked around and tried to convince myself that it wouldn't be so bad. I told myself that the time would go by quickly. I would spend the next few hours reading all the writing on the wall; reading all the names of men who had spent time in this same cell. I observed many makeshift tic/tac toe type calendars, where previous inhabitants of this cell tried to keep track of the time; I started one, but would struggle to maintain it as the days and nights never seemed to end. It was hard to determine where one started, and the other one ended; it was impossible to see through the small frosted glass window, which was no more than 2x2 feet. The variation of meals (when they weren't held back as a means of control or punishment) was probably the surest indicator to the time of day.

I spent that first day/night reading the ingredients on the toothpaste. It was the only other item with words minus the writings on the walls; I had no personal property in the "box" but the clothes on my back. We were told we would periodically get reading material, or be allowed to get things from our property, which was now being held in some storage area, but it never happened. Day after day I would reread the writings on the wall, read the ingredients in the core-craft toothpaste.

I was fortunate enough to spend less than a week in the "box". I was released early (on New Year's Eve 1999) due to a riot that took place in the yard that afternoon. They needed to make space. Even with such a relatively short stay, I can honestly tell you that it was one of, if not the lowest point of my life!

The pain was tangible! I worried about my family who must be surely concerned, as I had not spoken to them via phone, or sent them letters the past week. It was bad enough that I was in prison, which was already restrictive, but now I was so far removed from humanity that I began to doubt my own existence. In many selfish ways, I am thankful for that riot, which in many ways helped to preserve what little sanity I had left.

Developmental research indicates that people are hardwired for human contact; they even speculate that babies could die without intimacy, even if they are provided nutrition. What do we then expect to happen when we put people in these conditions? How do we then expect them to make successful transitions back into their communities once released?

The over utilization of solitary confinement from a developmental/cognitive perspective is particularly disturbing when we examine some recent research on the issue:

- 41% of the inmates housed in the Central Punitive Segregation Unit (CPSU) were mentally ill. On August 1, 2013, 26 women out of 31 (84%) who were in punitive segregation or Mental Health assessment unit for infracted inmates (MHAUII) at RMSC were mentally ill. Within the New York City jail system, inmates with mental illnesses are being disproportionately placed in solitary confinement.

- The New York City Department of Corrections reported that a typical period of punitive solitary confinement for fighting for adolescents between the ages of 16 and 18 is 20 days. The median period of punitive solitary confinement for adolescents, overall, is 29 days; the average period of punitive solitary confinement is 43 days. This suggests that some young people spend very long periods in solitary confinement. Furthermore, young people generally spend more time in solitary confinement than adults.

- According to the National Association of State Mental Health Program Directors Research Institute, the number of mentally ill prisoners that the Cook County, New York and Los Angeles jails handle daily is equivalent to 28% of all beds in the nation's 213 state psychiatric hospitals.Approximately40% of the inmates in Rikers Island have a psychiatric diagnosis, and a third of them exhibit acute or chronic psychopathology severe enough to constitute major mental illnesses.

- Younger inmates or people with mental illness, who are more vulnerable and significantly affected, are disproportionately represented in punitive segregation units

- A recent study (2014) examining medical records from the NYC jail system from 2010 to 2014 found inmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm than other incarcerated individuals.

- The US Supreme Court described the harmful effects of solitary confinement in the 19th century:

  A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane, others, still, committed suicide, while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the com-munity.
  —U.S. Supreme Court, In re Medley, 134 U.S. 160, 168 (1890)

Conclusion

I share this story as many men and women are not as "fortunate" as I was. Many, often with physical and or mental health challenges, pregnant or lacking appropriate cognition (in the case of our young people) are sent to the "box", "SHU", "solitary confinement" (and every other name used) for years at a time! I have heard stories from men at Fortune who have served over two decades in prison, with almost half of that time in solitary confinement, in isolation from other human beings. Can you imagine the inhumanity? Can you imagine being locked in a room often only a tad bigger than a NYC bathroom for years; the only outlet an hour of "recreation" in a cage? And that's when the "CO" allows you that "luxury"!

DRCPP believes that widespread use of the inhumanity that is solitary confinement must end. The evidence of human damage caused by its utilization is overwhelming (historically & contemporary). So while we strongly support the City Council initiative in its effort to create greater transparency regarding its utilization in New York City Jails, we strongly urge that you not stop there. Please, speak to the men, the women (some pregnant), the elderly, the LGBTQ, the young, the mentally ill, the disabled; ask them to recount their experiences in these "prisons within prisons". Listen to the trauma; listen to the pain that we at the Fortune Society hear every day doing this work. Then take the next step and end this "inhumane" over reliance upon solitary confinement.

Respectfully Submitted,

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TESTIMONY OF LISA SCHREIBERSDORF,
EXECUTIVE DIRECTOR, BROOKLYN DEFENDER SERVICES

Committee on Fire and Criminal Justice Services
Jointly with the Committee on Health and the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services:

Oversight – Examination of Violence and the Provision of Mental Health and Medical Services in New York City Jails

Int. 0292-2014 – A Local Law to amend the administrative code of the city of New York in relation to requiring the commissioner of the department of correction to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement.

June 12, 2014

My name is Lisa Schreibersdorf and I am the Executive Director of Brooklyn Defender Services (BDS). I am here today to testify on behalf of Brooklyn Defender Services about our experience representing adolescents and adults housed in city jails. The vast majority of our clients currently in city jails are in pre-trial detention because they have been unable to pay bail. We also represent clients who have been sentenced to serve time in these facilities.

ABOUT BROOKLYN DEFENDER SERVICES

BDS is a Brooklyn-based public defense office that represents approximately 40,000 clients per year in criminal cases. Within BDS, we have a number of specialized units – for adolescent clients, clients with a mental illness, veterans and trafficking victims.

Upwards of 6,000 of our clients will spend time in a city jail each year. The geographical isolation of Rikers Island, along with Department of Corrections logistical constraints, makes it exceptionally difficult for our attorneys to regularly connect with their clients while they are in pretrial detention. Similarly, it is often difficult for our clients to contact their attorneys,

particularly if they are in punitive segregation, solitary confinement or if their housing unit is locked down[1]. BDS has a Jail-Based Services Liaison who meets with clients every day, including many clients in solitary confinement, those with mental illness and many who are struggling to adjust to the violent and inhospitable jail environment. Our jail-based team of legal assistants and social workers also provides logistical support for the client's criminal case and have supportive personal interactions with clients to help them get through what is often a traumatic jail experience. In addition, our attorneys and social workers talk extensively with clients who are currently in or have been released from solitary confinement, especially when they appear in court in the telltale orange jumpsuit. The discussion in this memo includes information that we have received directly from clients and attorneys based on their personal experience.

SOLITARY CONFINEMENT

BDS would like to extend our thanks to the City Council Committees for taking up the topic of the use and over-use of solitary confinement at Riker's Island. In recent years, we have noticed a very significant increase in the use of solitary for infractions that are so minor as to be insignificant. The length of stay in solitary is also noticeably longer than it was even a few years ago, as clients are sometimes placed in "the box" for weeks on end. Every client who is placed in solitary suffers from the experience and the changes in their personalities and behaviors are readily apparent to attorneys, social workers and other staff. It is clear to us that the excessive use of this extreme punishment for minor incidents has reached an unacceptable level and that it contributes to the general violence in City facilities. In a way it is almost frustrating to have to have these public conversations due to the tremendous amount of study and research on the topics of confinement that already exist – stretching back several centuries to the birth of the very concept of jails and prisons.

Rikers Island – an entire island devoted to the warehousing of people accused of crimes who are too poor to post bail – houses a large number of people who have a mental illness. It is the largest provider of mental health services in the state, despite infrastructure and personnel entirely unqualified and ill-equipped to work with this population. Our clients who have a mental illness almost always fare poorly in jail. Many of these clients end up in solitary confinement because of actions related to their mental illness and such clients, once isolated in this way, rapidly deteriorate.

Another large segment of our clients who end up in solitary confinement are our youngest clients, ages 16 and 17. It is said in our office that anyone in that age range will be in solitary in

[1] We use the term solitary confinement to refer to the class of segregation cells in which our clients are placed as a form of punishment. We use the terms solitary confinement, punitive segregation, "the box" and "the bing" interchangeably. Other units such as CAPS and RHU, which ostensibly serve a non-punitive role, are defined as such.

a month unless we find a way to get them out of jail. This is because they are routinely placed in solitary because of actions very typical of teenagers. Once there, most of these young people start showing signs of serious mental problems. Teenagers, in particular, suffer from the experience of solitary. They tend to get distraught over being left alone for so many hours with their thoughts that they do self-destructive things that only serve to increase the time in solitary punishment.

In our experience, after only a short time in city jails, our clients begin to exhibit symptoms of Post-Traumatic Stress Disorder, especially hypervigilance and insomnia. Our clients who are placed in solitary confinement report conditions that appear to be particularly destructive to their physical and mental well-being. Our clients report that when in solitary confinement they are fed less, and that recreational time is only made available to them very early in the morning – when they are not yet awake. They are denied their rights to education, especially any special education services to which they are entitled. People in solitary are also denied access to phone calls and any group activities, including religious services. They report denials of access to water, to shower products and to mental health treatment and medication. The cells they are forced to live in are filthy and vermin infested. They also report hallucinations and thoughts of self-harm.

The Missouri Model utilized by many placements for clients younger than 15 is successful at reducing violence and recidivism in large part because of programming that includes recreation, education and group activities and collaboration – the very things that we typically see denied for our adolescent and adult clients at Rikers Island and other city jails. It has been adapted for use in secure placements in New York City for younger teenagers who are in ACS care. If this best-practice has been adopted by the city for use with 15-year-olds, what is the explanation for not using it with 16-year-olds?

Programming the City has found to be successful for one group of adolescents can and should be utilized for the slightly older adolescents currently at Rikers Island. The City already possesses the tools and know-how to resolve many of the issues that are particular to adolescents confined in city jails, but as a matter of policy has decided not to utilize these understandings – to the detriment of all.

Our adult clients with mental health challenges report that the environmental conditions at Rikers Island exacerbate their mental illness, with many clients preferring to do time upstate rather than continuing to deal with the considerably more chaotic atmosphere at city jails. Our adult clients with mental illness report confusion, disorientation and overmedication. Many report being prescribed medication for the first time in city jails and that they are unused to the side effects. Our clients who are not diagnosed with mental illness upon their arrival in city jails, who later develop symptoms of mental illness due to the environment there, often report difficulty in accessing mental health services. They report being denied medical attention. Some report that after being denied services they were forced to attempt suicide in order to be granted mental

health care. The conditions of solitary confinement directly exacerbate negative mental health symptoms. A March 2014 study published in the American Journal of Public Health of Public Health, reaffirmed the centuries-old research that social isolation and sensory deprivation directly lead to incidents of self-inflicted violence and harm[2].

It is our experience and belief that the conditions at Rikers Island contribute to the levels of violence our clients are exposed to. This should not be viewed as a surprise. Gilligan and Lee, mental health experts who studied Rikers Island in 2013 at the request of the Board of Correction found that the physical plant of the facilities made any therapeutic goals nearly impossible and that arbitrary and harsh levels of punishment inflicted upon residents created a unique atmosphere that seemed almost designed to stimulate violence. They found: "More than a century of research on the psychology of punishment has made it clear that punishment, far from preventing violence, is the most powerful tool we have yet created for stimulating violence." These experts paid particular attention to the issue of solitary confinement, which they argued was among the greatest contributors to violence in the facility, specifically as it pertained to people with mental illness.

While experts debate the efficacy of various jail-based programs insofar as they relate to the management of violence, the research on solitary confinement seems quite clear. Time and again solitary confinement – sensory deprivation and social isolation in filthy conditions – is pointed to by mental health experts as pathogenic. *That is, the conditions of solitary confinement create mental illness, decompensation and leave people more prone to anti-social behaviors and violence.* Furthermore, there has been no empirical research to support the use of solitary confinement as a means to reduce violence; and the practice has been rejected the world over both because of this and because it amounts to torture, according to the United Nations and various international human rights bodies. The long back-log on solitary cells at Rikers Island, which leaves people who have infracted jail rules among the general population for sometimes months before entering isolation suggests further evidence that this punishment is not essential for the maintenance of safety. **It is our hope that the City of New York stop the use of solitary confinement until the conditions of that confinement are such that they no longer risk permanent physical and psychological damage to people and until such time as the validity of using solitary confinement to impact positively future behavior in jail is established by concrete evidence.**

As Councilmember Crowley indicated at the February 28 hearing, much of the violence at Rikers Island involves the younger people who are housed there. The vast majority of jurisdictions in the United States and around the world have deemed it inappropriate to house 16 and 17 year olds in an adult facility, managed by corrections officers who are trained to work with adults. Although our state law requires that 16 and 17 year-olds are treated as adults in criminal proceedings, there is no statutory reason that adolescents cannot be housed in age-appropriate

[2] http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742

settings for the purpose of pre-trial or post-sentence detention. Through the "Close to Home" initiative, the City has decided that it is better to incarcerate 14 and 15 year-olds in their community; the same should be true of their slightly older peers. While there is significant evidence that teenagers simply should not go to jail, as we work towards that goal, we recommend using borough-specific facilities to house young people closer to their communities where they can better avail themselves of community support and services. In such facilities, models that are more appropriate for teens can be utilized for bad behavior and solitary confinement would need never be imposed on any young person.

There has yet to be a compelling case made by anyone that Rikers Island is properly equipped to handle the mental health challenges of the people who are confined there, and so it should not. Venus Singleton, a mother from Harlem, plainly stated what we see all the time---"They sent him to the Island, and he came back a monster. That boy they sent back is not the same boy I sent them. The Department of Corrections turned my son into a monster.[3]" It is a public safety imperative that we change our corrections philosophies and practices – that we commit pre-trial detainees to city jails as a matter of last resort, and that we utilize effective treatment models to assist people in overcoming their mental illnesses, addictions and trauma-based impairments. It is irresponsible from both a fiscal and a public safety perspective to commit people to city jails who will not have their needs met there, or are likely to be made worse by the conditions there. By partnering with more community-based providers and sending fewer pre-trial detainees to Rikers Island, criminal justice professionals can better facilitate the continuity of care and consistent standards that most healthcare providers indicate are the most reliable opportunities for treatment.

Int. 0292-2014 – A Local Law to amend the administrative code of the city of New York in relation to requiring the commissioner of the department of correction to post a monthly report on its website regarding punitive segregation statistics for city jails, including the use of solitary confinement.

BDS supports this bill that would bring more transparency to actions taken by the Department of Corrections. While this bill is only a small first step in the right direction, we are certain that if the numbers of people sentenced to punitive segregation were known, as well as the nature of the charges that caused this punishment, change would come quickly.

One of the biggest obstacles we face in terms of helping our clients in segregation is that we are not even aware that they have been moved to these facilities. Anything we could do, as their attorney, is limited by the complete lack of information and notification as to what is occurring. In addition, as with all unfair and questionable practices, holding them up to the light of day is the best way to guarantee they will be analyzed, studied and carefully considered.

[3] http://jjie.org/harlem-residents-we-asked-city-for-help-we-got-a-raid-instead/107031/

One of the worst and most secret aspects of solitary confinement is that inmates continue to rack up additional days in solitary while they are isolated there. In reaction to the terrible conditions and treatment they receive while in solitary, our clients act out, forcing open their food slots, or splashing guards, or harming themselves – in desperate attempts for human contact, attention and protest. Each of these actions can, and often do, result in significant additional time. Simply holding open the food slot, in the hopes of hearing a human voice can easily result in an extra 15 days in the box.

We suggest that there be clear standards for the appropriate use of solitary sentences and that DOC place greater emphasis on advising inmates as to what type of conduct can lead to a stay in solitary. Many of our clients express a lack of understanding about the rules of city jails, report that the rules apparently change without notice, and that they are often unsure what types of conduct qualify as punishable infractions. Even those already in the box often do not find out that they are not allowed to do things like hold the food door open until they do it and by that time they have racked up further time. When we listen to clients describe the anguish they feel when they are completely isolated from other human beings for weeks or even months, we are shocked by the cruelty embodied in these policies and frankly embarrassed as criminal justice professionals.

Aside from being harsh and cruel, the punishment regime in city jails appears entirely arbitrary. We cannot make any sense out of what will land our clients in the box or how much time they will get. Outside observers who have studied the process note the same thing. There is little doubt that forcing corrections to publicly report this information can only have a positive impact on the issue. It has reached such an oppressive level there is no way the actions and policies of DOC can withstand scrutiny of any kind.

In the past two weeks alone we have interviewed two clients who were placed into solitary confinement – subjected to torture conditions – who might not have been there had the type of reporting requirements been in place that Int. No. 292 recommends. One client was placed into solitary confinement immediately following his arraignment, ostensibly because he "owed" time from a previous incarceration. The altercation that led to the initial solitary segregation sentence is currently the subject of a civil lawsuit he has filed against the city alleging misconduct by correctional staff. We have several clients who report similar situations: being forced back into solitary confinement upon their return to Rikers Island on new charges for solitary time "owed," sometimes years after the initial DOC infraction and almost always involving an alleged incident with a corrections officer.

The second case was even more troubling. Our client was issued an infraction ticket on May 12th because a correctional officer alleged he found something in our client's rectal cavity during a cell search. As a result, our client was placed in isolation, in a contraband watch cell in OBCC. He was housed in this cell for 8 days, 24 hours a day, with no personal property and without the ability to flush the toilet because it was a contraband cell. Our client lived in this cell for over a

week, sleeping beside a toilet that was full of his own waste, which he covered with newspapers and his bath towel to fight off the illness provoked by the smell. He was denied showers, telephone usage, out-of-cell time, reading and writing materials, visits and court appearances. There were men in his housing unit who claimed that they had been held there for weeks and even months. It was only when a Deputy Warden visited the housing unit that the men were released, with the Deputy apparently finding that the men had been either placed there in error or held in these cells for too long. Had there been any kind of reporting requirement, both of these men, who were on Rikers Island in pre-trial detention – having not been convicted of any crime – would not have suffered through these experiences.

In addition to the recommendations outlined in Int. No. 292, BDS would like to suggest some additional amendments. To solve one common problem, we would ask that the inmate's attorney be notified whenever the client is charged with an offense while in custody, is moved to solitary confinement or is being seen for mental health treatment or evaluation.

It is not uncommon that having not heard from an incarcerated son or daughter for several days, a frantic family member will call our office to find out if we have heard from the client. It is almost impossible for us to ascertain their well-being in a timely manner. We recommend that when a person in city custody is sentenced to solitary confinement, that their lawyer be alerted by the DOC. Similarly, when a person in city custody is sent to the hospital following an altercation, their attorney should be notified. In addition to at least a minimal amount of accountability that such notifications would provide, both of these scenarios typically involve an interview of our clients by DOC staff that hold potential legal consequences, during which our clients are frequently asked to waive their rights against self-incrimination. Because these interviews can lead to additional criminal charges and certainly can result in the enhanced punishment of solitary confinement, it is essential that individuals know and are able to assert their civil rights to advice of counsel. There should also be a right to counsel at the infraction hearing, so that we would be able to provide our clients with a meaningful opportunity to contest infraction allegations of any kind.

Our mental health clients are the most vulnerable to severe negative outcomes during their time in solitary. Yet there are no clear guidelines regarding how to determine if a mentally ill person is able to withstand a stint in solitary confinement. With this in mind we would request documentation, notice and an opportunity to be heard when a client is moved from a mental observation unit to a punitive segregation unit pursuant to the DOC directive 4016R. We think there should be a requirement that we, as the attorney, be notified any time a client has been sent for a mental health review for the purposes of determining fitness for a solitary punishment as well. We seek notification when a client is referred for mental health services pursuant to directive 4018 and that there be a monthly report about the number of people referred to mental health services. We would also request that "splashing" be removed from the category of "assault" which carries severe penalties.

Additional information that would also be useful would be data about what services the inmates are actually receiving—like how many are actually going outside for their so-called recreational time, how many go to religious services, receive educational packets, receive special educational services, get a shower, use the phone, ask for food and are denied it -- information that can paint a much more accurate picture of what is happening in these secretive units.

Brooklyn Defender Services SUPPORTS the bill proposed by the City Council.

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Good afternoon. My name is Henry Weinstein and I am here today to testify on behalf of the New York County Psychiatric Society. The New York County Psychiatric Society ("NYCPS") is a nonprofit membership association of psychiatrists in Manhattan and Staten Island founded in 1955. For more than fifty years, NYCPS has been dedicated to improving the field of psychiatry and the psychiatric treatment and care of people with mental illness. With over 1,800 members, NYCPS is the largest district branch of the American Psychiatric Association.

I testify today not only as a long standing member of NYCPS but as a forensic psychiatrist who is currently a Clinical Professor of Psychiatry at the New York University School of Medicine and the Director of the Program in Psychiatry and the Law at the New York University Medical Center. For more than twenty years I also served as the Director of the Forensic Psychiatry Service at Bellevue.

NYCPS is very pleased that three City Council Committees have come together today to hold a hearing on such an important mental health issue. The recent deaths at Rikers Island have shed light on what many of us in the mental health community already knew; we are not adequately treating and caring for people with mental illness who end up in our jails. While the overall jail population may be decreasing, studies have shown that the proportion of people with mental health needs in the average daily jail population is increasing making the lack of adequate care even more alarming.

NYCPS believes more must be done at all stages of the criminal justice process; from pretrial detention to incarceration to post-release supervision and treatment. We are proud that many of our members are already working hard to effect change. For example, the Fellowship Program in Psychiatry and the Law of the Department of Psychiatry of the NYU Medical School has been instrumental in providing leaders for Forensic Psychiatry facilities in New York City including the New York City Court Clinics, the Kirby Forensic Psychiatric Hospital on Wards Island, as well as the Prison Ward of Bellevue Hospital. Most recently Dr. Elizabeth Ford, who led the forensic psychiatry program and fellowship, accepted a position as the Executive Director of Mental Health for Correctional Health Services for the NYC Department of Health and Mental Hygiene. She is one of many psychiatrists hoping to lead the way to better mental health services for this under-served population.

Once again, NYCPS is encouraged by the City Council's attention to this issue. We know that addressing the problems in our system will take time and careful consideration and we stand ready to be a resource to the Council wherever we are needed.

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FOR THE RECORD

TESTIMONY OF JOHANNA MILLER[1]
ON BEHALF OF THE NEW YORK CIVIL LIBERTIES UNION

before

THE NEW YORK CITY COUNCIL
COMMITTEE ON FIRE AND CRIMINAL JUSTICE SERVICES

on

INT. 292 (Requiring the commissioner of the department of correction to report punitive segregation statistics for city jails)

June 12, 2014

The New York Civil Liberties Union respectfully submits the following testimony regarding the City Council's consideration of Int. 292, which would require the commissioner of the Department of Correction to publicly report statistics on punitive segregation in city jails.

With 50,000 members and supporters, the New York Civil Liberties Union (NYCLU) is the foremost defender of civil liberties and civil rights in New York State. Our mission is to defend and promote the fundamental principles and values embodied in the Constitution, New York laws, and international human rights law, on behalf of all New Yorkers, including those incarcerated in jails and prisons. The NYCLU is an outspoken advocate for evidence-based corrections practices that improve public safety and respect fundamental human dignity.

We are pleased to support the City Council in bringing much-needed oversight to the practice of punitive segregation in city jails. On any given day, approximately 800 people are held in isolation in New York City jails. The overwhelming majority of individuals in New York City's jails are pre-trial detainees, meaning that hundreds of individuals are placed into solitary confinement—the most severe form of punishment currently practiced in the United States other than the death penalty—before they have even had their day in court. The use of punitive segregation is in direct conflict with basic constitutional and human rights principles.

[1] This testimony was researched and co-written by Elena Landriscina and Taylor Pendergrass.

Moreover, research has consistently shown that prolonged extreme isolation causes a grave risk of harm for prisoners and negatively impacts safety inside and outside jail walls.

We hope this oversight hearing and the legislation on today's agenda are the first step toward comprehensive reform of the myopically punitive and harmful conditions and practices that have persisted in New York City jails for far too long. Ultimately, New York City should abolish punitive segregation and turn toward evidence-based alternatives that have been proven to be safer, more effective, and more humane.

I. Introduction

"Solitary confinement" goes by many labels: lockdown, the Bing, the Box, Special Housing Unit, segregation. All these terms refer to the same basic practice of confining a human being in the most punitive and isolating conditions possible. Typically, this means confinement for approximately twenty-three hours a day in a space about the size of an elevator, without meaningful human contact, for weeks, months, or possibly years at a time.[2] As one man described the experience of isolation to the NYCLU:

> *With so little to do your mind rots with thoughts that are uncommon or unnatural and you wonder where the hell did that come from. . . . A lack of any constructiveness only contributes to destructiveness and the Prison System is designed to make a person like myself and other unfortunate to self destruct become numb lose the sense of reality to the degree that any commotion at all is better than vegetating by letting hours pass without nothing on your mind or will to do anything.*

The damaging effects of solitary confinement on an individual's mental health are well-documented.[3] A recent study of New York City jails confirms a strong link between self-harm and solitary confinement.[4] For healthy adults the impact of solitary confinement can be devastating even after a short period of time; but the risk is especially acute for adolescents, individuals with mental illness or disabilities, and those with serious health conditions. Because

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[2] *See* Nicole Flatow, *Teen Jailed at Rikers for 3 Years Without Conviction or Trial*, THINK PROGRESS, Nov. 25, 2013 (explaining that a teenager, Kalief Browder, spent three years in jail without charge or trial, including more than 400 days in solitary confinement).

[3] *See* Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325, 336 (2006) (noting impulse control and self-harm are psychiatric symptoms associated with solitary confinement); Craig Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*, 49 CRIME & DELINQ. 124, 131 (2003) (noting the association of suicide and self-mutilation with isolated housing); Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIM. & JUST. 441, 492-493 (2006) (noting problems with impulse control, violent reactions, self-mutilation, suicide associated with prolonged isolated confinement).

[4] *See* Fatos Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUBLIC HEALTH 442, 445 (2014) (explaining that "[i]nmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm" even after researchers controlled for other factors including length of jail stay, serious mental illness, age, and race/ethnicity).

solitary confinement exposes people to severe harm, international human rights bodies,[5] professional societies including the American Academy of Child & Adolescent Psychiatry and the American Public Health Association, and U.S. Senators have condemned its use and urged reform consistent with human rights standards.[6]

Solitary confinement is also extremely short-sighted and costly from a corrections and public safety perspective.[7] Inside prison, far less severe punishment in combination with interventions (for example, a referral to a counselor) has been shown to be as or more effective as a disciplinary response, while the use of solitary confinement itself can lead to higher rates of facility violence and disruption and make work even more difficult and dangerous for custody staff.[8] Outside of prison, researchers have found higher rates of recidivism among people released straight from solitary to the community.[9]

Around the country, corrections systems are reforming the way solitary confinement is used. Evidence-based alternatives to solitary confinement—such as targeted programming designed to address problematic behavior while maximizing as much human contact as can be safely allowed—have made corrections systems safer for prisoners and staff alike.[10] Here in New

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[5] *See Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Punishment or Treatment*, ¶¶ 70, 86, 87 U.N. Doc. A/66/268 (Aug. 5, 2011) (concluding that solitary confinement may amount to violations of International Covenant on Civil and Political Rights and the U.N. Convention Against Torture); U.N. Human Rights Committee, *General Comment No. 20*, ¶ 6 (Oct. 3, 1992) (stating that solitary confinement may violate the prohibition on torture and cruel, inhuman or degrading treatment or punishment contained in Article 7 of the International Covenant on Civil and Political Rights).

[6] American Academy of Child & Adolescent Psychiatry, Juvenile Justice Reform Committee, Policy Statement: Solitary Confinement of Juveniles Offenders (Apr. 2012), *available at* http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx; American Public Health Association, Policy Statement: Solitary Confinement as Public Health Issue (Nov. 2013), *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1462; Press Release, Durbin: Time to End use of Solitary Confinement for Juveniles, Pregnant Women, and Those With Serious Mental Illness (Feb. 25, 2014), *available at* http://www.durbin.senate.gov/public/index.cfm/pressreleases?ID=c684591f-9197-4306-8af0-f9914117f287.

[7] *See* Kaba et al., *supra* note 4, at 446 (noting that self-harming behavior by prisoners in solitary confinement in New York City jails represents a "significant and increasing drain on resources" because of increased escorts to medical and mental health units for evaluation, treatment, and hospitalization).

[8] A 2006 study that examined corrections systems in Arizona, Illinois, and Minnesota showed that increasing segregation had no beneficial effects on prisoner-on-prisoner violence. The same study showed it had a limited impact on prisoner-on-staff violence in Illinois, none in Minnesota, and increased levels of violence in Arizona. A similar study showed that increasing the use of segregation in California failed to reduce violence overall in the system and may have driven an increase in violence. Chad S. Briggs et al., *The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence*, 41 CRIMINOLOGY 1341, 1348-49, 1367 (2006).

[9] *See* David Lovell & Clark Johnson, *Felony and Violent Recidivism Among Supermax Prison Inmates in Washington State: A Pilot Study* (2004) (indicating that rates of recidivism increase when prisoners are returned directly from isolated confinement to the community with no re-entry planning).

[10] In Mississippi, the Department of Corrections reduced the segregation population by 75.6% from 2007 to 2012, and that reduction, coupled with additional programming, led to a 50% decrease in violent incidents. *Reassessing Solitary Confinement: the Human Rights, Fiscal and Public Safety Consequences: Hearing Before the Subcomm. on the Constitution, Civil Rights and Human Rights of the S. Comm. on the Judiciary*, 112th Cong. 2-3 (2012) (written testimony of Christopher B. Epps, Commissioner of Corrections for the State of Mississippi).

York, in response to a lawsuit brought by the NYCLU, the New York State Department of Corrections and Community Supervision initiated reforms to its solitary confinement practices by immediately reducing or eliminating its use for particularly vulnerable populations—juveniles, pregnant women, and the developmentally disabled—and by committing to an evidence-based analysis of its practices in collaboration with outside experts that will shape additional future reforms across the entire prison system that will benefit all prisoners.

The need for a similar examination of solitary confinement practices in New York City jails has been brought home by the recent deaths of Jason Echevarria, Jerome Murdough, and Bradley Ballard—all of whom reportedly had mental illness and were left to die gruesome deaths in isolation cells at Rikers Island.[11] Their deaths bring urgency to the Committees' consideration of segregation policies and practices in the city jails. Intro. 292 is a critical first step.

II. Reform Recommendations

Solitary confinement—the practice of subjecting human beings to extreme forms of isolation and deprivation—should be completely abolished. The NYCLU strongly urges New York City to take steps to implement the following recommendations:

a) Collect and analyze data on solitary confinement practices and use it to guide specific evidence-based reforms

Data collection and analysis has been the starting point for successful reforms to solitary confinement in other jurisdictions, including Washington, Colorado, Illinois, and Maine. Subject to the legislative recommendations below, the NYCLU believes that Intro. 292 will help lay a similar foundation for reforms to solitary confinement practices in New York City jails. As data becomes available, however, the City Council should also take steps to ensure the data is thoroughly analyzed and used to guide the direction of future reforms, for example, to inform a rule-making process or blue-ribbon panel convened to issue formal recommendations regarding the use of segregation. In addition, the Council should use its budgetary power to ensure the Department of Corrections has adequate resources to improve the situation and those resources are being used appropriately and with proper assessment.

b) Immediately Remove Vulnerable Populations from Segregation

While the use of solitary poses a serious risk of harm for any individual, the risk is especially severe for vulnerable prisoners, such as individuals with mental illness, individuals with disabilities, and juveniles. While removing these vulnerable populations from solitary

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[11] Jake Pearson, *2 Deaths Put NYC Jail System Under Scrutiny*, AP, May 22, 2014; Michael Schwirtz, *U.S. Accuses Rikers Officer of Ignoring Dying Plea*, N.Y. TIMES, Mar. 24, 2014; Michael Schwirtz, *Correction Dept. Investigating Death of Inmate at Rikers Island*, N.Y. TIMES, Mar. 19, 2014.

confinement should never be a substitute for comprehensive reforms to the practice in its entirety, the importance of taking immediate steps to protect these individuals is undeniable. Furthermore, implementing alternatives to isolation for these vulnerable groups can be an effective way of spurring a larger shift that reorients jail staff away from outdated punitive approaches and toward more effective and more humane corrections practices. Ultimately, initial steps with regard to specific vulnerable population can serve as the framework for broader system-wide reforms that will ensure that all prisoners are protected from inhumane and unconstitutional solitary confinement practices.

c) Implement comprehensive reform by eliminating punitive segregation and separating prisoners only when absolutely necessary for safety, under the least restrictive conditions and for the shortest time possible

If the New York City jails prove to be similar to other jails and prisons throughout the country, the data will show that an overwhelming number of prisoners are being thrown into solitary confinement for reasons that have nothing to do with a need to keep people safe.[12] For this large percentage of prisoners, jail staff can address misbehavior just as effectively and much more humanely by employing far less punitive sanctions. Accurately identifying the small percentage of prisoners who actually need to be separated from the general prison population, in and of itself, is likely to address a significant part of the problem and will, in turn, allow the Department of Correction to focus resources on the small number of prisoners who are actually so violent or chronically disruptive that they simply cannot be safely managed in the general prison population. For this group, however, there is no reason that removal and separation from the general prison population must consist of crushing punitive deprivation and near-total isolation from human contact. To the contrary, in these cases the conditions of confinement should be designed to maximize therapeutic programming aimed at assessing and addressing the root cause of the chronic misbehavior—mental illness, substance abuse, etc.—and to allow as much human contact as possible. For these prisoners, there must be an individualized treatment plan with well-defined milestones to be achieved in a set time frame that are designed to return the prisoner to general population and normal human interaction as soon as possible.

III. Legislative Recommendations

We applaud the City Council's efforts to bring transparency to punitive segregation practices in New York City jails, and in particular, the impacts of those practices on prisoners' mental and physical wellbeing. We have recommendations for categories of information that should be added to the reporting requirements at issue today.

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[12] *See* SCARLET KIM, TAYLOR PENDERGRASS, & HELEN ZELON, NEW YORK CIVIL LIBERTIES UNION, BOXED IN: THE TRUE COST OF EXTREME ISOLATION IN NEW YORK'S PRISONS 20 (2012), *available at* http://www.boxedinny.org/report/ (explaining that only 16% of disciplinary segregation sentences in the New York State prisons from 2007 to 2011 were for infractions related to violent misbehavior, specifically assault and weapons).

a) Contextual Data

First, we recommend the reporting include statistics about the general (non-segregated) population of city jails (disaggregated by facility) in order to provide relevant comparisons about the segregated population. Without contextual comparisons to the general prisoner population, the interpretive value of the data reported under Intro. 292 will be unnecessarily limited. Contextual data is the difference between knowing that 200 prisoners in punitive segregation are on antipsychotic drugs and knowing that prisoners in punitive segregation are 200 times *more likely* to be on antipsychotic drugs.

At a minimum, the following data should be included to allow relevant statistical comparisons:

- Total population;
- Race, age, and gender of prisoners;
- Number of prisoners in the general population who are receiving mental health services;
- Number of prisoners in the general population who died, committed or attempted suicide, are on suicide watch, caused injury to themselves, or were seriously injured;
- Number of prisoners in the general population who were transferred to psychiatric hospitals or MHU;
- Number of prisoners in the general population prescribed anti-psychotic medications, mood stabilizers or anti-anxiety medications, disaggregated by the type of medication;
- Number of requests from prisoners in the general population for medical or mental health treatment, attendance at religious services, telephone, shower, visitation and library privileges and the number granted;
- Number and type of allegations of use of force and sexual assault and the dispositions of those allegations.

b) Transition Services

An area that should be of serious concern to the council is the practice of releasing prisoners directly from segregation to the streets without transition services. If a prisoner's sentence or detention ends while he or she is in segregation, a direct transition to the streets of New York can be dangerous for both the released individual and the community. Re-entry after detention is a complicated and difficult process for all prisoners; those who have been in segregation may experience additional difficulty in social interactions, controlling their emotions, and readjusting to civilian life. We recommend this bill be amended to include reporting of the total number of prisoners released directly from segregation to the streets, a risky if not dangerous practice that should be reformed. In addition, the council should require an accounting of re-entry and transition services offered to prisoners while segregated or between segregation and release.

c) Criminal Charges & Pre-trial Detainees

The NYCLU's study of the use of segregation in New York State prisons revealed that prisoners were sometimes held in extreme isolation for months or years of their sentences for minor infractions of prison rules. In city jails, as many as 75 percent of prisoners are in pre-trial detention; approximately 40 percent are held on misdemeanor or violations charges.[13]

While we don't yet know the exact nature of charges that result in segregation sentences (a vital piece of information that this bill seeks to provide), the nature of the population is such that most prisoners in segregation are probably not there because of a serious safety risk. The United Nations has recommended limiting the practice of holding pre-trial detainees in solitary confinement.[14] Without knowing the reasons prisoners are held in segregation, their underlying charges or convictions, or their status as pre-trial detainees, the city cannot begin to take serious stock of its reliance on disciplinary segregation.

We recommend Int. 292 be amended to include reporting on the charges and/or criminal convictions against people who are held in segregation, including a separate count of pre-trial detainees.

d) Dispositions of Complaints/Allegations

We commend the council for seeking information on the number and types of complaints of abuse against and by prisoners in segregation. This is vital information for understanding the impact of segregation on prisoners and staff. For an even more complete picture, we recommend the city also require reporting on the dispositions of those allegations—whether substantiated or unsubstantiated—and what punishment or disciplinary actions were taken as a result. To protect prisoner and staff privacy, names should be redacted. Similar information is currently collected and reported by the Civilian Complaint Review Board about allegations of police abuse.

IV. Conclusion

We thank the Council for providing this opportunity to share our recommendations for reforming the practice of solitary confinement and segregation in city jails. As we have tragically seen in recent months, this is an issue with serious human costs. Achieving greater transparency is a first step in improving conditions for prisoners at city facilities; policymakers and the public must have access to information on the use of segregation and its impact on various groups in the prisoner population. We look forward to having additional conversations with the Council and the administration about reforming the use of segregation, and other ways to improve health and safety in New York City jails and in the larger community as prisoners are released.

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[13] New York City Independent Budget Office, Letter to Councilmember Melissa Mark-Viverito, Sept. 30, 2011. Available at http://www.ibo.nyc.ny.us/iboreports/pretrialdetainneltrsept2011.pdf.

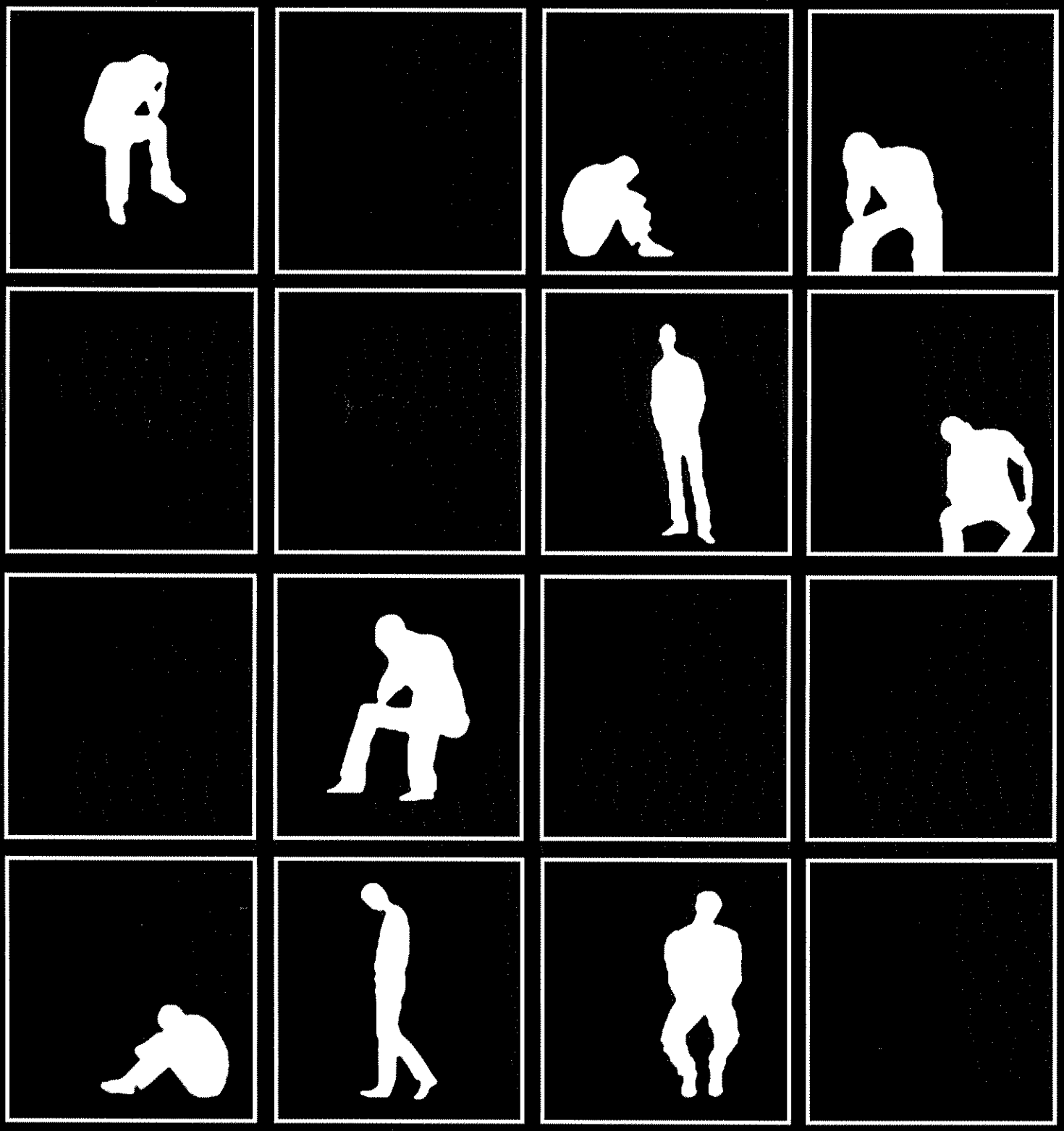
[14] *See* UN Human Rights, "UN Special Rapporteur on torture calls for the prohibition of solitary confinement," Oct. 18, 2011. Available at http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=11506&LangID=E.

BOXED IN

The True Cost of Extreme Isolation in New York's Prisons

A Report by the New York Civil Liberties Union

NYCLU
NEW YORK CIVIL LIBERTIES UNION



"A fair criticism that can be made is whether or not we're placing the right inmate in disciplinary segregation and are we keeping them there longer than necessary."

Brian Fischer, Commissioner, New York State Department of Corrections and Community Supervision, *Albany Times Union*, August 2012

"I'll be the first to admit – we overuse it."

Commissioner Fischer, January 2012, at New York State Bar Association Panel on Solitary Confinement

"I guess they forget people make mistakes which land them in jail & the fact that we was living a normal life, too, before our conviction. It's sad the things we have to go through just to make it home in one piece. . .

. . . I still be having a lot of mood swings lately, I don't be meaning any harm I just be mad at my situation . . .

. . . It gets real lonely in here, especially if you don't have family to communicate with or send you books. I'm grateful to have that, but after you be in this cell for so long it hard to keep your mind outside of these four walls, all you have is memories."

Donell, incarcerated at Upstate Correctional Facility

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DEDICATION

Boxed In is dedicated to the incarcerated men who so eloquently and courageously shared their stories with the NYCLU. Many of these stories were raw and painful in their telling. We are grateful to these men for entrusting us with their stories and sincerely hope that this report does justice to their experiences.

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EXECUTIVE SUMMARY

Every day, nearly 4,500 prisoners across New York live in extreme isolation, deprived of all meaningful human interaction or mental stimulation, confined to the small, barren cells where they spend 23 hours a day. Disembodied hands deliver meals through a slot in the cell door. "Recreation" offers no respite: An hour, alone, in an empty, outdoor pen, no larger than the cell, enclosed by high concrete walls or thick metal grates. No activities, programs or classes break up the day. No phone calls are allowed. Few personal possessions are permitted. These prisoners languish in isolation for days, weeks, months and even years on end.

What occurs inside our prisons may seem remote, but it affects all New Yorkers. It impacts public safety: Of the roughly 56,000 people incarcerated in New York's prisons,[1] about 25,000 are released and return to our communities each year, bringing their prison experiences home with them.[2] It reflects how we allocate increasingly scarce public resources: New York spends about $60,000 a prisoner – or $2.7 billion on state prisons – per year.[3] And it raises essential questions about how we value and protect human dignity.

Each of these concerns is directly implicated by an ongoing phenomenon behind New York's prison walls – the use of "solitary confinement" as punishment on an unprecedented scale and for extraordinary lengths of time.

New York employs an unusual brand of "solitary confinement." Roughly half of the 4,500 prisoners in "solitary confinement" spend 23 hours a day locked down alone in an isolation cell. The other half are locked down in an isolation cell with another prisoner – a practice known as "double-celling," which forces two strangers into intimate, constant proximity. The New York Civil Liberties Union (NYCLU) uses the term "**extreme isolation**" throughout this report to capture New York's particular practice of subjecting one or two prisoners in a cell to the conditions most commonly understood as "solitary confinement."

The purpose of **extreme isolation** is the absolute deprivation of meaningful human interaction and mental stimulation. Extreme isolation results in forced idleness and the complete cessation of education and rehabilitation. Like extreme isolation, **prisoner separation**, long an accepted corrections practice, removes violent or vulnerable prisoners from the general prison population. But unlike extreme isolation, separation aims to preserve, as much as possible, the social interaction, education and rehabilitation that maintains prisoners' psychological and physical well-being and supports a productive return to society.

New York employs an unusual brand of "solitary confinement." Roughly half of the 4,500 prisoners in "solitary confinement" spend 23 hours a day locked down alone in an isolation cell. The other half are locked down in an isolation cell with another prisoner – a practice known as "double-celling."

Over the past two decades, New York has spent hundreds of millions of dollars to build and operate an extensive network of extreme isolation cells, which the New York State Department of Corrections and Community Supervision (DOCCS) calls "Special Housing Units" or "SHUs" – and prisoners call "the Box." New York has nearly 5,000 SHU beds located in 39 prisons across the state,[4] including two dedicated extreme isolation prisons – Upstate and Southport Correctional Facilities – which cost about $76 million a year to operate.[5] From 2007 to 2011, New York issued more than 68,100 sentences to extreme isolation for violations of prison rules.[6] The average sentence was five months, although many prisoners are held in extreme isolation for years.[7]

The NYCLU set out to investigate New York's use of extreme isolation. We explored the history that led to the emergence and expansion of the practice in New York. We asked who New York subjects to extreme isolation, for what reasons, and for how long. We sought to understand and articulate its effects on prisoners and their families, as well as an often-overlooked population – the corrections staff assigned to watch them. We compared New York's use of extreme isolation with practices in other states and asked if the widespread use of the practice violates legal

standards. Finally, we considered how reforming the use of extreme isolation would affect the safety of New York's prisons and communities.

In order to answer these questions, the NYCLU conducted an intensive year-long investigation. We communicated with more than 100 prisoners who have spent significant amounts of time – in one case, more than 20 years – inside a SHU cell. We interviewed family members and corrections staff. We consulted corrections experts, mental health professionals, lawyers and academics. We read decades of DOCCS reports and press coverage recounting the history of New York's SHU expansion. We researched the scientific and academic literature regarding the use and effects of extreme isolation. We studied domestic and international legal standards governing extreme isolation and the steps undertaken by other states to reform their use of the practice. Finally, we reviewed DOCCS' internal regulations and policies and analyzed thousands of pages of official DOCCS records obtained through New York's open records laws.

The SHU sweeps in a wide swath of prisoners, including those uniquely vulnerable to conditions of extreme isolation, such as juveniles, the elderly, and people with mental illness or substance abuse issues.

Findings

Based on a year of study and analysis, the NYCLU found that New York's use of extreme isolation is arbitrary, inhumane and unsafe.

New York's use of extreme isolation is arbitrary and unjustified. Extreme isolation is too frequently used as a disciplinary tool of first resort. Corrections officials have enormous discretion to impose extreme isolation as a disciplinary sanction. Prisoners can be sent to the SHU for prolonged periods of time for violating a broad range of prison rules, including for minor, non-violent misbehavior. As a result, the SHU sweeps in a wide swath of prisoners, including those uniquely vulnerable to conditions of extreme isolation, such as juveniles, the elderly, and people with mental illness or substance abuse issues. This same discretion permits bias to corrupt the disciplinary process, as suggested by the disproportionate number of black prisoners in the SHU.

Nearly 2,000 people in New York are released directly from extreme isolation to the streets each year. Prisoners in extreme isolation receive no educational, vocational, rehabilitative or transitional programming.

Corrections officials can separate and remove violent or vulnerable prisoners from the general prison population without subjecting them to the punishing physical and psychological deprivation of extreme isolation.

Extreme isolation harms prisoners and corrections staff. Extreme isolation causes emotional and psychological harm, inducing apathy, lethargy, anxiety, depression, despair, rage and uncontrollable impulses, even among the healthy and mentally stable. For the vulnerable, particularly those with mental illness, extreme isolation can be devastating and potentially life-threatening. The emotional and psychological harm prisoners experience in extreme isolation is compounded by the formal and informal deprivation of basic necessities, including food, exercise and basic hygiene. Prisoners buckling under the emotional and psychological weight of isolation and deprivation often lack access to adequate medical and mental health care. For corrections staff, working in extreme isolation has lasting negative consequences that affect their lives at work and home.

Extreme isolation negatively impacts prison and community safety. People in extreme isolation find its psychological effects fuel unpredictable and sometimes violent outbursts. These outbursts endanger the prisoners

themselves, as well as other prisoners and corrections staff, who have few resources to manage prisoners struggling under the toll of extreme isolation. Prisoners with mental health issues fare even worse, some resorting to self-harm and suicide. Prisoners carry the effects of extreme isolation back into the general prison population. They also carry them home. Nearly 2,000 people in New York are released directly from extreme isolation to the streets each year.[8] While in the SHU, prisoners receive no educational, vocational, rehabilitative or transitional programming, leaving them less prepared to successfully rejoin society.

Quick Guide to Boxed In

Section I, *The Box*, provides an introduction to extreme isolation, explains why the NYCLU undertook its investigation of extreme isolation in New York prisons and describes the report's methodology.

Section II, *Building the Box*, recounts New York's history with extreme isolation and the factors that drove and enabled its modern resurgence.

Section III, *Box Hits*, describes DOCCS' process for placing prisoners in extreme isolation and provides a demographic and statistical overview of who serves time in extreme isolation, for what reasons, and for how long.

Section IV, *Life in the Box*, provides first-hand accounts of prisoners, corrections staff and family members regarding their respective experiences living, working and supporting loved ones in extreme isolation.

Section V, *Thinking Outside the Box*, outlines the NYCLU's findings, discusses recent reforms in other states, describes an emerging consensus among international human rights bodies and legal scholars critiquing extreme isolation and advocates for evidence-based practices that would end the use of extreme isolation in New York prisons. ■

RECOMMENDATIONS

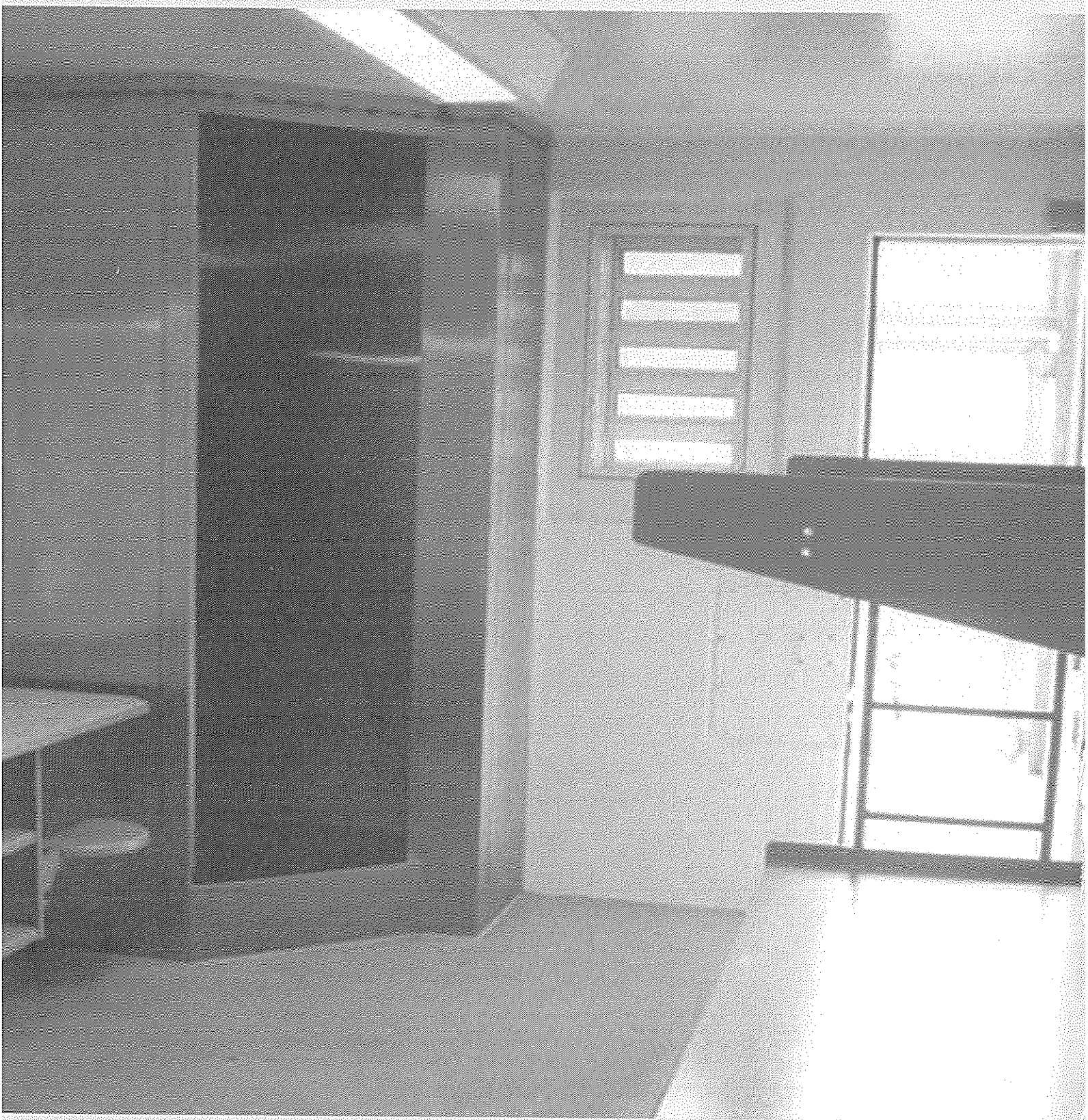
New York's arbitrary, inhumane and unsafe use of extreme isolation has led to an urgent human rights crisis. Extreme isolation is not synonymous with prisoner separation, which has long been an accepted corrections practice. Corrections officials can separate and remove violent or vulnerable prisoners from the general prison population without subjecting them to the punishing physical and psychological deprivation of extreme isolation – a point of consensus among corrections officials in other states, legal scholars and international human rights bodies.

New York must end its use of extreme isolation by:

(1) adopting stringent criteria, protocols and safeguards for separating violent or vulnerable prisoners, to ensure that prisoners are separated only in limited and legitimate circumstances for the briefest period and under the least restrictive conditions practicable; and

(2) auditing the current population in extreme isolation to identify people who should not be in the SHU, transitioning them back to the general prison population and reducing the number of SHU beds accordingly.

These steps will align New York's prisons with smart and effective evidence-based corrections practices. They will improve the safety of our prisons and communities, bring New York into compliance with international human rights law and emerging legal standards, and reaffirm our commitment to respecting basic human dignity.



A typical special housing unit (SHU) cell for two prisoners, in use at Upstate Correctional Facility and SHU 200s in New York. "New Concept in Disciplinary Housing: Upstate," DOCS Today, Apr. 2003, 15.

I. THE BOX

Introduction

On September 5, 2015, Adrian* will return home after spending more than 1,600 consecutive days in a room the size of a typical elevator. Adrian lives in the "Special Housing Unit" (SHU) at Southport Correctional Facility, located in Pine City, an hour outside of Ithaca. Since his arrival there in February 2011, Adrian has spent 23 to 24 hours a day alone, inside the Box. His one hour outside the Box is in a fenced-in recreation pen, smaller than Adrian's cell, which prisoners and staff alike call a human kennel. Inside the kennel, Adrian can glimpse the sky through heavy metal grates and hear the din of other isolated inmates.

On his cell wall, the 26-year-old has taped a newspaper photo of an executive's corner office, with glass walls and city views. Adrian dreams of the life he will live outside, but in the SHU, he does not have access to educational programs or vocational training. When Adrian nears his release, he will receive no transitional services to prepare for his re-entry to society. Like nearly 2,000 other New York prisoners each year, Adrian will be released from extreme isolation directly to the street.

Like most people who end up in the SHU, Adrian was placed in extreme isolation as punishment. Because Adrian has received additional SHU time for disciplinary infractions committed while at Southport, his original two-year SHU sentence has been extended to nearly five.

Adrian is already serving the rest of his sentence in extreme isolation, so if he's found to break a rule – like talking back or refusing to return a food tray – punishment with additional SHU time is meaningless. Instead, corrections officials may punish Adrian with food, by placing him on "the loaf," a hard, tasteless brick of bread-and-vegetable matter served with water and a wedge of raw cabbage three times a day.

But corrections officers (COs) also use food to punish Adrian informally. His meals have arrived covered with hair or spoiled. Sometimes meals don't come at all, an occurrence that happens so often that prisoners have a name for it: a "drive-by." COs "drive-by" Adrian's cell without delivering his meal, or leave a covered tray with no food beneath the cover. Adrian has quickly learned that in the Box, little can be taken for granted.

***

On May 16, 2012, Marcus marked his 120th day in extreme isolation at Upstate Correctional Facility, in Malone, a town on the Canadian border. Inside a concrete cell about the size of a parking space, the 22-year-old spent 23 hours a day locked down with another prisoner.

For four months, Marcus had little human contact beyond his cellmate. The two men urinated and defecated in clear view of each other. They showered in an open steel cabinet in the corner of the cell. Water flowed three times a week, for 15 minutes. Both men stripped down and washed in sequence: One stepped out, dripping onto the concrete floor, as the other stepped in, all before the clock ran out.

Like Adrian, Marcus received an hour a day of recreation. At the beginning of the hour, a metal door at one end of the cell, controlled remotely by prison guards, swung open. Marcus could step out into a rec pen, where he could hear and see other isolated prisoners in their rec pens – shouting, cursing, babbling – until the rec doors clamped shut.

Marcus was sent to the Box for misbehavior in the general prison population: tattooing his own hands (a broken star, with his initials at the center), smoking in the bathroom, failing to report for work duty and visiting another prisoner's dormitory.

*Prisoners are represented by pseudonyms to protect individual privacy and safety.

Soon after he arrived at Upstate, Marcus began to notice changes in himself: Anxiety and depression that suddenly shifted into uncontrollable bursts of aggression and violence that he took out on his cellmate. Impulses to *do something*. But extreme isolation means doing nothing. By design, extreme isolation affords no opportunity to take classes, learn a trade or otherwise prepare for life after prison. Instead, Marcus and his cellmate spent their days pacing, sleeping, reading, writing. Always, waiting. Waiting for time to run out; waiting to leave the Box.

***

Malone native Dan Benware worked for a quarter-century as a DOCCS corrections counselor. In his last decade on the job, Benware, trained as a social worker, witnessed the dramatic increase in New York's use of extreme isolation. He saw the effects on prisoners he counseled who returned from extreme isolation to the general prison population: men who were broken, filled with uncontrollable rage or who had succumbed to deep depression.

Extreme isolation means doing nothing: No opportunity to take classes, learn a trade or otherwise prepare for life after prison.

Benware also saw the effects of extreme isolation on his close friends and neighbors, the men and women who worked at Upstate. Prisoners' responses to extreme isolation frequently boiled over into violent hostility and erratic behavior; mental illness flourished. COs at Upstate felt as cooped-up as the prisoners they guarded. Although the state expected COs to manage prisoners in extreme isolation – many with mental illness or histories of substance abuse – most COs were hired with only a high school diploma or GED. For many, Benware says, what they did and saw inside the prison affected their personal lives and their families.

Monsignor Dennis Duprey, pastor of St. Peter's Church in Plattsburgh, served as Upstate's chaplain from the day it opened in 1998 until 2003. He knows the toll that extreme isolation takes on COs: "A system that asks COs to walk into a place for eight hours a day at a minimum, where the people they look after ... do not trust a single word they say, or a single action they do – that's not a wonderful way to conduct human relationships. When they go home, officers have trouble with their own relationships, with their sons and daughters; they treat them like inmates."

"When it comes to human beings, we are keeping them in cages that wouldn't be fit for our cows... It doesn't take half a brain to realize, we're not going to get a good product out of this. It's a Holocaust in our own backyard that few people know about."

Both Benware and Duprey understand that violent and vulnerable prisoners must be separated from others. But both men say that separating prisoners does not have to entail extreme isolation. They are baffled that thousands of prisoners, men like Marcus and Adrian, have been placed in the SHU for breaking minor prison rules, drug-related infractions or routine scuffles in the prison yard. These infractions merit a response, to be sure, but a response that is proportional to the offense.

"Where we live, it's a large farming community," Benware said. "We have laws on the books against cattle being confined to these huge, huge barns. The Department of Agriculture watches for that type of abuse. ... Yet when it comes to human beings, we are keeping them in cages that wouldn't be fit for our cows.

"It's a strange parallel, but anybody that's locked in like that, for those extended times, it doesn't take half a brain to realize, we're not going to get a good product out of this. It's a Holocaust in our own backyard that few people know about and, among those that do, we acknowledge and say 'ok.' But it doesn't work and it's inhumane."

***

Lynn Finley knows firsthand what Benware and Duprey are talking about. Her son spent five months in extreme isolation at Upstate after he was discovered taking medication, prescribed during a pre-incarceration detox program, without official authorization. Depressed and "hopeless" in extreme isolation, Finley said, her son's despair turned into constant hyper-alertness and overwhelming anxiety.

Finley has only one child. Yet on the occasions when she was able to travel the four hours from her home in Albany to Upstate, she barely recognized her son. He lost 30 pounds in the SHU, Finley said.

His hands cuffed and secured to a waist chain, Finley's son and the other prisoners were brought by COs to the visiting room. Each man was placed in a numbered cage, physically separated from his visitor. Inside each cage, small slots at table height allow enough room for a vending-machine food packet or a hand-clasp, no more.

The negative effects of the SHU persisted after her son returned to the general prison population.

"He's emotionally damaged," Finley said, adding that her son was terrified of being with other prisoners and terrified of returning to the Box.

"[My son] had a serious addiction problem and he was trying to treat it," Finley said. "Instead of facilitating his recovery, the prison system punished him severely with extreme isolation. It's absolutely baffling, and one of the hardest things I've had to witness as a mother."

***

These five stories are representative of the tens of thousands of human lives marked by extreme isolation each year in New York. Prisoners experience the daily effects of extreme isolation and its indelible consequences. Corrections staff, who must manage the anxiety, anger and mental illness of men in extreme isolation, endure consequences in their personal and professional lives. Family members on the outside, unable to readily communicate or support their loved ones in isolation, also undergo a particular kind of punishment, imposed on the innocent. New Yorkers collectively bear the expense of the hundreds of millions of dollars it costs to incarcerate people in extreme isolation and we all live in the communities that prisoners will return to when they are released. The NYCLU undertook this study to document the true costs – for all of us – of New York's use of extreme isolation.

Prying the Box Open

What occurs behind prison walls is murky. What occurs inside a "prison within a prison," as many describe New York's SHUs, is murkier still. The NYCLU produced this report to ensure that all New Yorkers, including policymakers and corrections officials, have information regarding the use and effects of extreme isolation in New York prisons.

From September 2011 to October 2012, the NYCLU conducted an intensive year-long investigation of the social, economic and human costs of extreme isolation in New York prisons. To understand those costs, the NYCLU relied on a variety of quantitative and qualitative sources of information.

First, the NYCLU communicated with more than 100 prisoners. Most were housed at Southport and Upstate Correctional Facilities, although the NYCLU also communicated with prisoners isolated in other SHUs across the state.[†]

[†] Where prisoners' letters are quoted, they are quoted verbatim, with spelling and grammatical errors intact. Below are the pseudonyms of prisoners quoted throughout the report and the SHU facilities where they were housed during the course of the NYCLU's investigation; some have been in both facilities, over time.

Upstate	Southport
Chris, Miguel, Daniel, Marcus, Kevin, Samuel, Donell, Daryl	Adrian, Trevor, Tevin, Na'im, Stephan, Justin, Hector

See It Online:
Correspondence from prisoners in extreme isolation is available online at **www.nyclu.org/boxedin.**

Second, the NYCLU consulted with lawyers and mental health professionals with experience representing prisoners in extreme isolation in New York. We also reviewed DOCCS' regulations and policies and researched applicable law and legal standards. The NYCLU also consulted with attorneys and academic experts on the use of extreme isolation in other parts of the country, including states that have significantly reformed their use of extreme isolation.

Over the last two decades, New York has employed extreme isolation on a massive and unprecedented scale.

Third, the NYCLU interviewed corrections employees regarding their perspectives on the use of extreme isolation and its impact on their working environment. The NYCLU also spoke with family members and friends of those in extreme isolation who described the toll of isolated confinement on themselves and their loved ones.

Finally, under the New York Freedom of Information Law (FOIL), the NYCLU obtained thousands of pages of records from DOCCS and the Office of Mental Health (OMH). These records include statistical information regarding DOCCS' use of extreme isolation, as well as prisoners' disciplinary and mental health histories.

See It Online:
Documents obtained by the NYCLU from DOCCS and OMH are available online at
www.nyclu.org/boxedin.

Extreme isolation reaches across a broad range of institutional settings in New York: a pre-trial detainee on Rikers Island,[9] a teenager in a juvenile detention facility,[10] a person serving a 10-year prison sentence or an immigrant in a federal detention facility[11] all may be subjected to extreme isolation. This report focuses on the population in New York most frequently subjected to extreme isolation: men in the state prison system.[12]

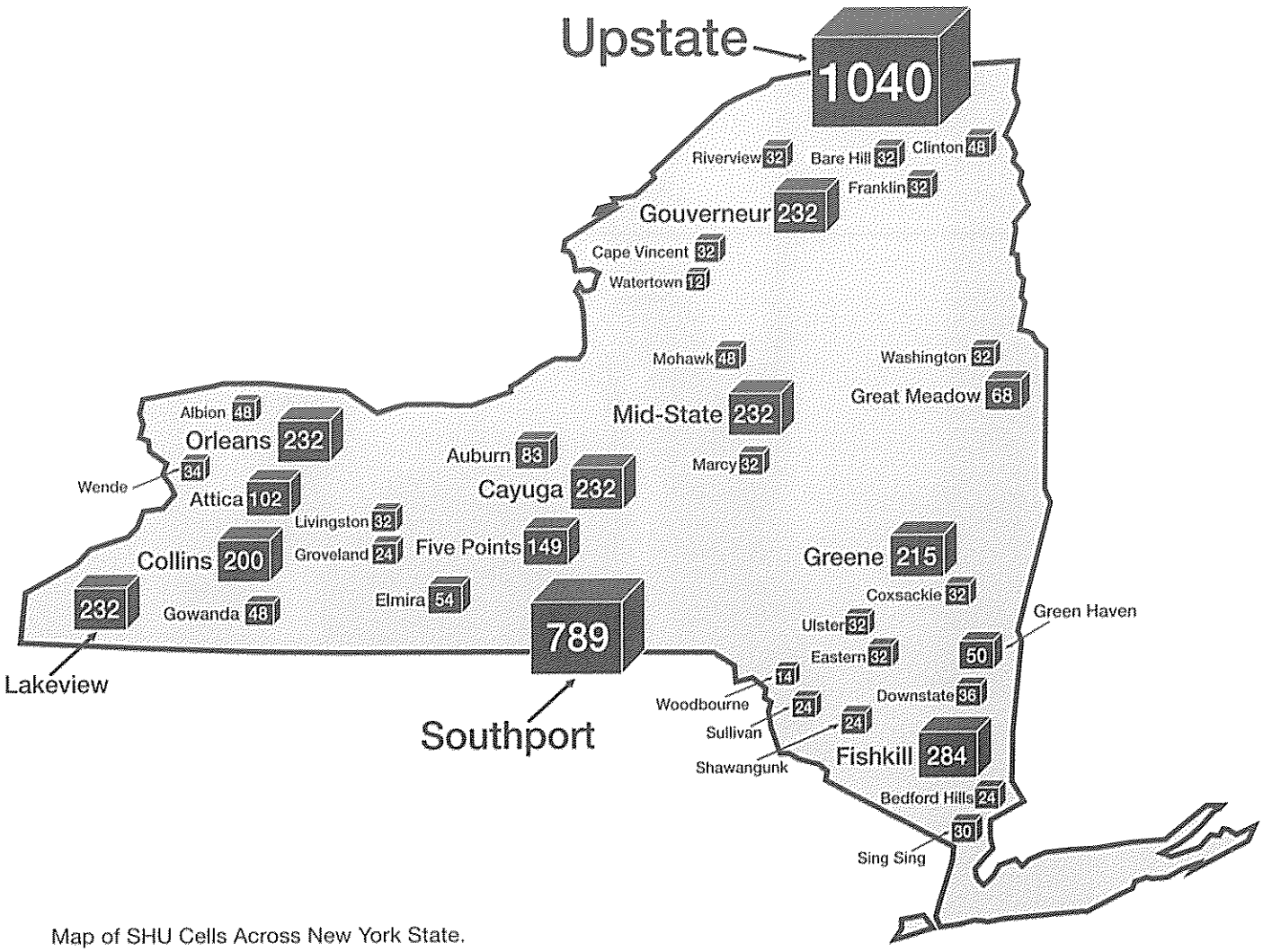
While this report does not explore the use of extreme isolation in other New York detention settings, all facilities that employ extreme isolation share a common purpose: to cut the individual off from all meaningful human contact and mental stimulation. The effects of extreme isolation are constant despite superficial differences in the physical environment or the particular label an institution uses for its brand of extreme isolation. Accordingly, this report's findings and conclusions about extreme isolation in New York prisons apply broadly to all detention settings in New York.

What happens in the Box is far from clear. The NYCLU's inquiry was limited by this lack of transparency as well as DOCCS' reluctance to provide factual information sought by the NYCLU during our investigation.[13] This study relies on statistics and anecdotes, hard numbers and personal experiences. But it is not a comprehensive, technical accounting of every aspect of extreme isolation in New York. Ultimately, this study is an educated glimpse inside the Box. It has answered some questions; many persist.

New York's Boxes

New York's SHU cells are located in dedicated extreme isolation facilities and in designated buildings or cellblocks on the grounds of New York's minimum-, medium- and maximum-security prisons. New York has two dedicated SHU facilities – Southport, which contains 789 SHU beds, and Upstate, which contains 1,040 SHU beds. In addition, New York has eight designated SHU buildings (SHU 200s) located on the grounds of medium-security prisons, which each have 200 SHU beds. More than 70 percent of the prisoners in the SHU are concentrated at Southport,

Map of Extreme Isolation Beds Across New York State



Map of SHU Cells Across New York State.

"DOCCS Daily Population Capacity Report – 06/11/12," obtained through FOIL and on file with the NYCLU.

Upstate and the SHU 200s. Finally, 29 additional minimum-, medium- and maximum-security prisons have SHU cellblocks or SHU beds separated from the general prison population.[14]

The extreme isolation of prisoners such as Marcus and Adrian may vary slightly but is fundamentally identical in most meaningful aspects. They are physically confined to a cell for 23 to 24 hours a day. They receive their meals through their cell door. They may recreate for one hour a day in a small cage, no larger than their cell, enclosed by concrete walls or heavy metal grating. They receive no educational, vocational or rehabilitative programming, and no transitional services to help them prepare for their return to society – even when they are soon to be released. Their personal possessions are strictly limited to legal materials and a few personal books and magazines. They are handcuffed and escorted by corrections officers every time they exit their cells, which may not be for weeks or months.

Subjecting prisoners to extreme isolation raises serious moral, social, penological and economic concerns. Over the last two decades, New York has employed extreme isolation on a massive and unprecedented scale. How New York arrived at this state of affairs is explored in **Section II**, *Building the Box*. ■

II. BUILDING THE BOX

The Early Life and Death of Extreme Isolation

From 1821 to 1823, New York's Auburn state prison experimented with extreme isolation, housing a group of prisoners in individual cells "without any labor or other adequate provisions for physical exercise."[15] Alexis de Tocqueville and Gustave de Beaumont, who toured Auburn during this period, reported:

> This trial, from which so happy a result had been anticipated, was fatal to the greater part of the convicts: in order to reform them, they had been submitted to complete isolation; but this absolute solitude, if nothing interrupt it, is beyond the strength of man; it destroys the criminal without intermission and without pity; it does not reform, it kills. The unfortunates, upon whom this experiment was made, fell into a state of depression, so manifest, that their keepers were struck with it; their lives seemed in danger, if they remained longer in this situation.

Both Beaumont and Tocqueville also challenged the idea that extreme isolation could aid rehabilitative efforts, noting that "this system, fatal to the health of the criminals, was likewise inefficient in producing their reform." The governor of New York subsequently pardoned 26 of those subjected to the experiment, 14 of whom "returned after a short time after into the prison, in consequence of new offences."[16]

"A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition... others became violently insane; others still, committed suicide; ... [those who stood the ordeal better] did not recover sufficient mental activity to be of any subsequent service to the community."

A handful of other states also experimented with extreme isolation only to quickly reject the practice.[17] In 1890, the Supreme Court surveyed the history of extreme isolation and concluded that "experience demonstrated that there were serious objections to it." In particular, the court described devastating psychological effects:

> A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.[18]

By the turn of the 20th century, extreme isolation had largely ceased to be a significant feature of incarceration in America.[19]

The Resurrection of Extreme Isolation in the United States

On October 22, 1983, prisoners at the United States Penitentiary (USP) in Marion, Ill., a federal correctional facility, killed two corrections officers in separate incidents. The warden declared a state of emergency and placed USP Marion on permanent lockdown status. For the next 23 years, all prisoners incarcerated at USP Marion were confined to their cells for 23 hours a day.[20]

The lockdown at USP Marion prompted many states to construct or repurpose freestanding facilities entirely devoted to the extreme isolation of prisoners.[21] By 1991, Human Rights Watch reported that 36 states, including New York, had constructed or repurposed facilities emulating USP Marion, while demonstrating "creativ[ity] ... in making the

conditions particularly difficult to bear, at times surpassing the original model."[22] Today, at least 44 states have such freestanding "supermax" facilities housing approximately 25,000 prisoners.[23]

Many states also expanded the number of extreme isolation units within lower-security facilities.[24] Given these varied housing arrangements, obtaining an accurate count of all prisoners confined to extreme isolation has proven elusive. In 2006, the Commission on Safety and Abuse in America's Prisons, a bipartisan committee of experts, reported that the figure provided by the U.S. Department of Justice in 2000 – approximately 80,000 – was "just a fraction of the state and federal prisoners who spend weeks or months in expensive, high-security control units [within lower-security facilities] over the course of a year, and it does not capture everyone incarcerated in supermax prisons."[25]

Beginning in the 1970s, American penal culture and policy witnessed the birth of a newly punitive climate and the rejection of rehabilitation as a major goal of incarceration.

Why were so many states eager to embrace the USP Marion model? The rate of incarceration in the United States began to increase dramatically in the early 1970s. From 1973 to 1993, the U.S. prison population increased by 346 percent, from roughly 204,000 to 909,000.[26] This extraordinary growth put tremendous pressure on correctional systems, which began to experience overcrowding and attendant management and control problems.[27]

Beginning in the 1970s, American penal culture and policy also began undergoing dramatic changes that helped support the expansion of extreme isolation. This period witnessed the birth of a newly punitive climate and the rejection of rehabilitation as a major goal of incarceration.[28] The construction and operation of extreme isolation facilities became "politically and publicly attractive" – potent "symbols of how 'tough' a jurisdiction has become."[29] And a new rhetoric about prisoners, and the need to house them in extreme isolation, began to emerge. Prison officials depicted a "new 'dangerous' prisoner," one "more violent, more disturbed, more disruptive" – "the worst of the worst" – that had to be separated from the general prison population.[30]

Such rhetoric was seldom supported by hard evidence. From the outset, policymakers failed to examine the link between the exponential increase in the prison population and violence – and to scrutinize whether extreme isolation was an effective response to such violence. Corrections systems failed to establish effective tracking mechanisms to analyze the efficacy of extreme isolation, exemplified by the lack of basic data on how many prisoners are even placed in such conditions. And political officials, who funneled millions to expand the use of extreme isolation, failed to consider the net costs to society when prisoners subjected to these conditions returned home. The vast majority of state prisoners do return to society; at least 95 percent will eventually be released.[31]

New York Embraces Extreme Isolation

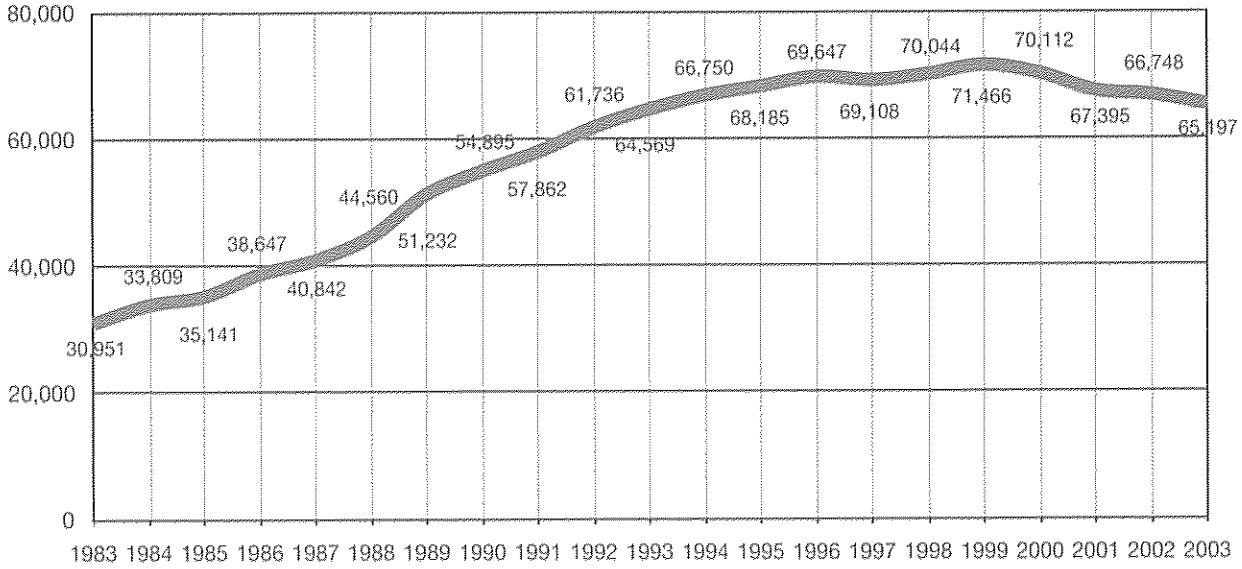
New York epitomized the modern trend to expand extreme isolation. In 1991, the state converted Southport Correctional Facility, a maximum-security prison opened in 1988, into a dedicated extreme isolation facility. Southport was transformed from a prison that "offered extensive classes and clean hallways" to one where prisoners are "kept isolated, shackled at the waist and wrists when allowed out of their 6-by-10 cells and made to spend their daily recreation hour in newly built cages." As part of its conversion, Southport "ended its vocational and academic classes" and emptied its "instructional wing ... of chairs, tables, chalkboards," which were sent to other correctional facilities.[32]

Prior to Southport's conversion, New York used designated cellblocks in lower-security facilities to place prisoners in extreme isolation.[33] Southport was the first facility dedicated solely to housing prisoners in these conditions.

Between 1998 and 2000, New York constructed 10 additional facilities dedicated to extreme isolation, with the combined capacity to house approximately 3,000 prisoners.[34] Nine of these facilities were free-standing buildings – called SHU 200s – located on the grounds of pre-existing medium-security correctional facilities.[35] Each SHU 200

Growth in New York State Prison Population

Number of prisoners from 1983-2003



By the mid-1990s, New York's prisons were filled to 130 percent of their capacity. Statewide, the prison population, less than 31,000 in 1983, more than doubled by 1999, when more than 71,000 people were incarcerated in New York prisons.

Inmates Under Custody at End of Calendar Year: New York State Department of Correctional Services 1950-2003, Correctional Association of News York, Mar. 2012.

consisted of 100 double-occupancy cells. The 10th facility was Upstate Correctional Facility, a stand-alone prison with the capacity to house 1,200 prisoners in 600 double-occupancy cells.[36]

Many of the same factors underlying the national movement toward extreme isolation were in play in New York. Throughout the 1980s and 1990s, New York prisons experienced the growing pressures of overcrowding. In 1983, when USP Marion entered permanent lockdown, New York's prison population was 30,951. By 1990, it was 54,895, and by 1999, it had reached a historic high of 71,466.[37]

Even as New York's use of extreme isolation was dramatically expanding, a robust body of scientific evidence had already linked extreme isolation with grave personal harm.

Non-violent drug offenders made up a large percentage of newly admitted prisoners. The Rockefeller Drug Laws – a program of mandatory minimum sentences for drug offenses enacted in 1973 – coupled with intensified street drug enforcement from the mid-1980s to the 1990s, led to a growing tide of drug commitments to state prison.[38] Annual drug commitments, which totaled 886 in 1980, surged to a high of 11,209 in 1992, and remained above 8,000 until 2000. These commitments constituted approximately 45 percent of total state prison system commitments from 1989 until 2000.[39]

SHU SYNDROME

Studies have demonstrated that in otherwise healthy and mentally stable individuals, adverse psychological effects manifest even after short, defined periods in extreme isolation. In the mid-1980s, psychiatrist Stuart Grassian studied a group of prisoners living in extreme isolation in the "Special Housing Unit" (SHU) of a Massachusetts prison. He identified a variety of negative physiological and psychological symptoms, which he called "SHU syndrome," exhibited by these prisoners. These symptoms included social withdrawal; anxiety and nervousness; panic attacks; irrational anger and rage; loss of impulse control; paranoia; hypersensitivity to external stimuli; severe and chronic depression; difficulties with thinking, concentration and memory; and perceptual distortions, illusions and hallucinations.[46] Other studies have documented similar responses by prisoners housed in extreme isolation.[47] For people with pre-existing mental health issues, studies have demonstrated that extreme isolation can be devastating and result in further mental deterioration.[48]

In the mid-1990s, New York also began punishing violent offenders with harsher sentences. In 1995, Governor George Pataki successfully ushered passage of legislation increasing sentences for violent offenders and abolishing parole for individuals convicted of a second violent offense.[40] Three years later, Pataki steered a bill through the Legislature abolishing parole for individuals convicted of a first violent offense.[41] Thus, as the population of non-violent drug offenders continued to swell, New York also began imposing much longer sentences for violent offenses. By the mid-1990s, New York prisons were filled to "130 percent of their capacity."[42]

The relationship between harsher sentencing and the construction of extreme isolation beds in New York reflected the national embrace of the punitive penological model. In 1994, Congress passed the Violent Crime Control and Law Enforcement Act, which staked federal funds to states for new prisons in return for enacting laws eliminating parole for violent offenders.[43] In 1998, the United States General Accounting Office documented the influence of federal grants on states' decisions to abolish parole for violent offenders; the grants were a "key factor" in passing such legislation in New York.[44] Between 1996 and 2000, New York received nearly $200 million in federal funding to construct Upstate and the SHU 200s, which cost roughly $238 million in total to build.[45]

Judicial Oversight and the Expansion of Extreme Isolation

Even as New York's use of extreme isolation was dramatically expanding, a robust body of scientific evidence had already linked extreme isolation with grave personal harm. But New York continued to embrace and sustain its use of extreme isolation, even in the face of this evidence.

In these circumstances, our system of government provides that individuals can turn to the courts to ensure that executive and legislative action does not violate fundamental constitutional rights. Indeed, the Supreme Court has affirmed that "[c]onfinement in … an isolation cell is a form of punishment subject to scrutiny under Eighth Amendment standards."[49] And yet, courts presented with evidence of prisoner suffering and trauma in extreme isolation have, for the most part, been unable or unwilling to effectively apply that scrutiny to constrain its use.

By the turn of the 21st century, New York had constructed a massive network of extreme isolation cells.

Several factors have impeded meaningful judicial review of extreme isolation. Beginning in the 1980s, the Supreme Court issued a series of rulings instructing lower courts to grant enormous deference to executive officials operating corrections systems.[50] At the same time, the Court began requiring prisoners to meet difficult thresholds to prove constitutional violations. With respect to claims challenging conditions of confinement under the Eighth Amendment, the Court has established an elusive

standard.[51] Finally, prisoners seeking to challenge conditions of confinement in federal courts face significant procedural and legal obstacles under the Prison Litigation Reform Act, enacted by Congress in 1996.[52] To date, the few federal courts that have held extreme isolation to violate the Eighth Amendment have narrowly restricted their holdings to those prisoners with serious pre-existing mental illness or who are prone to suffering severe mental injury.[53]

By the turn of the 21st century, New York had constructed a massive network of extreme isolation cells. This expansion was driven by a misguided response to prison overcrowding, fanned by political rhetoric, untethered to evidence-based analyses and largely unchecked by the courts. **Section III**, *Box Hits*, explores how DOCCS currently employs extreme isolation – who is subjected to extreme isolation, why and for how long. ■

III. BOX HITS

DOCCS separates prisoners for three reasons: to punish violations of prison rules (disciplinary segregation); to isolate prisoners who pose a threat to the safety and security of the prison (administrative segregation); and to shield vulnerable prisoners, such as those potentially targeted for violence in the general prison population (protective custody).[54]

The overwhelming majority of separated prisoners are placed in extreme isolation for breaking prison rules (disciplinary segregation). From 2007 to 2011, DOCCS placed prisoners in SHU cells more than 75,000 times; more than 68,100 – roughly 90 percent – of those placements were for disciplinary reasons.[55]

How Violations of Prison Rules Lead to Extreme Isolation

Individuals sentenced to prison enter a strictly regimented environment where they must conform to an elaborate set of rules. Corrections officials may discipline prisoners for violating these rules by levying a range of penalties, from a simple reprimand to the progressive deprivation of privileges. In New York, the violation of many rules – from the minor and non-violent to the disruptive and violent – may also result in a "sentence" of extreme isolation (what prisoners call a "Box hit") to one of New York's roughly 5,000 SHU beds.

DOCCS regulations contain the "Standards of Inmate Behavior," a list of more than 100 rules prisoners must obey. These rules govern every aspect of prisoner behavior, from personal grooming ("an inmate shall not grow a beard or mustache over one inch in length") and eating ("an inmate shall not waste food items") to intellectual stimulus ("an inmate shall not possess literature or any other material which has been disapproved by the Media Review Committee") and personal interactions ("an inmate may not provide legal assistance to another inmate without prior approval of the superintendant").[56]

Particular rules operate as a disciplinary catch-all. For example, Rule 106.10 states: "An inmate shall obey all orders of department personnel promptly without argument."[57] Thus, even a momentary lapse in obedience can bring harsh consequences: Kevin once received 30 days of keeplock for violating Rule 106.10 after continuing a conversation with another prisoner after a corrections officer ordered him to stop.[58]

See It Online:
For the complete list of New York's prison rules, "Standards of Inmate Behavior," go to
www.nyclu.org/boxedin.

Whether a prisoner receives a punishment of extreme isolation for breaking a prison rule depends on three phases of DOCCS' disciplinary process, which determine: (1) the severity of an alleged rule infraction; (2) whether a prisoner is guilty of the rule infraction; and (3) whether a conviction warrants a punishment of extreme isolation. The operation of each of these phases often differs on paper and in practice.

KEEPLOCK IN ISOLATION

Prisoners may also experience extreme isolation as a result of being sentenced to "keeplock," a form of confinement that DOCCS imposes as punishment for less serious disciplinary infractions.[59] Keeplock subjects prisoners to 23-hour lockdown; the prisoner may remain confined to his ordinary cell within the general prison population or be transferred to a block of keeplock cells within the same facility. Prisoners sentenced to keeplock, however, may also be transferred to the SHU to serve their keeplock time, where they are subject to the same restrictions as those sentenced directly to the SHU.[60] From 2007 to 2011, DOCCS issued more than 136,500 keeplock sentences.[61] A January 2012 snapshot of the SHU population revealed that 428 prisoners – roughly 10 percent – were serving their keeplock time in the SHU.[62]

Determining the Severity of an Alleged Rule Infraction

DOCCS regulations describe how corrections staff should respond to rule infractions. When staff believe a prisoner has committed a rule infraction for conduct "involving danger to life, health, security or property," they are directed to submit a "misbehavior report" initiating a formal disciplinary process.[63] DOCCS regulations counsel against submitting misbehavior reports for "minor infractions, or other violations of rules and policies governing inmate misbehavior, that do not involve danger to life, health, security or property." Rather, DOCCS instructs staff to respond to such misbehavior "by counseling, warning, and/or reprimanding the inmate."[64]

Each misbehavior report contains a description of the alleged incident and a citation to the rule(s) allegedly violated.[65] A "review officer" at each correctional facility reviews all misbehavior reports and determines the "tier rating" of the alleged rule infraction(s).[66] Every prison rule has a predetermined range of tier ratings that may be assigned to its infraction: (a) I to II, (b) II to III or (c) I to III. The review officer assigns a tier rating from this predetermined range based on the severity of the infraction. The tier rating then determines the type of hearing afforded the prisoner and the range of potential penalties the prisoner may receive if convicted at hearing. (See centerfold, page 30, for an example of the tier rating process.)

Tier I infractions are the least serious; tier III infractions are the most serious. A prisoner convicted of an infraction assigned a tier II rating may receive a sentence to keeplock, which can be served in the SHU.[67] A prisoner convicted of an infraction assigned a tier III rating may receive a sentence to keeplock or the SHU.[68] Thus, infractions assigned either a tier II or III rating may ultimately result in a punishment of extreme isolation. Since every rule has multiple tier ratings, any rule infraction may potentially result in a punishment of extreme isolation – whether a prisoner is housed in a minimum-, medium- or maximum-security facility.

Any rule infraction may potentially result in a punishment of extreme isolation – whether a prisoner is housed in a minimum-, medium- or maximum-security facility.

DOCCS regulations suggest that review officers assign tier I ratings to less serious infractions and tier III ratings to the most serious. Yet DOCCS provides no mandatory standards and little detailed guidance on how review officers should assign tier ratings to infractions in practice. Rather, DOCCS has chosen to vest corrections officials with wide discretion in assigning tier ratings. As a result, DOCCS permits corrections officials to assign tier II and III ratings to alleged infractions that involve non-violent misbehavior.

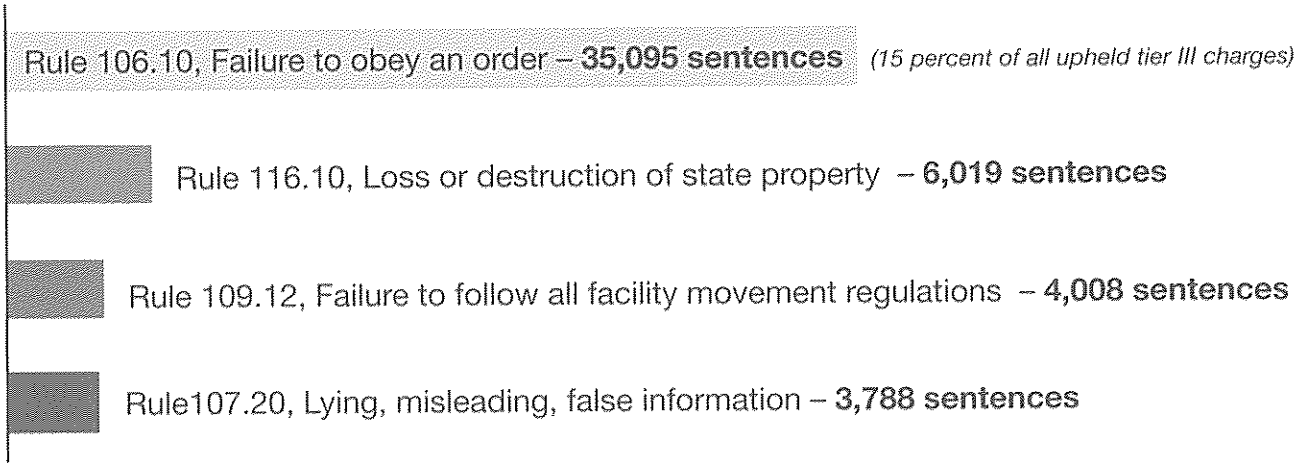
DOCCS has described tier III ratings as reserved "for the most serious offenses, such as assaults on staff or other inmates."[69] But many rules proscribing non-violent misbehavior have potential tier ratings of III. For example, consider Rules 106.10 ("an inmate shall obey all orders of department personnel promptly and without argument"), 116.10 ("an inmate shall not lose, destroy, steal, misuse, damage or waste any type of State property"), 109.12 ("an inmate shall follow all facility regulations and staff directions relating to movement within the facility") and 107.20 ("an inmate shall not lie or provide an incomplete, misleading and/or false statement or information").[70] Each of these rules prohibits non-violent misbehavior, yet all carry potential tier III ratings that could result in a punishment of extreme isolation.

In fact, DOCCS regularly assigns tier III ratings to these rule infractions in practice. From 2007 to 2011, DOCCS assigned tier III ratings to these rule infractions and upheld the charges at disciplinary hearing the following number of times: 106.10 – 35,095, 116.10 – 6,019, 109.12 – 4,008, and 107.20 – 3,788. The violation of Rule 106.10 alone constituted roughly 15 percent of all upheld tier III charges over this period.[71]

Determining Whether a Prisoner is Guilty of a Rule Infraction

A prisoner accused of a tier II or III rule infraction receives a formal disciplinary hearing. At the hearing, the prisoner, unaided by legal counsel, may respond to the charges and evidence, call (but not cross-examine) witnesses,

Upheld Tier III Infractions Leading to Extreme Isolation Sentences, 2007-2011



DOCCS tier ratings indicate the severity of infractions, which determines whether prisoners can be punished with extreme isolation. Some rules, like Rule 106.10 ("an inmate shall obey all orders"), seem to encompass a broad range of misbehavior and constitute a large subset of cited tier III infractions. From 2007 to 2011, infractions of Rule 106.10 accounted for 15 percent of all upheld tier III charges, reserved for the most serious infractions.

"DOCCS Disciplinary Charge File Analysis – Incidents Occurring between 01/01/2007 and 12/31/2011," obtained through FOIL and on file with the NYCLU.

and submit evidence or witness statements on his behalf.[72] Prisoners found guilty may appeal the conviction to the facility superintendent (tier II) or the commissioner (tier III).[73]

"My story was credible. I appealed ... to Albany. You can never beat a ticket. The disciplinary hearings are unfair ... [T]he hearing officers are friends with the COs." – Donell[1]

Disciplinary hearings often boil down to the testimony of a corrections officer against that of a prisoner.

In practice, disciplinary hearings often boil down to the testimony of a corrections officer against that of a prisoner. Hearing officers, who are themselves DOCCS employees, may credit the testimony of a CO over that of a prisoner.[74] From 2007 to 2011, DOCCS held more than 105,500 tier III disciplinary hearings. Nearly 100,000 – roughly 95 percent – of those hearings resulted in a conviction.[75] In many of the disciplinary dispositions that the NYCLU reviewed, hearing officers found prisoners guilty based solely on the misbehavior report and the CO's testimony while dismissing conflicting prisoner testimony.

"The hearing officer didn't listen to the facts ... I'm not wrong, but [they] find me guilty ... We are incarcerated for a crime. We are in here repaying that. We shouldn't be punished in here with unfairness." – Adrian

By placing greater weight on CO testimony than on prisoner testimony, DOCCS' disciplinary process risks erroneously convicting prisoners because of a CO's mistake or animus towards a particular prisoner. Indeed, many prisoners who spoke with the NYCLU identified instances where they insist they were erroneously convicted of a particular infraction, even as they took full responsibility for committing other infractions. Errors in the disciplinary

[1] Prisoners' communications are quoted verbatim (spelling and grammatical errors intact).

process have severe consequences in a system like New York's where a guilty conviction does not just result in a reprimand or a loss of privileges but may result in a sentence of extreme isolation.

Determining Whether a Conviction Warrants a Punishment of Extreme Isolation

If a prisoner is convicted of an infraction with a tier II or III rating, he may be punished with extreme isolation. Approximately 68 percent of tier III disciplinary hearings resulting in conviction also result in a sentence to the SHU.[76] As with tier ratings, DOCCS provides no mandatory standards and little detailed guidance on when corrections officials should punish convictions with extreme isolation. DOCCS guidelines recommend penalties for certain classes of offenses, but corrections officials are free to craft sentences according to mitigating or aggravating circumstances, such as the prisoner's prior record, the facility type and the nature of the infraction.[77] Therefore, DOCCS vests corrections officials with wide discretion to punish convictions for a broad range of misbehavior with extreme isolation.

> "My first ticket ever was for a fistfight in the yard. It was just a misunderstanding. I was a 20- year-old kid. It was my first time in a max facility and I was scared out of my mind. I got six months." – Kevin

DOCCS characterizes prisoners in extreme isolation as "disruptive, dangerous or violent," whose isolated confinement prevents their "assaulting inmates, attacking staff or endangering prison operations."[78] But in New York, people can be placed in extreme isolation for non-violent misbehavior or a single violent altercation – such as a fistfight in the recreation yard – despite no indication they are a serious threat to prison safety and security. Even DOCCS' highest authority, Commissioner Brian Fischer, has acknowledged extreme isolation's potential overuse.[79]

> DOCCS provides no mandatory standards and little detailed guidance on when corrections officials should punish convictions with extreme isolation.

DOCCS did not disclose exactly how many people are sent to the SHU for non-violent misbehavior. In December 2011, the NYCLU requested from DOCCS, through the New York Freedom of Information Law (FOIL), a breakdown of the specific infractions resulting in SHU time, which would have revealed the number of prisoners who receive SHU time for non-violent misbehavior. At the time this report went to print, nearly 10 months after the NYCLU's initial FOIL request and after repeated follow-up requests, DOCCS was still unable or unwilling to produce this information. DOCCS' inability to readily access or share data on the specific infractions that lead to SHU time suggests it is not closely tracking its use of extreme isolation – including who it subjects to extreme isolation, for what types of misbehavior, and for how long.

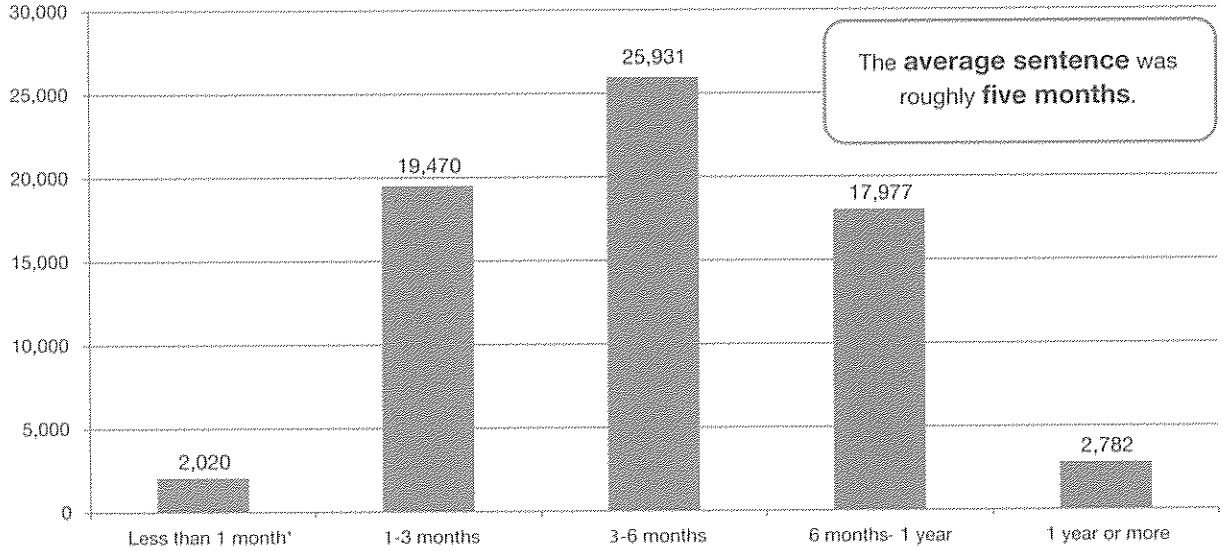
DOCCS was able to provide limited information on the broad categories of infractions resulting in SHU time. From 2007 to 2011, DOCCS held more than 68,000 tier III disciplinary hearings resulting in SHU sentences. Only 16 percent of those sentences were for infractions related to violent misbehavior, specifically assault and weapons.[80]

INCONSISTENT BOX HITS

The substantial discretion afforded corrections officials in crafting SHU sentences is exemplified by several instances uncovered by the NYCLU where prisoners received widely disparate SHU sentences, even when the underlying circumstances were substantively similar. For example, Chris received a four-and-a-half month SHU sentence for his first marijuana infraction; Trevor received a one-month keeplock sentence for the same offense. Chris, who received the longer sentence, had not received any prior misbehavior reports for violent conduct, whereas Trevor had received prior misbehavior reports for fighting. In another example, Kevin and Miguel, neither of whom had any prior misbehavior reports, were each involved in a fistfight at their respective prisons. Kevin received a six month SHU sentence; Miguel received a one month keeplock sentence.

New York Extreme Isolation Sentence Length

Total Sentences 2007-2011



From 2007 to 2011, DOCCS issued more than 68,100 SHU sentences. Of these, more than 20,700 – or roughly 30 percent – were for six months or longer.[81]

*"DOCCS Dispositions with SHU Sentences – 01/01/2007-12/31/2011: Length of SHU Sentence by Incident Year," obtained through FOIL and on file with the NYCLU.

Prisoners' experiences suggest the regularity with which DOCCS uses extreme isolation to punish non-violent misbehavior. According to DOCCS' disciplinary records, John received six months in the SHU after a CO discovered homemade alcohol and another person's television set in his cell. Chris received three months in the SHU after a CO discovered gambling chips and a list of prisoners who owed him chewing tobacco in his cell. Trevor received 45 days in the SHU for tattooing himself.

Drug-related infractions can often lead to sentences in extreme isolation.[82] From 2007 to 2011, DOCCS held more than 21,000 tier III disciplinary hearings resulting in SHU sentences for drug-related infractions. These hearings constituted roughly 23 percent of all tier III disciplinary hearings resulting in SHU sentences during this period.[83]

Roughly 90 percent of drug-related charges are assigned a tier III rating.[84] More than half of drug-related charges are for the violation of Rule 113.24, which prohibits prisoners from using or being "under the influence of any narcotics or controlled substances unless prescribed by a health service provider." In fact, the violation of Rule 113.24 was one of the top five most commonly upheld tier III charges from 2007 to 2011.[85]

> Prisoners in extreme isolation are offered virtually no resources to break the habits that may have brought them to the SHU or extended their SHU sentences.

DOCCS penalty guidelines specifically contemplate punishing prisoners with extreme isolation for alcohol and drug-related infractions – up to three months for a first offense, three to six months for a second offense, and six to 12 months for a third offense. Corrections officials may, however, impose longer sentences at their discretion.[86] Several prisoners that communicated with the NYCLU received SHU sentences that exceeded these recommendations,

THE UNENDING BOX HIT

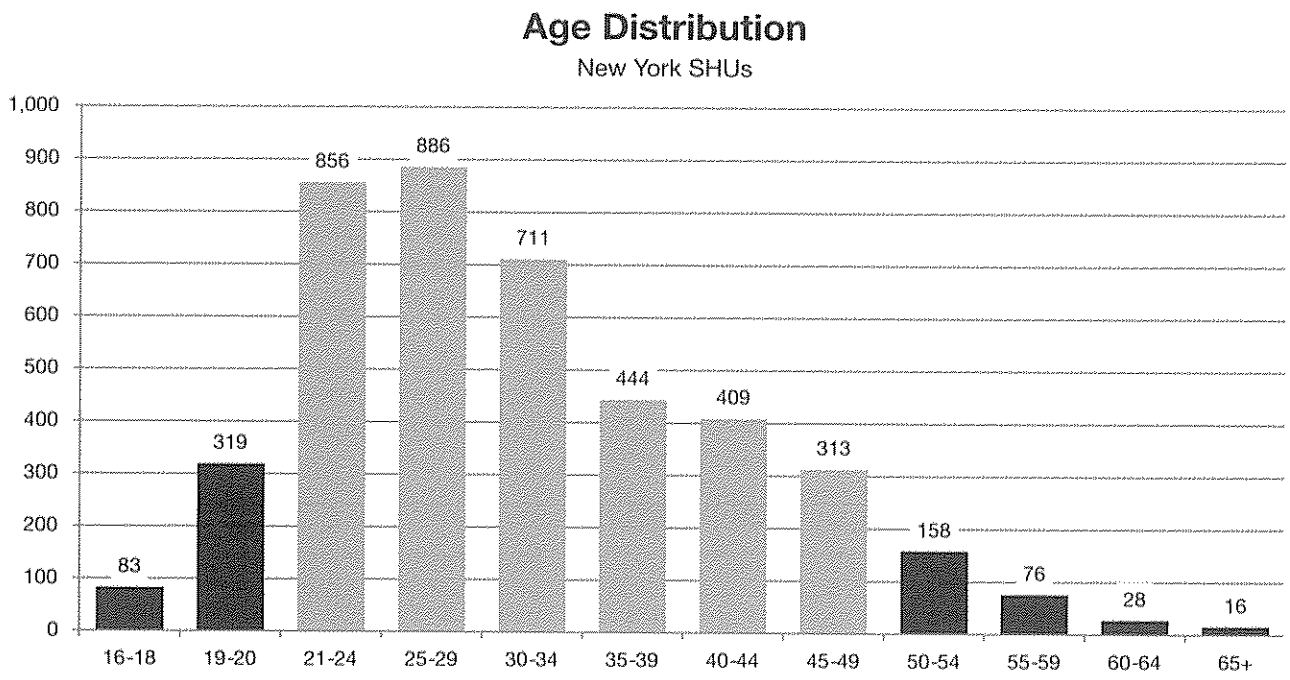
"Once you get to Southport, it's hard to get out. They keep us hostage." – Tevin

While DOCCS is quick to impose extreme isolation in response to misbehavior in the general prison population, additional punishment for misbehavior once a prisoner is in the SHU is even more swift and severe. Prisoners in extreme isolation can earn additional disciplinary sentences that keep them in the SHU far beyond their initial SHU sentence. DOCCS places no upper limit on the ultimate length of time that a prisoner may spend in extreme isolation.

Samuel has earned an additional two-and-a-half-years of SHU time since he arrived at Upstate, all for non-violent misbehavior. For refusing to hand his food tray back to a CO, for example, he received an additional six months in extreme isolation (see centerfold, page 30). Samuel is set to return to the general prison population in October 2012, more than four-and-a-half years after he first arrived at the facility. Donell has received an additional seven months of SHU time for two counts of "tampering with property": He received a SHU sentence of one month for returning a broken razor to a CO who was collecting used razors, and six months when garbage jammed his cell door.

even for their first drug infraction. For example, Chris received four-and-a-half months in the SHU for his first drug infraction after testing positive for marijuana.

As the guidelines recommend, prisoners found guilty of multiple drug infractions often receive increasingly longer SHU sentences. For example, Stephan, who received one month in the SHU for his first drug infraction



New York's SHUs house both very young and old prisoners, people that are particularly vulnerable to the harsh conditions of extreme isolation.[88] A January 2012 snapshot of the SHU population revealed that 402 prisoners were 20 or younger; 83 were 18 or younger. The snapshot further revealed that 278 prisoners were 50 or older – elderly, in prison demographics[89] -- including 44 who were 60 or older.[90] According to the snapshot, roughly 1-in-6 SHU prisoners was younger than 21 or older than 49.

"Age by Facility for Offenders Housed in SHU – DOCCS Under Custody Pop. Jan. 1, 2012," obtained through FOIL and on file with the NYCLU.

and three-and-a-half months for his second, received seven-and-a-half months for his third – all for testing positive for marijuana.

Prisoners in extreme isolation are offered virtually no resources to break the habits that may have brought them to the SHU or extended their SHU sentences. They may not participate in any programming, including substance abuse treatment. This prohibition holds true even if that prisoner was enrolled in a rehabilitative program, such as a substance abuse treatment program, in the general prison population when he committed the disciplinary infraction that led to SHU time.

> Bias may corrupt the disciplinary process that leads to sentences of extreme isolation.

When it comes to substance abuse, many prisoners report being able to obtain illegal and pharmaceutical drugs while in the SHU and many incur subsequent drug infractions while in the SHU. From 2007 to 2011, at Southport and Upstate alone, DOCCS upheld nearly 1,700 drug-related charges.[87]

Kevin, who received additional SHU time after testing positive for marijuana at Upstate, has requested substance abuse treatment to help him avoid future drug-related disciplinary infractions. In a letter to a corrections counselor, Kevin wrote:

> [T]his is my 4th dirty urine [and] it is evident that I have a real drug problem and need help (I've asked for help once before) and I firmly believe that by keeping me in "SHU" is not going to help in any way, it's only going to make matters worst for me. So if at all possible may you please help me! (I am sincerely begging you).

Consistent with similar observations by several prisoners about drug use in extreme isolation, Kevin noted that using drugs keeps him "out of trouble" in the SHU:

> It keeps me calm. Instead of thinking about the present, I reflect on family events, parties, family and friends. When I'm sober, I'm bored, aggravated, and miserable.

Who is in the Box?

The DOCCS disciplinary system grants corrections officials wide discretion to charge prisoners with infractions that can lead to extreme isolation, to rely on the word of a corrections officer over a prisoner during the disciplinary hearing and to punish convictions with lengthy sentences to extreme isolation. Not surprisingly, the demographic and statistical evidence illustrates that the SHU captures a wide swath of prisoners, including individuals uniquely vulnerable to conditions

Disability Advocates, Inc. Lawsuit and SHU Exclusion Law

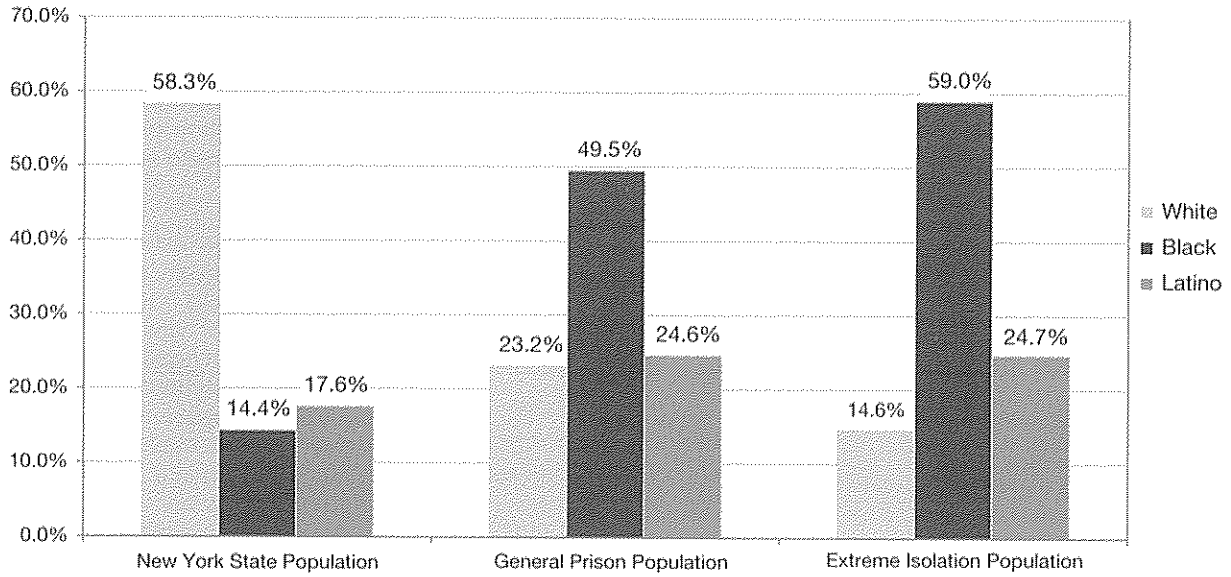
The number of people in extreme isolation with mental health problems would likely be greater if DOCCS was not subject to an important limitation on who it can place in the SHU – prisoners diagnosed as "seriously mentally ill."[96]

In 2002, Disability Advocates, Inc., the Legal Aid Society's Prisoners' Rights Project and Prisoners' Legal Services of New York filed a landmark lawsuit against DOCCS and OMH alleging that prisoners with mental illness were not receiving adequate mental health treatment in violation of the U.S. Constitution and federal statutes.[97] In particular, the complaint highlighted how the failure to adequately treat prisoners with mental illness often resulted in their placement in extreme isolation, where they deteriorated further.[98] In 2007, OMH and DOCCS agreed to a settlement establishing major improvements to the provision of psychiatric treatment for prisoners with mental illness, including prisoners diagnosed as seriously mentally ill serving disciplinary sentences in extreme isolation.[99]

As the lawsuit wound its way through the judicial system, a coalition of former prisoners, family members, advocates and lawyers – Mental Health Alternatives to Solitary Confinement – began pushing for state legislation to end the use of extreme isolation for prisoners with serious mental illness. In 2008, Governor Eliot Spitzer signed the SHU Exclusion Law, which was co-sponsored by Assemblyman Jeffrion Aubrey and Senator Michael Nozzolio. The law, which came into full effect on July 1, 2011, reinforces and expands upon the settlement provisions pertaining to prisoners with serious mental illness in extreme isolation.[100] At its core, the law mandates the diversion of prisoners with serious mental illness from extreme isolation to units operated jointly by DOCCS and OMH whose purpose is therapeutic, not disciplinary.[101]

Racial Distribution

New York State vs. General Prison Population vs. Extreme Isolation Population



A disciplinary system where government officials may act with substantial discretion creates opportunities for bias and prejudice to influence who receives punishment. One manifestation of this may be the disproportionate number of black prisoners in the SHU as compared to the overall prison population.

State population data from Census 2010. Prison population data from "Security Level and Facility by Ethnic Status, DOCCS Under Custody Pop. Jan. 1, 2012," obtained through FOIL and on file with the NYCLU. SHU population data from "Table 3H: Race/Ethnicity for Offenders Housed in SHU – DOCCS Under Custody Pop. Jan. 1, 2012," obtained through FOIL and on file with the NYCLU.

of extreme isolation. These data also suggest that bias may corrupt the disciplinary process that leads to sentences of extreme isolation.

DOCCS has identified 83 percent of New York prisoners as "substance abusers" in need of treatment.[91] According to a sampling of self-reporting data from 2007 to 2012 among prisoners housed at Southport, Upstate and the SHU 200s, an average of 88 percent of men reported some form of substance abuse.[92] These prisoners receive no meaningful treatment and may incur additional SHU time for alcohol or drug-related disciplinary infractions.

The SHU also houses many prisoners with mental health problems. Data released by the New York State Office of Mental Health (OMH) shows that in March 2012, more than 600 prisoners in the SHU – roughly 14 percent of the total SHU population – were on the mental health caseload.[93] (Roughly 14 percent of prisoners in the general prison population were also on the mental health caseload.)[94] Among prisoners in the SHU on the mental health caseload, roughly 35 percent had been diagnosed with a major or serious mental illness.[95]

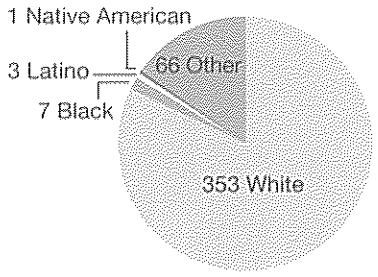
Policies are abstract. Punishments are concrete. **Section IV,** *Life in the Box*, goes inside the SHU, using the voices of prisoners, their family members and corrections employees to bring life in extreme isolation fully and vividly into focus. ■

RACIAL TENSION IN EXTREME ISOLATION

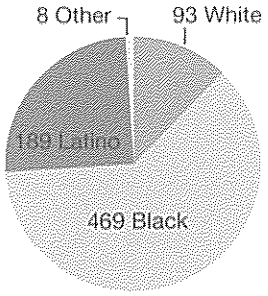
The racial make-up of prisoners in the SHU contrasts particularly sharply with the racial make-up of SHU corrections staff. For example, the corrections staff at Southport and Upstate is about 80 percent white, in marked contrast to the SHU prisoner population at both facilities, which is about 12 percent white.[102]

Southport

Corrections staff
(430 total)



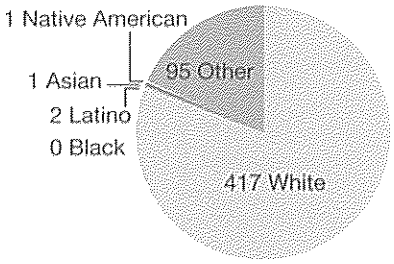
Prisoners
(761 total)



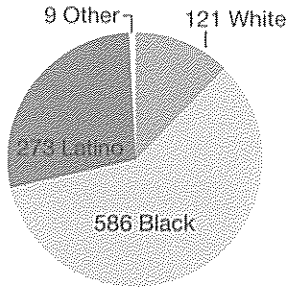
(Includes 2 "unknown")

Upstate

Corrections staff
(516 total)



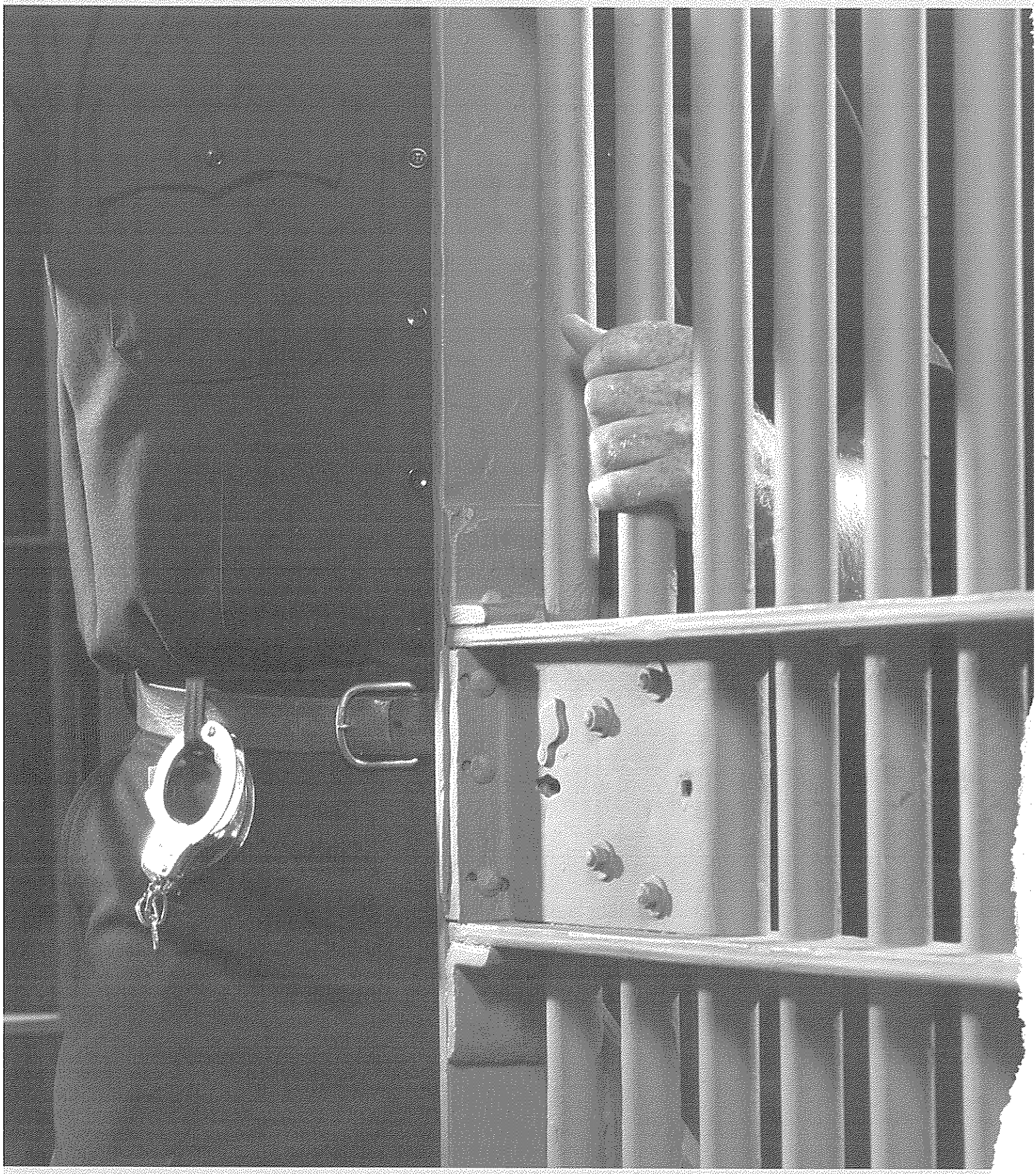
Prisoners
(994 total)



(Includes 5 "unknown")

Prisoners of varying racial and ethnic backgrounds who communicated with the NYCLU consistently noted high levels of racial tension between staff and prisoners. Many black prisoners reported the repeated use of virulent racial epithets by corrections staff at Southport and Upstate. One black prisoner observed that corrections staff at Upstate "call you nigger to your face quicker than anyone else." Several Southport prisoners reported that staff use the prison's internal public address system to broadcast racially charged insults or jokes. One prisoner shared a joke he recently heard over the loudspeaker: "What do a black person and a bicycle have in common? They both only work with chains on them."

White prisoners also commented on the racially charged interactions between prisoners and corrections staff. One white prisoner, who was sent to Upstate for a weapon, recalled, "When I was booked into Upstate ... on the way to my cell, several COs asked me if I was 'making weapons to stab niggers' and made several 'nigger' jokes, which I had to continue to endure for the rest of my stay there." Another white prisoner at Upstate observed, "It sucks to be black in here."



IV. LIFE IN THE BOX

The experience of extreme isolation is most keenly expressed through the first-hand accounts of the individuals who endure it. From the effects of extreme isolation on the psyche and spirit to the wholesale culture of deprivation to the challenges of effective medical and mental health care, prisoners' lives are shaped and often scarred by their time in extreme isolation. The complicated experience of visiting or working in the Box is not to be underestimated. Even those who are not incarcerated feel its effects.

Isolation, Idleness, Violence and Suicide

New York's 19th century experiment with extreme isolation linked these conditions of confinement with mental anguish and pain.[103] Recent experience has verified what New York discovered nearly two centuries ago: Extreme isolation inflicts grave harm. In otherwise mentally stable individuals, adverse psychological effects manifest even after short, defined periods in extreme isolation.[104] These same conditions ravage individuals with pre-existing mental illness, who may deteriorate tragically, sometimes to the point of self-mutilation and suicide.[105] The experiences of prisoners who shared their stories with the NYCLU vividly illustrate these findings.

Prisoners in extreme isolation live in a world of unrelenting monotony, marked by isolation and idleness, where all extrinsic purpose and structure slowly unravels. When men in the SHU were asked to picture their lives in the general prison population, many pointed to social interaction, activities and programming around which they structure their time. Stephan misses "communicating with family, talking to other inmates, and playing chess."[§] Daniel, with more than 20 years in and out of the Box, expressed even simpler desires: "I want to interact with others, see others. I want to go to the yard or the shower. I want the liberty of walking down the company [gallery] so that I can feel human."

"You could be in outer space." – Daniel

By design, the SHU frustrates social interaction. Daniel described feeling like he is expected "to just sit quietly like in a space capsule in a cell with very little human contact or cordial conversation." Trevor shared that living locked down in a cell has left him feeling "isolated, forgotten, like you don't matter." Kevin explained: "Nobody likes to be alone. It's not human nature. We're social. When you take that away from a person it's standing still, with nothing. Nothing forward, backward, sideways. You just have you."

The SHU also imposes upon prisoners a deeper and more profound isolation from the outside world. Prisoners in the SHU may not make phone calls. Yet "there is nothing like talking on the phone to a loved one, it's something to give you a sense of normal," Kevin said. Beyond the geographic challenges posed by the far-flung locations of New York's prisons, family visits are neither easy nor encouraged. Prisoners in the SHU must wear restraints – handcuffs secured to a waist chain – and sit behind a physical barrier separated from their loved ones. Kevin described how a friend who visited him at Upstate "couldn't do nothing but cry" at the sight of him shackled and in a cage.

At times, extreme isolation strains relationships to the breaking point. Miguel described how the SHU has taken a negative toll on his family:

> Many of us have kids, bad enough we're in a SHU ... but the visit floor has a gate between you and your family. You can't kiss, or hug your family ... A lot of our family and wives abandone or refuse to visit us due to this which in turns mentally break us down and eventually leads to problems ... I've lost my wife and haven't seen my son due to this living condition.

Miguel described the one occasion that his wife and son traveled eight hours by bus to visit him. His son, who was 7 years old, couldn't understand why he couldn't touch his father. They have not come to visit Miguel again.

[§] Prisoners' communications are quoted verbatim (spelling and grammatical errors intact).

This isolation from loved ones can be traumatic and hinder rehabilitation; studies have documented that prisoners who sustain contact with loved ones are less likely to recidivate after their release.[106] Daniel had no contact with family members during the first 15 years of his incarceration, most of which was spent in extreme isolation. He began receiving regular "support and correspondence" from his sister after his mother's death and described the grounding effect of their communication: "I truly believe that if it were not for her support coming when it did that my disciplinary record would've deteriorated to such a degree that to say I was uncivilized would be inadequate description."

Without meaningful human interaction, prisoners in extreme isolation have little choice but to focus on themselves. But many who communicated with the NYCLU made clear that the SHU prevents them from positively channeling this focus because they lack access to educational, vocational or rehabilitative programming. Whatever progress they might have been making in the general prison population – towards earning a GED, learning a trade, or dealing with substance abuse or anger management issues – essentially halts upon placement in the SHU. Often, fragile gains are lost.

Many prisoners pass the time reading, writing or sleeping.[109] If their good behavior has earned the privilege of a pair of headphones, they may also listen to a pre-selected radio station.[110] But these activities fail to stave off boredom, listlessness and torpor. Tevin, who spends most of his day reading or exercising, said that he "doesn't feel like it sometimes" and ends up "just sitting there." Trevor described "reading what you've already read, re-reading," finding it difficult to concentrate. Daryl similarly reported that after a short period in the SHU, his "motivation started to drain away," and he "started to do less and less" until he "stopped doing anything." Adrian explained constantly fighting sleep, "trying to stay awake." Stephan described succumbing to his lethargy, simply "try[ing] to sleep the day away."

With little to do and nowhere to be, some prisoners describe time collapsing in on itself. Weeks, months and years begin to bleed together. The distinction between night and day becomes meaningless, and strange and erratic sleeping patterns are commonplace.

Isolation and idleness corrode prisoners' psyches. Some changes are subtle, almost imperceptible given the nature of isolation, such as withdrawal. Others are more obvious and frightening: the sudden onset of anxiety or rage, or a rapid descent into depression. Virtually every prisoner who communicated with the NYCLU reported disturbing changes in themselves and in those around them. Many fear these changes are permanent.

Some prisoners withdraw into apathy or indifference. Several family members and friends note these changes. Adrian reported that his aunt, after visiting him in the SHU, described him as "withdrawn, less talkative, disinterested." Trevor's brother had a similar reaction. Trevor called his brother after returning to the general prison population from Southport. His brother said he noticed changes in the way Trevor spoke and acted. Trevor saw in himself a slow

Families, Inside and Outside

"The effects that SHU have aren't restricted to us confined in the actual SHU. Our loved ones are somewhat 'confined' too and endure stresses which at times may be more extreme than what we prisoners endure." – Adrian

Families and loved ones say they experience a peculiar form of punishment when they visit the SHU – or when distance, economics and daily responsibilities prevent crucial personal contact. Extreme isolation facilities like Southport and Upstate, which house more than a third of New York's total SHU population,[107] are hundreds of miles from New York City and its suburbs, the home communities of 60 percent of the total prison population.[108] Many family members say they suffer sentences along with prisoners, burdened by the inability to change or improve their loved ones' circumstances.

Taylor Alonso's son was sent to the SHU for suspected gang involvement.

"What the family goes through – other people are being sentenced without direct involvement, i.e., the families," Alonso said. "My wife's Parkinson's [disease] has flared, it's through the roof, she can't even write a letter anymore. As for me, my doctors put me on antidepressants so I can try to make it through the day. I don't sleep, I'm awake all the time. That's good, though. I drive to [the prison in] Buffalo and back [to Long Island] in a day, to visit."

Visiting means metal detectors and long waits to greet a loved one in a cage or behind a glass barrier.

"You don't get in right away," said Lynn Finley, whose son spent five months in extreme isolation. "You can wait two hours [to be screened]. I wear nothing metal, nothing at all. I learned that the first time I went up. I don't wear earrings, underwires – I usually wear an underwire bra – I don't want any problems at all."

Finley described the chaos of waiting for vending machines in the visiting room: "Everyone's in line for the food. … My son is starving, he said to me, 'get me everything.' For a mother to hear that, it's beyond anything you ever imagined

you'd hear. I get in the line – this woman would stand there and take out chicken after chicken, 10 of them! People would yell at her, 'what are you doing?' ... People were angry she was taking all the chicken, they were afraid it was going to run out. It's the inhumanity of the whole thing, right down to the chicken."

Sade Jackson, a legal secretary and church volunteer, visited her brother at Upstate.

"I had the worst experience," she said. "I felt like I was treated like a criminal. It was extremely upsetting. I went through metal detectors, took off my shoes and all that stuff, and it was still ringing. They said, 'go in the bathroom, take off your bra.' For a woman – I felt violated, they were all male corrections officers."

Removing her brassiere didn't silence the metal detector. Next, Jackson said, corrections officers began to examine her hair.

"I wear a lace front, kind of like a wig, with [metal] pins [to hold the hairpiece in place]. I had to take it off. I was just like, wow ... I felt humiliated. I wanted to cry. I didn't do anything to deserve it. They use it like a power trip."

Her sister Monet Jackson, a hospice worker, visited their brother, too. She negotiated the metal detectors and waited for her brother.

"When I got there, I couldn't touch him," she said. "He was in shackles and in handcuffs. He had to eat with handcuffs."

"They take people in small groups – they go through packages, everything is very slow," Finley said. "You can't bring anything in but your driver's license and money for the vending machines. If you get there at 7:30 [a.m.], if you're lucky, you'll see them [your family member] at about 10, 10:30. You wait in the room until you're called, you go through screening devices, metal detectors, then into the room with the cages and vending machines. Sometimes your inmate is waiting, most often not. It's really traumatic."

Alonso shared a story from his first SHU visit. "My son's a big guy, 220 lbs, 6' 4"," Alonso said. "He's a Type 1 diabetic, and he has ulcerative colitis. The first trip I was up, in the last half hour, he started to go into diabetic shock, sweating and shaking, asking for juice. I didn't take any money [inside, because] I was told I was only going to see him through glass. They wouldn't let me go out [to my car] to get money for orange juice. He would rather have gone into shock and have another 15 minutes with us, you can see it in his eyes."

Alonso's wife, Patricia Trainer, expressed deep frustration with the state prison system.

"Who can sit in a box 23 hours a day, either alone or with another man? How are you supposed to change? How do they correct you? They don't do anything for you, they don't give you any education. Prison infantilizes you. Nothing is given or forgiven. I know he's a knucklehead, but he doesn't deserve this."

Pamella Watson, whose daughters Sade and Monet Jackson visited their brother at Upstate, hasn't seen her son since 2006. A resident of Warrenton, Ga., she could speak to her son on the phone when he was in the general prison population. Now she cannot.

"He's not able to call, he can't call anybody," Watson said. "He pours his heart out in his letters." Since his SHU bid began, Watson said, "he's more emotional. There's a change in him." But he refuses medication for his bipolar disorder despite a prior diagnosis, she said. "He says it leaves him disoriented, unaware of his surroundings."

"They don't treat them like human beings. I'd be the world's most blessed mom if he comes out of solitary sane."

"They don't treat them like human beings" at Upstate, she said. "I'd be the world's most blessed mom if he comes out of solitary sane."

"Who would want to be locked up in one room for 365 days of a year and not have any contact?," Sade Jackson asked. "We were designed to be social beings. It's debilitating to be alone that long. The thing he struggles with more than anything is not having easy access to his family, or his family having access to him."

"They don't even do this to animals," she said. "If I took my dog and locked him into a room for a year, I would go to jail. Why is it acceptable to do this to human beings?"

---

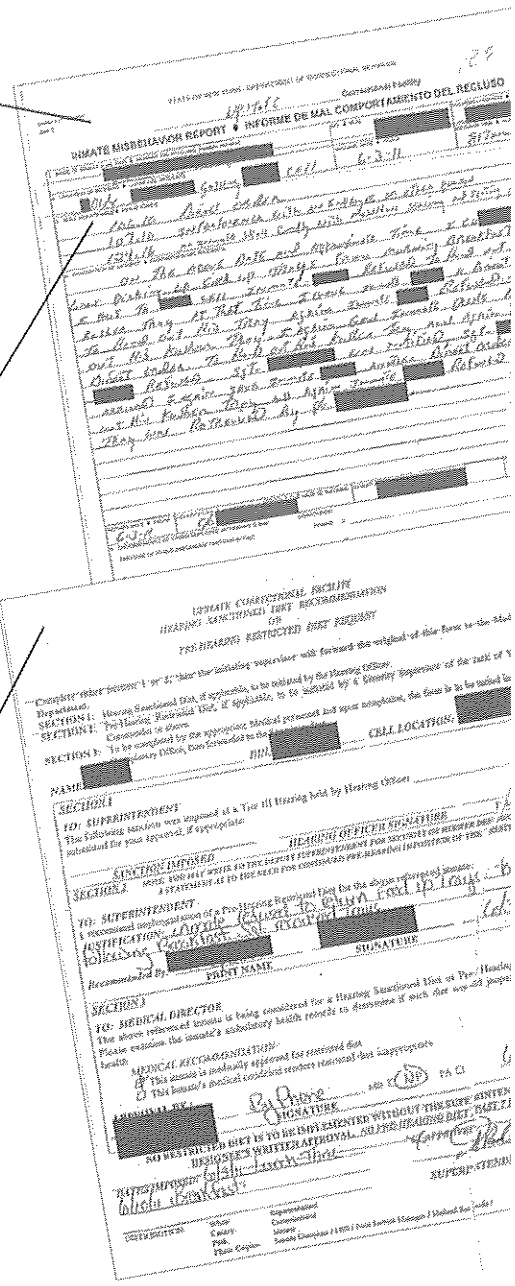
distancing from his loved ones. He said, "I know I love [my brother], but now I put the focus all on me."

Many prisoners experience the onset of anxiety in extreme isolation, sometimes catalyzed by "an intense fear of walls closing in on you" or the distinct sensation of living in "a cage." Marcus described his anxiety as stemming from a "horrible ... caged feeling," which would ascend until he "was about to have a nervous breakdown." Daryl described feeling like he was living "in a void of nothingness." In this void, he found "his thoughts racing for no reason" and was "a nervous wreck for no reason."

AN OPEN &

The disciplinary process that led to a six month sent

This "misbehavior report" describes an incident that occurred at 8:17 a.m. on June 3, 2011 involving Samuel, a prisoner at Upstate correctional facility, a dedicated "Special Housing Unit" (SHU) prison with 1,040 extreme isolation beds. Prison regulations instruct all corrections officers (COs) who witness "inmate misbehavior involving danger to life, health, security or property" to submit a misbehavior report, which triggers disciplinary action against the prisoner. Prisoners at Upstate receive all three meals in their cells, delivered on trays by COs. A CO submitted this misbehavior report after Samuel refused to return his food tray following breakfast.

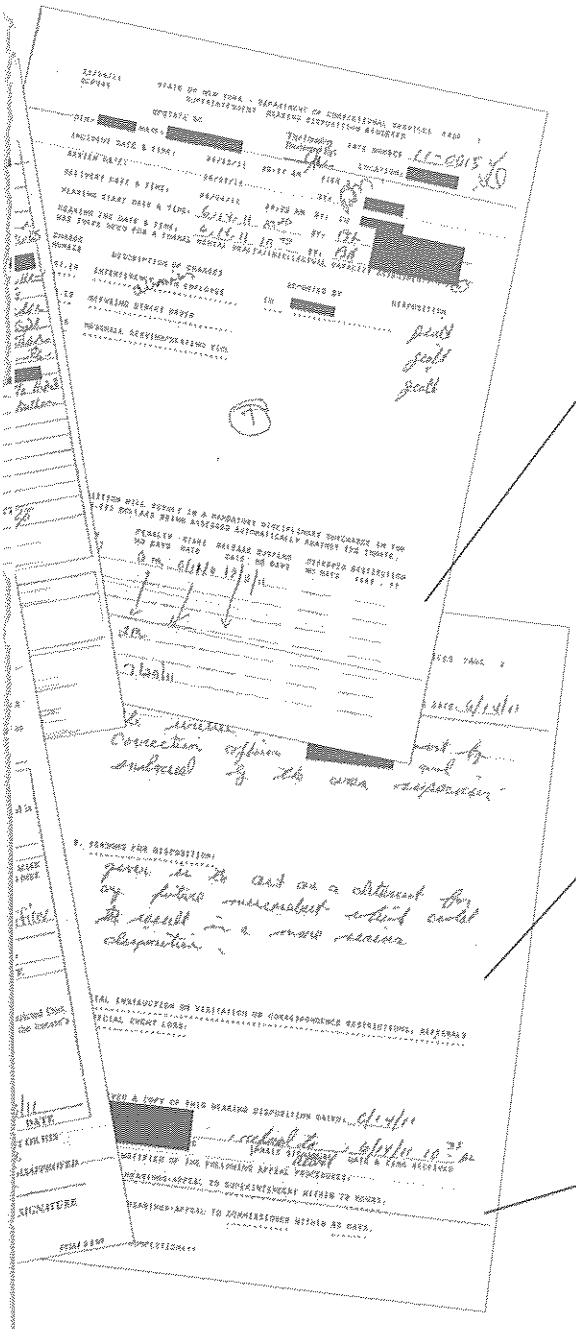

INMATE MISBEHAVIOR REPORT • INFORME DE MAL COMPORTAMIENTO DEL RECLUSO

The CO alleges in the misbehavior report that Samuel has violated three prison rules: failing to obey a direct order, interfering with an employee and failing to comply with mess hall policies. A "review officer" at each facility reviews all misbehavior reports and assigns a tier rating to the report based on the severity of the underlying rule infractions. Tier I infractions are the least serious; tier III are the most. The Department of Corrections (DOCCS) provides little guidance on how tier ratings relate to rule infractions. For Samuel's refusal to return his food tray, the review officer assigned a tier rating of III, which DOCCS describes as reserved "for the most serious offenses, such as assaults on staff or other inmates."

Prisoners in the SHU accused of certain misbehavior resulting in a tier III rating may be immediately placed on a "restricted diet" for up to seven days prior to the disciplinary hearing, which determines their guilt or innocence. The "restricted diet," commonly known as "the loaf," is a brick of bread-and-vegetable matter, which comes with a wedge of raw cabbage and water. For withholding his food tray at breakfast, Samuel was placed on the loaf for 21 meals – from lunch on June 3 to breakfast on June 10. Samuel does not eat the loaf because it leaves him "constipated for days." Instead, he "drink[s] plenty of water and fast[s]." He feeds the loaf "to the birds outside" his recreation cage.

SHUT CASE

ence in extreme isolation for refusing to return a food tray.



Samuel's disciplinary hearing, at which he was found guilty of failing to obey a direct order and failing to comply with mess hall policies, occurred on June 14. Samuel refused to attend the disciplinary hearing. According to Samuel, "the hearings are unfair so I don't care. The[y] need to be transparent, they don't follow their own rules, they need more guidelines." Samuel was found guilty of refusing to return his food tray, and punished with an additional six months in the SHU. From 2007 to 2011, DOCCS held more than 68,000 tier III disciplinary hearings resulting in SHU sentences. Only 16 percent of those sentences were for infractions related to violent misbehavior, specifically assault and weapons.

According to the hearing officer, Samuel's punishment was "to act as a deterrent for any future misconduct which could result in a more serious disposition." But Samuel is not likely to be deterred by this punishment. In his words, "they gave me so much Box time for nonsense, I've become immune to it." When it comes to withholding food trays, Samuel echoed what the NYCLU heard from many other prisoners in extreme isolation, "the only way you can see a area supervisor sometime is to hold your tray refusing to give it back to see the Sgt."

Samuel has received an additional 30 months of SHU time since arriving at Upstate in January 2008, all for non-violent misbehavior. "COs escalate situations, escalate drama, find a reason to give you tickets for little, simple things," Samuel said. "They give tickets because they are trying to justify the existence of this place . . . the Box only winds a person up, the way they are treated and humiliated, it gets to the point where they don't care. After being in the Box for so long, it don't mean anything to him."

FORCED IDLENESS

Many prisoners reported that they do not wish to remain idle, but that they are denied access to any educational, vocational or rehabilitative programming in the SHU. Some prisoners may earn the privilege of signing up for in-cell study packets – GED, substance abuse or aggression management – which consist of little more than materials handed through the food slot, for prisoners to complete on their own.[111]

Marcus, who was 20 when he first arrived at Upstate, requested the GED in-cell study packet. During his first month at Upstate, he received essay and math assignments, which he completed and returned. He never received any feedback on these assignments. Marcus, who will be released in 2014, would "like to go to school" and hopes DOCCS can help him with "outreach to colleges." But he noted that "the Box keeps you away from all that."

Many wait months simply to access the substance abuse or aggression management packets. Donell requested the aggression management packet, but was informed he would have to wait more than six months. Marcus was quoted a similar waiting period when he requested the substance abuse packet. Samuel requested both "a couple of times but received no response."

For many prisoners, anxiety is accompanied by severe mood swings, manifested by irrational and uncontrollable outbursts of anger and rage. Daryl described his mood swings:

"[T]hey were kind of like the temper tantrums I threw as a child. Raw & helpless moments of overwhelming & unchanleable emotions exploding out of you. I couldn't seem to function properly & then I would get so annoied with my bunkies that I would just beat on them or scream at them & afterward I would feel so horrible, like some monster or something. I know it wasn't right but at the same time I couldn't control it either."

[T]hey were kind of like the temper tantrums I threw as a child. Raw & helpless moments of overwhelming & unchanleable emotions exploding out of you. I was anxious & overly frustrated because I couldn't seem to function properly & then I would get so annoied with my bunkies that I would just beat on them or scream at them & afterward I would feel so horrible, like some monster or something. I know it wasn't right but at the same time I couldn't control it either.

Kevin also felt that extreme isolation stirred up a whirlwind of emotions: "All the emotions you experience in 15 years, you experience in one day."

Many prisoners said that they try to bottle up their emotions but they eventually explode in dangerous ways. Donell has found himself "snapping at others" in "daily outbursts." He "wasn't like this before." Donell's explanation: "Anger is built up and not released."

Some men admit that extreme isolation has aggravated longstanding difficulties controlling their frustration and anger. Marcus described himself as having "always had a trigger-snap mentality, but not so intense." He discussed developing "a hair trigger reaction to situations" in extreme isolation; the "littlest things" caused "a crazy adrenaline rush, increased blood pressure, heart racing." Justin admitted "I suffer from rage," and that his emotions are "harder to control in the Box."

"Hostility is endemic to the SHU." – Justin

The intense emotions that prisoners experience in extreme isolation have little outlet for release. In the general prison population, when your mood is negative, Justin said, "you can take a walk and clear your mind." In the Southport SHU, "you take out your aggression ... on the gate," standing by the cell door and arguing with adjacent prisoners or

corrections staff. Tevin saw arguments erupt over "petty things;" "people go off, people you think you have a rapport with, you really don't." Na'im similarly noted that "the smallest things set people off." Adrian witnessed prisoners "losing their social skills."

When prisoners leave extreme isolation and return to the general prison population, they often find themselves trapped by the intense emotions and uncontrollable impulses they developed while in the SHU. As Donell put it, "population problems start in the Box." Daryl, who experienced anxiety, depression and mood swings in the SHU, found his transition to a maximum-security facility difficult:

> When I arrived here I was terror stricken for the first two weeks, at least. That kind of behavior is nothing like me at all. It's when I got here that I noticed how badly the box had effected my charrecter. I've always been somewhat anti-social, but my confidence in myself & my ability to communicate is more challenged now than it has been since I was a teenager. My depression is pretty bad off too. All I know tho is I was fine in Attica & then I went to Upstate & it seems like part of me is still there.

"I've always been somewhat anti-social, but my confidence in myself & my ability to communicate is more challenged now than it has been since I was a teenager. All I know tho is I was fine in Attica & then I went to Upstate & it seems like part of me is still there."

Marcus described his return to the general prison population in similar terms. After the extended lack of real social interaction, the thought of "actually talking to people face-to-face" made him "paranoid." When he did return to general population, Marcus "noticed things were different." He was "more ready to jump at the littlest things, such as words," and he couldn't "hold a conversation without feeling anxious and paranoid."

Donell expressed fear that his "outbursts of anger" were permanent: "When I go home, I don't want to be acting like I do in Upstate. I'm hoping I change back." He said he realizes that these "outbursts of anger might cause you to go back in." But as Trevor, who is currently serving his seventh SHU sentence, said, the SHU has lasting effects. When a prisoner returns to the general prison population, he said, "no-one knows what you've dealt with in the SHU." If some "guy disrespects you, instead of saying something, you attack him."

MAXING OUT

In some cases, a prisoner's disciplinary sentence to the SHU eclipses the remainder of his entire prison sentence. DOCCS requires these prisoners to serve the balance of their sentence in extreme isolation; every year, roughly 2,000 people are released directly from the SHU back to the community.[112] Prisoners in the general prison population nearing release undergo transitional programming, which assists with release plans and relevant documentation, including a resume, cover letter and letters of reference. Prisoners in extreme isolation, however, are barred from any transitional programming prior to their release.

Adrian will return home directly from the SHU in 2015. He wants to work in an office after his release, but he is worried that won't be possible. "I have the ambition, but no preparation," Adrian said. "I thought the goals of DOCCS was to help us 'correct' our wrongs. All they've done was lock many of us up in a cell. But the nightmare starts with the realization 'I'm going home from the Box' lacking any transitional services of all sorts. Me personally, I read to keep my mind busy & intellect growing! And I have a strong desire to never return to jail. But I need help from the 'professionals' that work for the state because it's so obvious my ways aren't quite the right ones."

Tevin, who is serving a four-year prison sentence, will also return home directly from the SHU in 2014. He observed, quite obviously, that he is "not prepared" to return to society.

"Mentally, being here drains energy out of you. I feel like the walls are closing in on me. I get suicidal." – Stephan

Confronted with long-term isolation and idleness, some prisoners succumb to depression. Daryl described careening from anxiety to depression while double-celled at Upstate:

> [M]y poor bunkie is going through hell in this cell with me. One minute I'm having an anxiety attack and hes rubbing my back telling me to calm down and the next I'm depressed as all bloody hell telling him listen I gotta make some incision on my arm to releas the pressure. Depresion makes me irrational, though. I can't control that emotion when it comes over me.

Every year, roughly 2,000 people are released directly from extreme isolation back to the community.

For Na'im, extreme isolation intensified his bouts of depression. Na'im attempted suicide after two years at Upstate. He recalled the sensation of "being in a cage all day" and thinking "what do I have to lose – I ain't leaving the Box soon." Overwhelmed by "a sense of hopelessness," he thought, "you just can't take it anymore, don't care what happens." Na'im is "absolutely afraid" that he might attempt to take his life again. Extreme isolation "makes depression harder to deal with," he said, because there is "nothing to do to relieve stress." In the SHU, depression just "builds up" until "you let it out with violence," he said.

"When I go home, I don't want to be acting like I do in Upstate. I'm hoping I change back."

Other prisoners in extreme isolation commit acts of self-mutilation or self-injury, which constitute a violation of prison rules. Rule 123.10 dictates that "An inmate shall not inflict or attempt to inflict bodily harm upon his or her person."[113] Prisoners who harm themselves in extreme isolation – likely due to the mental anguish caused by such conditions – may find themselves punished with additional SHU time.

Daniel, who at 52 has spent more than two decades in and out of extreme isolation, has a long history of self-mutilation. He has used razors, staples, envelope clasps and cigarette butts to inflict pain upon himself. He described the psychological toll the SHU has taken on him:

> With so little to do your mind rots with thoughts that are uncommon or unnatural and you wonder where the hell did that come from. It goes further than daily doldrums because a lack of any constructiveness only contributes to destructiveness and the Prison System is designed to make a person like myself and other unfortunate to self destruct become numb lose the sense of reality to the degree that any commotion at all is better than vegetating by letting hours pass without nothing on your mind or will to do anything.

Daniel has received 15 misbehavior reports for self-harm. The majority of these reports resulted in a formal reprimand, but the most recent resulted in a four-month SHU sentence.

Two in a Box

"It's two grown men in a small space." – Miguel

Every day, roughly 2,250 men at Upstate and the SHU 200s wake up in extreme isolation with another prisoner, their "bunkie."[114] Double-celled prisoners experience the same isolation and idleness, withdrawal and anxiety, anger and depression as do prisoners living alone in the SHU. But double-celled, they must also endure the constant, unabating presence of another man in their personal physical and mental space. The detrimental effects of housing two people in a cell for 24 hours a day have been documented.[115] The stories of double-celled prisoners provide a vivid and disturbing human counterpoint.

Cellmates must constantly negotiate a small and cramped space of roughly 100 square feet – about the size of a parking spot – that includes a toilet, open shower stall, writing platform and bunk beds. The unrelenting lack of privacy is the primary cause of tension, many double-celled prisoners say, particularly while showering or using the toilet. No curtain or barrier separates the shower from the rest of the cell, forcing prisoners to expose themselves to their cellmates while bathing. Similarly, no curtain separates the toilet from the rest of the cell; a prisoner urinating or defecating must do so in full view of, and mere feet away from, his cellmate. Daryl described, with equal parts amusement, irritation and disbelief, how one bunkie asked him to stand in the corner and sing whenever the bunkie used the toilet, both to mask sound and ease tension.

> Double-celled, prisoners must also endure the constant, unabating presence of another man in their personal physical and mental space.

The lack of privacy grinds down prisoners' patience. Small things that might normally go unnoticed suddenly become pronounced and grating. Marcus vividly described the pungent odor that permeated his cell when sharing the space with cellmates close in age. He observed that young men in their late teens and early 20s are still "going through changes, hormones" that left the cell "stink[ing] from bad odors."

Some prisoners express that the lack of privacy hinders their ability to think. Kevin "need[s] solitude to get [his] thoughts together," but is constantly distracted by his cellmate's presence. For Miguel, this distraction disrupts any rehabilitative process. He stated that "double-celling makes it much more difficult to take personal responsibility for your own actions" because you find yourself constantly "reactive to your bunkie."

Not surprisingly, many double-celled prisoners find it nearly impossible to establish or maintain healthy, positive relationships. Rather, these relationships are marked by frustration and antagonism, often devolving into violence or the constant threat of violence. Marcus, whose misbehavior reports document no prior violence, shared that double-celling resulted in several physical altercations. Sometimes, he would "want to fight just because of the close space."

Locked In: COs in the Box

Corrections officers in extreme isolation settings are a study in contrasts: Authority figures, they also perform menial tasks, such as delivering food trays and mail, which can undermine their ability to maintain control. Many say that prisoners in the SHU take out their frustrations on COs. Many also note that the job requires adherence to a near-military code of honor – a culture that is, in its own way, as hierarchal and isolating as the prison culture they monitor.

"Overall, SHUs are more stressful to work," a retired CO, who served two multi-year assignments at Upstate, wrote. "Inmates are more dependent on officers in confinement since the officers provide the feed-up trays to feed them three times a day, give them requested supplies and turn on the shower water, open the rec pen doors, etc."

Monsignor Dennis Duprey, who served as chaplain at Upstate for six years and now leads a church that includes COs and their families, said COs struggle with the reality that they must in some ways serve the people they're assigned to guard.

"I heard more than once, 'I feel like I'm a waiter to them,' [because] everything that the inmate gets has to be delivered by a CO – even their laundry," he said. "The position of the CO changes. Some COs find it demeaning; they have become a waiter to those they thought they were guarding. That process of being demeaned – COs are affected by the experience."

"There are so many different noises, cat calls, whistles, yelling, foul language worse than anything you ever heard on the outside," wrote the retired CO, who lives near the New York-Canada border. "Hearing the different languages [prisoners speak] was a big eye-opener for a country boy who had never heard much more than French from the Canadians in the shopping malls."

The SHU's smell followed him home.

"You got used to the smell somewhat, but when you got out, the smell was in your clothes and hair," he wrote. "It was nasty."

COs and prisoners alike face constant scrutiny, he wrote.

"Your first impression walking through Upstate is how long the corridors are," he wrote. "They seem to stretch on for miles. All the gates are controlled by one person. There were some 800

He explained that "the littlest things cause people to bug out." Even if his cellmate "didn't do nothing," he would just get "so pissed off."

Tevin, a self-described "neat freak," discussed his frustration when his bunkies would "look in the mirror, as they brush their teeth, leaving toothpaste speckz on the mirror & all over the sink" or "blow their nose in the sink while washing their face." After "constantly cleaning up after them & respectfully explaining that we both have to be mindful," Tevin would eventually "get physical." For Tevin, double-celling is a process of "built up irritation [that] leadz to provoked violence."

"I was a happy-go-lucky guy when I married my wife, but she tells me over the years I became more serious. Lots of officers have gotten divorced, become drinkers or too rough and bossy with their family. The job changes you. You have to be on edge all the time."

Daryl experienced the unusual situation of double-celling with someone he "consider[ed] a close personal friend," but the arrangement quickly unraveled:

> To be clear, we did not fight for any other reason than that we found we simply could not get along while being locked together if locked 24 hours in a cell. I was having my problems & he was burdend by the fact that his wife had just died & with both our moods being dark & depressing all the time we didn't mix well & after a few days I ended up attacking him.

One of Marcus's bunkies was a "good dude" who reminded him of his brother. But Marcus still got "aggetated or annoyed ... when I [had] to share a shower day, shit while he [wa]s awake, or when we work[ed] out because it smell[ed]."

Some prisoners said that when they sensed that violence with their cellmate was imminent and asked corrections staff to intervene, staff refused to take any action. Chris explained:

> First off they put you in a cell with just about anyone & you've got to just handle it. If you & your bunky don't get along & tell the COs they

video cameras recording everything inside and out of the facility, so you always felt you were being watched by Big Brother."

One retired DOCCS staffer says that civilian prison staff have to watch their backs because trusted allies are few.

"I had to have two mouths and play it well," he said. "For security, I had to be an inmate-hater to [prison staff], yet I played a different role when dealing with the inmates. It was always a balancing act."

For another retired CO, the challenge wasn't balance but separation.

"There's a thin line between officer and inmate," he said. "If they [prisoners] know they can rattle you, you're gone – and you lose control."

Two things that might help COs, Duprey said, are more education and wider exposure to diversity.

"Going into working with this kind of population, never having been further than 50 miles from home in these multicultural facilities, they're not equipped to deal with it," he said. "It's easier to become a hard ass, to put it plain."

The retired CO wrote that his tenure at Upstate, constantly on guard and in "serious mode," changed his personality.

"I was a happy-go-lucky guy when I married my wife, but she tells me over the years I became more serious," he wrote. "Lots of officers have gotten divorced, become drinkers or too rough and bossy with their family. The job changes you. You have to be on edge all the time."

A third CO said officers know that inmates can "get at them."

"They know, I have to choose a side to maintain my own safety," he said.

The code of honor must be maintained by inmates and COs alike.

"I have to behave a certain way, even if I don't believe in the culture," he said.

"You have to go along [with the culture]," he said. "It's brutal. It's political. It's not just inmates. You have to be known to be 'one of us.' What we do may not be 100 percent morally comfortable, but it could be your life."

"There is no neutral on either side," he said. "The blue has to stay with the blue."

PUNISHED FOR SEEKING HELP

Time and time again, prisoners explained to the NYCLU that refusing to return their food tray was one of the only ways to get corrections staff to address a particular problem or concern. Locked into their cells, prisoners have few other options for summoning the attention of staff. Na'im described how he and eight other individuals on his gallery refused to return their trays to gain the attention of a CO. They sought to alert the CO that the "porter," a prisoner on the gallery permitted to assist corrections staff, had refused to deliver food to several men. In response, all nine prisoners were charged with disciplinary infractions, and Na'im received the loaf for seven days.

> tell us there is nothing they can do unless we are fighting & bleeding. So basically to avoid a problem & fight the CO want you to fight & then we get tickets.

When violent outbursts occur, prisoners can receive additional SHU time. Daryl's physical altercation with his friend resulted in a misbehavior report – and two more months in the Box.

Culture of Deprivation

The deprivation of many basic necessities, including food, exercise and basic hygiene, compound the psychological effects of life in the Box. Such deprivations occur routinely as a matter of formal DOCCS policy – as additional punishment in the SHU – and as informal practice.

See It Online:
DOCCS restricts what prisoners can have in the SHU, from the number of underwear to the size of a bar of soap. For a list of property prisoners are allowed in the SHU, go to **www.nyclu.org/boxedin.**

DOCCS policy officially sanctions the denial of basic necessities. DOCCS regulations permit "deprivation orders" stripping prisoners in the SHU of any "specific item, privilege, or service … when it is determined that a threat to the safety or security of staff, inmates, or State property exists."[116] No "item, privilege, or service" is exempt from a deprivation order, including "minimum standard items," such as showers, recreation, clothing, bedding and paper (including toilet paper).[117]

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Consistent with DOCCS' overall disciplinary philosophy, which permits corrections officials to punish a wide range of offenses with extreme isolation, DOCCS grants corrections officials comparably wide discretion to impose deprivation orders. Deprivation orders must be reviewed daily and renewed every day after seven days. However, DOCCS regulations do not cap the total amount of time such orders may ultimately span.

At Southport, where prisoners are escorted from their cells for shower and recreation, deprivation orders stripping prisoners of these privileges are not uncommon. But Southport returns privileges one at a time, a week at a time. For example, Adrian was denied showers, recreation, cell-cleaning supplies and haircuts after a tier III misbehavior report for altering state property (his state-issued trousers) and having a weapon (the trousers' "sharpened zipper"). After one week, Adrian received cell-cleaning supplies; after two weeks, haircuts; after three weeks, showers; after four weeks, recreation. All in all, Adrian

RECREATION RESTRAINTS

For their first 30 days in the facility, prisoners at Southport must wear handcuffs secured to a waist chain during recreation. After a minimum of 30 days without a disciplinary infraction, they may attend recreation without restraints. But if they incur an additional disciplinary infraction, they lose this privilege until they have again accumulated 30 days without a disciplinary infraction.[123]

Not surprisingly, restraints make it almost impossible to engage in even the small modicum of exercise that the recreation pen permits. Tevin observed, "only thing I could do is stand up in the cage. There is no way of working out period." Stephan similarly noted, "The only thing we could do during that hour is walk back and forth in the cage so I am not able to exercise." Restraints make recreation particularly onerous in the winter. Being "force to stand out there handcuff around the waist with cuffs on my wrist," Stephan explained, "I can't put my hands in my pockets to warm up."

observed, "the entire process last for roughly 28 to 30 days."

Daniel received a deprivation order stripping him of clothing (save what he was wearing), bedding and towels after receiving a tier III misbehavior report for having property in an unauthorized area, refusing a direct order and obstructing visibility. Daniel had covered the window of his cell door with his shirt, in his words, "for the purpose of getting the area supervisor to appear." After Daniel removed his shirt from the window, corrections staff entered his cell where they discovered towels hanging on a line from the end of his bed. Daniel's deprivation order lasted approximately a week.

"The only thing Upstate works for is losing weight. It's a starving diet." – Kevin

DOCCS also authorizes the deprivation of nourishing, edible food as a form of punishment. Prisoners in the SHU who commit certain disciplinary infractions may be punished with a "restricted diet," or what is commonly known as "the loaf."[118] The loaf is a "football-sized" brick of baked bread-and-vegetable matter, which the prisoner receives, with a wedge of raw cabbage and water, for every meal over the course of the punishment. Na'im, who received "the loaf" for one week, described it as a "hard, big piece of bread" that "you have to break … with your hands." Donell described it as "something you'd feed a bird or dog."

Samuel, who has received the loaf at Upstate, does in fact, "feed it to the birds outside," from his recreation pen. But he doesn't actually eat it. He and others choose to fast because they say eating the loaf results in painful constipation. Tevin, who has received the loaf several times, said that after eating it once, he "never touched it again," living only on "water! literally for 7 days all 3 meals."

DOCCS regulations acknowledge the serious dangers of food deprivation by requiring that prisoners on the loaf receive a medical examination "within 24 hours of the commencement of the restriction and daily thereafter during the period of restriction."[119] Yet several prisoners reported that these examinations did not occur. Tevin, for example, observed: "There is rules before being placed on the loaf, I'm suppose to see the nurse, so she could check my vitals, weight, to make sure I'm healthy enough for the loaf. None of that took place on my behalf."

DOCCS also authorizes the deprivation of nourishing, edible food as a form of punishment.

Just as minor misconduct can result in SHU time, minor misconduct in the SHU can result in the loaf. Prisoners in the SHU may receive the loaf as punishment for throwing food, committing "unhygienic acts" or refusing to return a food tray. Prisoners may also receive the loaf as punishment for "refusing to obey a direct order at the time of meal distribution," covering virtually any misbehavior even if unrelated to food or hygiene. Finally, prisoners may receive the loaf for any infraction if they have already been sentenced to the SHU for the remainder of their prison sentence.[120]

A person who receives a tier III misbehavior report in one of the circumstances above may also receive the loaf for up to seven consecutive days prior to the disciplinary hearing ("pre-hearing restricted diet"). Thus, the mere allegation that a prisoner has committed a particular infraction can trigger punishment even before he has been found guilty at the disciplinary hearing.[121]

For refusing to return a Styrofoam cup, Tevin was put on the loaf for seven days prior to his disciplinary hearing. In Tevin's words: "I refused to give it up, so I could have a cup to eat my oatmeal out of or my cold cereal, or drink water out of." At the hearing, Tevin received an additional two days of the loaf – and two months of additional SHU time.

The denial of food also occurs as a matter of unwritten policy. Many prisoners experience the informal deprivation of food when a CO distributing food trays passes their cell without delivering their meal, an unwritten practice universally known as a "drive-by." (More subtly, some COs deliver covered trays – visible on security cameras – that carry no food under the cover.) Hector described an extreme experience, where COs deprived him of food for several days:

> Sometimes if the guard it is angry with the inmate do not give it the eat and put him under starvation. I personally already suffered those kind of violations and mistreatments. One time some of those guards did not feed me for four days and after a sergeant take care of that matter and made them to feed me those guards depriving me of food two more days.

Many men also consistently reported that COs deprive them of their opportunity for "recreation." These deprivations occur both as a matter of official policy (as the subject of a deprivation order) as well as unofficial sanction.

"There is no rec. You just go from one cage to another." – Daryl

Some prisoners refuse to participate in recreation because of the harsh environment of the recreation pens, which prisoners and COs alike describe as "human kennels."[122] Inside the pen, prisoners are surrounded by concrete walls or heavy metal grating, obstructing an open view of the sky. They are empty, barren spaces, smaller than the SHU cell itself.

Prisoners describe recreation as frustrating – there is little to do but pace – and terrifying. Marcus said that whenever he set foot in the recreation pen, he was assaulted by a cacophony of "guys screaming like crazy people." Na'im described recreation pens filled with men "yelling and screaming about nothing," which he concluded was "a product of the SHU."

Even as they experience the deprivation of basic necessities, prisoners in extreme isolation may also face threats to their physical safety. Prisoners at Southport reported that incidents of staff-on-prisoner violence were common. Many incidents occurred while prisoners were being escorted to shower or recreation, the primary points of contact between staff and prisoners at Southport. Adrian witnessed COs assault his neighbor as they returned him to his cell:

"USE BUTTER"

DOCCS restrictions on prisoners' possessions in extreme isolation force some men to request medical assistance for simple personal care. For example, several prisoners reported requesting ointment for dry skin, a minor but pervasive problem, particularly in the winter. Na'im requested ointment for his lips, which he described as "cracked to the point of bleeding." He recalls the nurse responding, "We don't give ... ointment here," and recommending he drink water. "They're basically saying because I'm in SHU I can't receive ... ointment," he said. Na'im resorted to "us[ing] margarine we get with our meals" as an emollient. Chris suffered a similar problem with his nose, which he described as "really dried out" with "open sores." When he requested ointment during sick call, the nurse recommended he drink water. Chris persisted and asked to see a doctor. The doctor's response: "Use butter."

> [S]till cuffed and chained being pushed into his cell from behind by officer [*redacted*] and followed by officer [*redacted*]. At which point they started to beat him up. A number of other officers came and the beating continued for a number of minutes. Finally a few sergeants arrived all action stopped.

Some Southport prisoners forgo recreation entirely in order to limit the potential for conflict with staff that could escalate into violence.[124] Na'im explained why he chose not to participate in recreation:

> I have not been outside since my arrival and I have no intention of going to rec before my SHU release date. I've seen to many individuals get jumped by staff and receive extra SHU time just because. To avoid that I stay in so I can stay out of their way and leave when I'm supposed to.

The combined effects of extreme isolation and deprivation prompted many prisoners to express a desire for mental health counseling and treatment. In the SHU, however, meaningful treatment, like so much else, is elusive, if not altogether absent.

Denied When Needed Most: Medical and Mental Health Care

Studies have documented the culture of medical and mental health neglect that often pervades correctional environments of extreme isolation.[125] The provision of meaningful medical and mental health care in extreme isolation is made more difficult by barriers to confidentiality.[126] Prisoners recounted these realities to the NYCLU and detailed some of the consequences.

Prisoners in extreme isolation who have a medical problem, whether minor or serious, may not leave their cells to meet with medical staff. Instead, they must alert staff by submitting a "sick call slip" or, in an emergency, notifying a corrections officer. They must then wait until a member of the medical staff, accompanied by a CO, comes to their cell door. Once medical staff arrives, the prisoner must explain his problem through the locked cell door, sometimes huddling or crouching at the food slot and speaking loudly or shouting. Samuel described the situation as, "all medical care thru a door yelling back and forth."

> "You got the correction officers standing in front of the cell listening to you speak to the nurse about your medical concerns." – Justin

Prisoners have described staff passing by their cells even when they have submitted a sick call slip. Donell wrote this grievance, which was denied, describing this experience:

> On March 14, 2012, I filled out a sick call for March 15th morning sick call rounds. The description of the sick call I stated 'I've been having a lot of sharp chest pains, I've been trying to deal with it but it seems like its getting worst & sometimes its hard for me to breath.' When RN [*redacted*] … did sick call rounds she stoped at my neighbor cell to give him his meds & kept walking. I tried telling her I signed up for sick call & she totally ignored & didn't acknowledge my statement.

Several people reported that unless they stand right at the cell door when the nurse arrives, the nurse will pass, without speaking to them.

Neglect is also the dominant theme of prisoner accounts of mental health care in extreme isolation. Some prisoners arrive in extreme isolation with pre-existing mental health diagnoses for which they must continue to receive counseling and treatment. Many others seek counseling and treatment while confined in the SHU. Whether receiving or seeking mental health care, prisoners consistently described the prevailing sensation of being "brushed off" by mental health staff.

Prisoners with mental illness who are on the "mental health caseload" go on regular and confidential "call-outs" to meet with a social worker and a psychiatrist. Even these prisoners, however, describe serious difficulty receiving appropriate attention.

At Southport, several people described their interviews with the social worker as "short conversations." Trevor, who suffers from depression and paranoia, sees a social worker every two to three weeks. Trevor said the conversations consist of little more than two questions: "How are you?" and "Are you thinking of suicide?" He observed, "Short of attempting suicide one has to flip out and go to an outside source to get anything done." Trevor did attempt suicide during a prior bid at Southport after he failed to receive the mental health care he felt he needed. For his suicide attempt, he received a misbehavior report and two additional months in extreme isolation at Southport. Reflecting on the suicide attempt, Trevor said: "It's as though I am being forced to act out before they get up to anything – then they ask stupid questions like 'why did you do that?' This place is not built for [mental health] and we should not be here."

Stephan, who also suffers from depression and paranoia, sees a social worker every six weeks. He described the conversation as lasting a "maximum of 15 minutes." He noted that every time he attempts to discuss his mental health problems, the response is a "brush off." In March 2012, Stephan attempted suicide. He explained that his paranoia was getting increasingly worse; it seemed as if "the chains getting tighter for rec, more shit-talking from COs, COs using racist slurs, playing with my food." He concluded, "They are going to kill me anyway, might as well do it myself." Stephan was placed on suicide watch at another facility for a few days before he was transferred back to Southport.

At Southport, prisoners meet with a psychiatrist via teleconference – commonly referred to as "doc in a box."

Interviews with a psychiatrist occur even less often than with social workers. At Southport, prisoners meet with a psychiatrist via teleconference – commonly referred to as "doc in a box" – which further attenuates the relationship between mental health professional and patient. Na'im, who suffers from depression and has attempted suicide, "sees" the psychiatrist once every three months. He observed that it was "hard to open up to a TV screen." Trevor, who sees the psychiatrist every 90 days, similarly observed, "Video-conferences are non-personal and allow OMH doctor's (and [OMH] as a whole) to dismiss inmates at any point and there is nothing the inmate can do about it."

Aside from the roughly 600 prisoners in the SHU who are on the mental health caseload,[127] prisoners who are not on the caseload, but who experience a mental health problem while in the SHU, must submit a written request or flag down a staff member on rounds. As in the medical context, confidentiality is nil: The prisoner must discuss his mental health problem within earshot of COs and other prisoners, provided there is an opportunity to speak with mental health staff at all. A number of prisoners at Upstate described long delays, sometimes of a month or more, before a request to speak with mental health staff was answered.

Several prisoners said that even when they caught the attention of a staff member, the ensuing exchanges were unproductive. Marcus tried several times to describe his feelings of anxiety, frustration and anger to mental health staff. He said that he found staff "don't look you in the eyes" or "roll their eyes, look down the hall, act like they're not listening." He had hoped to have a "one-on-one conversation with someone where I could express my feelings" and receive "help finding different ways to deal with things." He eventually gave up trying to receive help.

Daryl's story, which documents sustained efforts to access mental health treatment in the SHU, is also typical of what others report. Two weeks after arriving at Upstate in November 2010, Daryl wrote a letter to OMH requesting mental health services. He described his feelings as "either wanting to explode for no reason or lay down and cry." He could not concentrate and felt he was deteriorating daily.

In mid-December, Daryl's first meeting with a mental health staff member went poorly. Daryl described having to yell through the door, his words reverberating around his cell. He explained that he had a history of mental health issues, including ADHD, and wanted to be able to focus, particularly on his studies. He felt the staff member was "evasive" and "mocking" and that "OMH was trying to talk me out of thinking I needed treatment."

From December 2010 to March 2011, Daryl repeatedly wrote to OMH requesting assistance. He received no response. He continued feeling like a "nervous wreck" and that his life had "no substance, nothing to grasp onto." On March 17,

2011, he flagged down a mental health staff member. He asked to see a doctor and to be placed on medication. Daryl recalled the staff member responding, "There is nothing wrong with you, get away from the door."

Following this meeting, Daryl began writing many letters, to the Upstate OMH unit chief, to DOCCS officials and to prisoners' rights advocates, explaining his desire to receive mental health services. On May 31, 2011, Daryl wrote to the Upstate OMH unit chief:

"I[t] seems like we're all just caged animals to these people & if we suffer, so what."

> I ... am asking you once 'again' for your help in aiding me to receive mental help. My conditions is getting wors as time gos by & I have no way to 'help myself' with this matter. All im asking for is a chance to be heard & receive treatment for my mental ailments. On top of the fact that I have ADHD. I also have a learning disability. How am I suposed to make any progress? If somebody in your unit would actually listen to me I would have a chance to get better. My agitation & depresion at [OMH] failure to help me in anyway have already driven me over the edge twice now & I've now been in two fist fights. I have not been this adgitated or been in any fist fights prior to comming to this facility & the longer I go without help the wors I get. Please help me.

On June 21, 2011, Daryl's cellmate wrote to the Upstate OMH unit:

> I am not a doctor but I do know for a fact because he is my bunkie that not only do we discuss alarming incidences in his past, it is more than obvious that Daryl needs help right now. You even motioned to me through the locked cell door that Daryl is not quite right, and I nodded back in agreement.
>
> What I really do not understand is that he (Daryl) most definitely seems to 'want and need' psychological help and you also apparently agree however, 'no' help is being afforded or offered to him (Daryl) by Upstate CF or DOCCS.

On August 23, 2011, in a letter to an attorney who had been assisting him in trying to obtain mental health services at Upstate, Daryl stated:

> All I know is what im feeling & all I can do is relay that to the people who are supposed to be professionals. But the vibe im getting is that they just don't give a fuck. I[t] seems like we're all just caged animals to these people & if we suffer, so what. I am an emotional & passionate person & im in physical & emotional pain 24 hours a day. So how do you think I take being treated like a dog? I live this insanity every day. Theres empty promises of help just around a corner that never comes into view. Well im telling you now that I am a defeated man. The prison system has won. They broke me. I'm broken & defeated & all I want to do now is go to sleep. No pain, no insanity ... just blissful eternal rest.

A few days later, Daryl attempted suicide. ■

V. THINKING OUTSIDE THE BOX

New York has become trapped inside a Box of its own design.

Over the past two decades, New York has spent hundreds of millions of taxpayer dollars building and operating a vast network of extreme isolation cells – without a comprehensive accounting of the impact of extreme isolation on prison safety, its effects on incarcerated people and corrections staff, or the costs when prisoners held in extreme isolation return to the general prison population or to their home communities.

New York's abuse of extreme isolation represents a catastrophic distortion of an essentially acceptable practice. Separating violent or vulnerable prisoners from the general prison population is an important last-resort option for corrections officials. In New York, however, two decades of using extreme isolation as a one-size-fits-all disciplinary response has corrupted the legitimate use of prisoner separation beyond all recognition. New York's use of extreme isolation as punishment is inhumane, regressive and counter-productive. It harms prisoners and corrections staff, while undermining, rather than promoting, prison and community safety.

Corrections officials in other states have dramatically reformed their use of extreme isolation while maintaining and improving prison safety.

New York's decades-long use of extreme isolation makes ending the practice appear difficult or impossible. But there is ample guidance to help New York move towards humane and effective evidence-based corrections practice: Corrections officials in other states have dramatically reformed their use of extreme isolation while maintaining and improving prison safety. In addition, international human rights bodies and legal scholars are reaching the consensus that extreme isolation inflicts grave and potentially irreparable harm, and that its use is no longer legally defensible. Reflecting this consensus, groups like the American Bar Association have recommended the abolition of extreme isolation and promulgated standards properly constraining the use of prisoner separation.

With these guideposts in mind, New York must take immediate steps to end its use of extreme isolation: New York must (1) **Adopt** stringent criteria, procedures and safeguards for separating prisoners; and (2) **Audit** the population of prisoners in extreme isolation.

Findings

Finding No. 1: New York's Use of Extreme Isolation is Arbitrary and Unjustified.

The NYCLU found that extreme isolation is too frequently used as a disciplinary tool of first resort. Corrections officials have wide discretion to impose lengthy periods of extreme isolation as a disciplinary sanction for a wide range of misbehavior, including minor and non-violent disciplinary infractions. The substantial discretion afforded to corrections officials means the SHU sweeps in many prisoners, including individuals – such as juveniles, the elderly, and people with mental health issues and substance abuse problems – uniquely vulnerable to conditions of extreme isolation. Such discretion also permits bias to corrupt the process for determining who receives extreme isolation as punishment, as suggested by the disproportionate number of black prisoners in the SHU.

Finding No. 2: Extreme Isolation Harms Prisoners and Corrections Staff.

The NYCLU's study confirms what New York discovered nearly two centuries ago and what numerous scientific studies have concluded since: Extreme isolation causes grave harm.

Prisoners who communicated with the NYCLU reported experiencing some combination of apathy, lethargy, anxiety, depression, despair, rage and uncontrollable impulses. These anecdotal reports are consistent with the robust body of scientific evidence demonstrating that in otherwise healthy individuals, isolation causes measurable cognitive and emotional impairments, even over short and defined periods of time. These impairments inflict serious emotional and psychological pain on prisoners. Prisoners who are double-celled face the added, constant pressure of co-existing in confinement with a total stranger, violating norms of personal privacy and basic human dignity.

The NYCLU also found that the emotional and psychological harm experienced by prisoners in extreme isolation was compounded by the formal and informal deprivation of basic necessities, including food, exercise and basic hygiene. At the same time, the NYLCU found that prisoners buckling under the emotional and psychological weight of isolation and deprivation often lacked access to adequate medical and mental health care.

Prisoners buckling under the emotional and psychological weight of isolation and deprivation often lacked access to adequate medical and mental health care. Over the course of the NYCLU's study, several prisoners attempted suicide or seriously contemplated taking their lives.

Vulnerable prisoners, particularly those with mental illness, reported greater harm. Over the course of the NYCLU's study, several prisoners attempted suicide or seriously contemplated taking their lives. Several others had previously attempted suicide or engaged in self-harm while confined to extreme isolation. Again, these accounts are consistent with scientific literature documenting the deterioration of prisoners with mental illness in conditions of extreme isolation.

For corrections staff, working in extreme isolation had lasting negative consequences, including persistent discord and stress that permeated their lives even outside the workplace. Staff reported that the SHU relegates them to performing menial functions, undermining their ability to maintain authority and increasing the likelihood of conflict. Moreover, gaps in basic education and training hamper the ability of staff to respond effectively to prisoners living in the difficult environment of extreme isolation. An atmosphere of distrust in the SHU creates a parallel culture of isolation among corrections staff, who fear retribution by isolated prisoners and potential exposure by peers. This distrust discourages staff from seeking help for their own mental health and emotional concerns and from intervening on behalf of prisoners.

Finding No. 3: Extreme Isolation Decreases Prison and Community Safety.

The NYCLU found that extreme isolation negatively impacted safety within the SHU. Consistent with the scientific literature, prisoners described how the psychological effects of extreme isolation resulted in uncontrollable outbursts of anger, rage and aggression against other prisoners and corrections staff. In particular, the practice of double-celling prisoners – some of whom were ostensibly separated from the general prison population for violent behavior – increased the risk of additional violent behavior between cellmates.

Vulnerable prisoners also reported that extreme isolation caused particular harms that led to decreased safety inside the SHU. Prisoners with mental illness reported severe emotional and psychological consequences, including self-harm and attempted suicide. Prisoners, including those with substance abuse problems, reported access to illegal and pharmaceutical drugs in the SHU, even as they were denied access to substance abuse therapy or treatment. Several prisoners noted that their personal drug use, particularly marijuana, increased while in extreme isolation in an effort to ease the intense emotional and psychological toll of living in the SHU.

The NYCLU also found that many of the negative effects of extreme isolation persisted when prisoners returned to the general prison population. After long periods in extreme isolation, prisoners reported that social interactions were difficult and challenging. They further found it difficult to control their emotions, reacting aggressively and violently to situations that would not previously have provoked such a response. Corrections staff similarly noted that

prisoners returning from the SHU to general population often struggled to respond appropriately to minor stresses or avoidable confrontations.

Finally, the NYCLU found that extreme isolation increased the potential for negative outcomes when prisoners return to the community. Extreme isolation results in the complete cessation of any rehabilitative activity. Many prisoners in the SHU reported progress in educational or vocational programming in the general prison population, but found those gains abruptly halted by their transfer to extreme isolation. Prisoners who were going to be released to the community directly from the SHU reported that their inability to access any programming – including transitional services that prepare prisoners for re-entry – left them feeling less equipped to return home and significantly increased their fear of reverting to behavior that resulted in their incarceration.[128]

Alternatives: Reconsidering Extreme Isolation Across the United States

New York is not alone in its unjustifiable use of extreme isolation. Across the United States, prisons and jails abuse extreme isolation. Several states, however, have recently undertaken a critical analysis of their use of extreme isolation, resulting in dramatic reductions in the number of prisoners held in these conditions without jeopardizing prison safety and security. These reforms provide a clear road map for rethinking the use of extreme isolation in New York.

The recent experience of three states is instructive. Mississippi, following a successful American Civil Liberties Union lawsuit, formed a task force in 2006 to evaluate the population in extreme isolation and the rationale for their placement there.[129] In Maine, a grassroots political campaign urging reform of the state's use of extreme isolation resulted in a year-long study commissioned by the state Legislature in 2010.[130] In 2011, the Colorado Legislature similarly ordered an independent review of the state's use of extreme isolation.[131]

Each of these states came to the conclusion that they were grossly overusing extreme isolation. Each responded by dramatically reducing the number of people confined in such conditions. In Mississippi, Deputy Commissioner Emmitt Sparkman explained:

> Many of the negative effects of extreme isolation persisted when prisoners returned to the general prison population. Extreme isolation increased the potential for negative outcomes when prisoners return to the community.

> If you had talked to me before we started our project to reduce the use of segregation, I'd have told you that the majority of offenders in our long-term segregation were dangerous and a threat to staff and offender safety. But when we looked at their cases, we saw that many of the people we were holding in segregation were not a threat. They started with minor violations, were put in segregation, and continued with disruptive – but not violently disruptive – behavior.[132]

Mississippi ultimately transferred roughly 85 percent of people in extreme isolation back to the general prison population.[133]

In Maine, the legislature-sponsored study recommended sweeping reforms to the state's use of extreme isolation, including dramatically reducing the number of men subjected to these conditions.[134] Commissioner Joe Ponte, appointed in 2011, supported the study's recommendations. Within his first few months as commissioner, Ponte reduced the population in extreme isolation by 70 percent.[135]

In Colorado, the legislature-sponsored study also reached the conclusion that the state was overusing extreme isolation. In particular, the study noted that only about 25 percent of prisoners had been placed in extreme isolation for injuring other prisoners or staff.[136] As a result of the study, the Colorado Department of Corrections began reducing the population in extreme isolation. It has currently transferred more than 30 percent of the prisoners in extreme isolation back to the general prison population.[137]

Each state reformed its use of extreme isolation without adverse safety and security consequences. In Mississippi, Deputy Commissioner Sparkman noted, "when we started moving people to lower security levels, we found that there was no increase in violence." Moreover, for those individuals who remained in isolation, the Department of Corrections "gave them more freedoms" and saw, as a consequence, "a huge decrease in violence."[138]

In Maine, limiting the use of "segregation to the more violent offenders [had positive results;]... all of our data show us that the situation actually has improved and not gotten worse."

Sparkman also observed that reducing the use of extreme isolation had "positive effects on staff too," by "improv[ing] their work conditions." He noted that in extreme isolation, "you typically have two-on-one escorts and use restraints, and there are continuous searches – and that's a drain on staff." With fewer men in extreme isolation, Sparkman concluded, "there's much less stress on staff."[139]

Maine also experienced a decrease in violence, both in the general prison population and among the people who remained in isolation, as Commissioner Ponte observed:

> We had to measure the outcomes. Did we increase inmate violence? And every measure we've had, first in segregation – the acting out, the use of chemicals, the use of force, use of restraint chair – those numbers have dropped significantly, so segregation is a better place. And then we took those measurements and looked at them in population – inmate assaults, staff assaults, use of force – did they increase after we limited the use of segregation to the more violent offenders? All of our data show us that the situation actually has improved and not gotten worse.[140]

Similarly, Colorado has not reported any increase in violence or other disruptive activity.[141]

The finding that reducing the population in extreme isolation has a neutral or positive effect on levels of prison violence is supported by experiences in other corrections systems. An inquiry by the Commission on Safety and Abuse in America's Prisons, a bipartisan committee of experts, concluded that the increasing use of extreme isolation "is counter-productive, often causing violence inside facilities."[142] The Commission cited to evidence suggesting "diminishing returns in safety," including a study of corrections systems in Arizona, Illinois and Minnesota, which concluded that extreme isolation had little to no effect on lowering overall violence.[143] The Commission also cited to a study that suggested that corrections officers who work in extreme isolation "are more likely to be assaulted."[144] The Commission noted that while "[i]t may be that segregated prisoners ... pose a greater threat to officers ... it may also be true that harsh living conditions in segregation only exacerbate those tendencies." It concluded that extreme isolation "is not the only option" and that "dangerous prisoners can be safely managed without isolating them in locked cells 23 hours a day."[145]

Mississippi, Maine and Colorado have also experienced significant economic savings as a result of reducing their use of extreme isolation.

Mississippi, Maine and Colorado have also experienced significant economic savings as a result of reducing their use of extreme isolation. In Mississippi, the dramatic reduction in the number of prisoners in extreme isolation allowed the state to completely shutter its dedicated extreme isolation facility, saving roughly $5.6 million a year.[146] Colorado's reforms will allow the state to close one dedicated extreme isolation facility, saving Colorado taxpayers $4.5 million in fiscal year 2012-13 and $13.7 million in fiscal year 2013-14.[147]

Maine also anticipates savings from the state's reforms. Because prisoners in extreme isolation require additional supervision, reducing that population enables the state to use staff more efficiently, lowering overtime costs. Whereas overtime costs were between $1,800 and $2,000 per two-week pay period per officer before the reforms, Commissioner Ponte stated: "Now they're running between $400 to 500 in a pay period. It's a substantial reduction."[148]

INTERNATIONAL HUMAN RIGHTS AND EXTREME ISOLATION IN THE UNITED STATES

Treaties ratified by the United States are binding under the Supremacy Clause of the U.S. Constitution: "[A]ll treaties made ... under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the constitution or laws of any state to the contrary notwithstanding."[153] The following is a summary of the key treaties containing provisions governing the treatment of prisoners and the human rights bodies that monitor their implementation:

International Covenant on Civil and Political Rights (ICCPR): The ICCPR is an international human rights treaty that provides a range of protections for civil and political rights. Together with the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, the ICCPR is part of the International Bill of Human Rights. The ICCPR obligates state parties to respect the civil and political rights of individuals, including the right to life and human dignity; equality before the law; freedom of speech, assembly and association; freedom of religion; freedom from torture; and due process and fair trial. The United States ratified the ICCPR in 1992; 167 countries have ratified the ICCPR to date.

Human Rights Committee (HRC): The HRC is a body of independent experts responsible for issuing interpretive guidance on the ICCPR and monitoring its implementation by ratifying countries. The HRC publishes its interpretation of ICCPR provisions in the form of "general comments." State parties are obligated to report to the HRC every four years; the HRC examines each report and addresses its concerns and recommendations in the form of "concluding observations."

Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT): CAT is an international human rights treaty that obligates state parties to prohibit and prevent torture and cruel, inhuman or degrading treatment or punishment. The United States ratified CAT in 1994; 151 countries have ratified CAT to date.

Committee Against Torture: The Committee Against Torture is a body of independent experts responsible for issuing interpretive guidance on CAT and monitoring its implementation by ratifying countries. State parties are obligated to report to the Committee every four years; the Committee examines each report and addresses its concerns and recommendations in the form of "concluding observations."

The Vera Institute of Justice, an independent non-profit that conducts research and analysis of criminal justice systems, has similarly concluded that reducing the use of extreme isolation can benefit states. Through its Segregation Reduction Project, Vera is working to demonstrate "that it is possible for states to save money and achieve better outcomes by significantly reducing the numbers of prisoners held in segregation without jeopardizing institutional safety, and to create a model that can be adapted for use in many other U.S. jurisdictions."[149] Vera is currently working with state corrections agencies in Illinois, Maryland, New Mexico and Washington to assess and reduce their use of extreme isolation.

Extreme Isolation is Legally Indefensible

Even as a growing number of states are undertaking a long-overdue, evidence-based analysis of their use of extreme isolation, international human rights bodies and legal scholars are reaching the consensus that the separation of violent or vulnerable prisoners should be used sparingly and under stringent controls and safeguards. Guidance from these sources makes clear that New York must radically reform how and when it separates prisoners.

New York is subject to international human rights standards contained in treaties ratified by the United States. The United States is a party to the International Covenant on Civil and Political Rights (ICCPR) and the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT), which contain provisions specifically applicable to the treatment of prisoners.[150] Both treaties prohibit torture and cruel, inhuman or degrading treatment or punishment.[151] In addition, the ICCPR further requires state parties to treat prisoners "with humanity and with respect for the inherent dignity of the human person" and to establish rehabilitation as the "essential aim" of incarceration.[152]

The Human Rights Committee (HRC) has found that conditions of solitary confinement may amount to cruel, inhuman or degrading treatment or punishment, in violation of ICCPR Article 7.[154] The HRC has specifically observed that solitary confinement in the U.S. may violate the terms of Article 10, by incarcerating prisoners "in general conditions of strict regimentation in a depersonalized environment."[155] The Committee Against Torture has similarly noted that the practice of extreme isolation in U.S. prisons may violate that treaty by constituting "cruel, inhuman or degrading treatment or punishment."[156]

International human rights authorities are unanimous that solitary confinement should be an exceptional measure imposed as a last resort, for as brief a period as possible.

The United Nations Special Rapporteur on Torture, an independent human rights expert, recently concluded that:

> Given its severe adverse health effects, the use of solitary confinement itself can amount to acts prohibited by article 7 of the International Covenant on Civil and Political Rights, torture as defined in article 1 of the Convention against Torture or cruel, inhuman or degrading punishment as defined in article 16 of the Convention [against Torture].[157]

International human rights authorities are unanimous that solitary confinement should be an exceptional measure imposed as a last resort, for as brief a period as possible. International human rights authorities have also called for the blanket prohibition against solitary confinement for particular vulnerable populations, including juveniles and those suffering from mental disabilities.[158]

These conclusions are echoed by mainstream legal scholars in the United States, including the largest association of American lawyers, the American Bar Association (ABA). In its Standards for the Treatment of Prisoners, the ABA recognized that:

> Some dangerous prisoners pose a threat to others unless they are physically separated. But such separation does not necessitate the social and sensory isolation that has become routine. Extreme isolation is not about the physical protection of prisoners from each other. It is a method of deterrence and control – and as currently practiced it is a failure.[159]

The ABA's standards call for a complete abolition of conditions of extreme isolation.[160] The standards also include a strict set of safeguards and protocols to ensure that prisoners are only separated when absolutely necessary, based on a demonstrable need for separation,[161] and that separation is "for the briefest term and under the least restrictive conditions practicable."[162] The standards acknowledge that special care must be taken whenever separating juveniles and prisoners with mental illness,[163] and that no prisoner with a serious mental health illness should ever be separated for longer than 30 days.[164] These basic principles and protections mirror those recommended by other legal scholars and experts, including the Commission on Safety and Abuse in America's Prisons[165] and the ACLU's National Prison Project.[166]

International human rights bodies, legal scholars and corrections officials in other states have concluded that the separation of violent or vulnerable prisoners should occur sparingly and under tight controls. To date, federal courts applying U.S. constitutional standards have accorded state corrections officials using extreme isolation an extraordinary amount of deference – deference that has contributed to the harmful use of extreme isolation across the United States. Courts must re-examine these conclusions, especially in light of the growing body of scientific and academic scholarship demonstrating that extreme isolation inflicts grave harm upon all prisoners and has a potentially detrimental effect on prison safety and security. New York's systemic misuse of extreme isolation cannot indefinitely elude judicial review. New York should take immediate action to implement humane, effective and sweeping reforms.

Recommendations

Violent and vulnerable prisoners can be separated from the general prison population without extreme isolation. In New York, however, extreme isolation and prisoner separation have become inextricably intertwined. Under New York's current regime, separating a prisoner – for reasons capricious or substantial – entails subjecting that prisoner to punishing physical and psychological deprivation.

New York must end its use of extreme isolation. This goal can be achieved by two practical steps: (1) adopting stringent criteria, procedures and safeguards for prisoner separation and (2) auditing the current population of prisoners in extreme isolation.

Recommendation No. 1: Adopt Stringent Criteria, Procedures and Safeguards for Prisoner Separation.

New York must adopt clear and objective standards to ensure that prisoners are separated only in limited and legitimate circumstances, for the briefest period and under the least restrictive conditions practicable. To achieve this objective, New York standards must incorporate the following major principles drawn from the ABA, ACLU's National Prison Project, Commission on Safety and Abuse in America's Prisons and international human rights standards:

Use clear and objective criteria consistent with the limited and legitimate uses of separation: New York must adopt standards and procedural protections that ensure that a prisoner is separated only when officials have proven through specific and demonstrable evidence that the prisoner: (1) is chronically violent or assaultive, (2) presents a serious escape risk or (3) otherwise poses a serious ongoing threat to prison safety and security or whose personal safety is at risk, while in the general prison population.[167]

Create individualized plans for separated prisoners and conduct periodic reviews of prisoner separation: Whenever a prisoner is separated, an individualized plan should be developed, which includes an assessment of the prisoner's needs, a strategy for correctional officials to assist the prisoner in meeting those needs, and a statement of expectations for the prisoner to progress toward fewer restrictions and eventually return to the general prison population based on the prisoner's behavior. A prisoner's separation must be periodically reviewed to evaluate the prisoner's progress under the individualized plan and to determine whether the prisoner continues to meet the criteria for separation. This review must include an ongoing evaluation of any harm the prisoner is experiencing as a result of the separation. If at any point it is determined that separation is no longer necessary or threatens the physical or mental health of the prisoner, it should be immediately terminated.

Account for prisoners' vulnerability when deciding whether separation is appropriate: When determining whether separation is appropriate, the particular characteristics of the prisoner and the potential effects of separation on that prisoner must be taken into account. DOCCS must give special attention to vulnerable populations, such as juveniles, the elderly, prisoners with mental illness or developmental disabilities, prisoners with substance abuse problems, monolingual non-English speakers, and prisoners with mobility, visual and hearing disabilities. It may never be proper to separate particular types of vulnerable prisoners. Certainly it is true that, as separation is currently practiced in New York, juveniles and persons with mental illness should be categorically barred from the SHU.

Establish a centralized, high-level and multidisciplinary body to review prisoner separation: The decision to separate a prisoner according to the criteria above should be reviewed by a centralized body, appointed by the commissioner, which includes qualified mental health professionals, counselors and community supervision staff.

Ensure that conditions of separation are the least restrictive possible: When prisoners are separated, the conditions of confinement should be the least restrictive possible. Meaningful human interaction and mental stimuli should not be stripped away. Pre-existing mental health treatment, substance abuse treatment, educational and vocational classes, and other rehabilitative programming should be continued whenever possible. Prisoners' rights to adequate and confidential medical and mental health services should never be compromised. The practice of punishing prisoners with the deprivation of basic human necessities – food, recreation, hygiene – should be abolished. Double-celling should never be used in situations where a prisoner has been separated from the general prison population for violent behavior

or potential vulnerability.

Provide for transition when separation is discontinued: When separation is no longer deemed necessary, the prisoner should transition back to the general prison population in a manner that best prepares the prisoner to successfully reintegrate. If a prisoner will still be separated at the date of release from prison, the prisoner must receive transitional programming and be transferred to a less restrictive setting well in advance of release.

Recommendation No. 2: Audit the Population of Prisoners in Extreme Isolation.

Adopting stringent criteria, procedures and safeguards for prisoner separation will ensure that DOCCS' future use of separation is appropriately constrained. But a significant number of prisoners currently in the SHU should never have been separated in the first place. Even in those limited cases where a pre-existing SHU sentence may have been initially appropriate under the criteria outlined above, the need for separation may have long since passed. Thus, New York should conduct a comprehensive, transparent audit of the current SHU population, including the following steps:

Establish an independent audit committee: New York should appoint an independent multi-disciplinary committee to audit DOCCS' entire SHU population. This audit should identify which prisoners in extreme isolation do not qualify for separation consistent with the criteria outlined in Recommendation No. 1. DOCCS should transition these prisoners back to the general prison population and reduce the number of SHU beds accordingly.

Ensure that audit process and results are transparent: New York's use of extreme isolation has been facilitated, in part, by the dearth of publicly available information about its use. The audit process and its results should be made publicly available. In addition, DOCCS should collect and publish data on a quarterly basis reflecting statistical and demographic information on the prisoners who have been separated from the general prison population, for what reasons and for how long.[168]

Reinvest financial savings back into DOCCS: New York has asked DOCCS to accomplish critically important public services – maintaining safe prisons and ensuring positive outcomes when prisoners return to the community – with far too few resources for far too long. DOCCS should retain control over any financial savings that accrue from reforming New York's use of extreme isolation so that it can reinvest those funds in programming and staff. ■

EPILOGUE

New York's use of extreme isolation exemplifies the costly mistakes that have afflicted other aspects of American criminal justice policy over the last few decades: Laws based on rhetoric and assumptions instead of evidence and analysis; policies hyper-focused on punishment at the expense of rehabilitation, to the point of compromising public safety; politics that discredit the humanity of those who commit crimes, sanctioning treatment that conflicts with our fundamental values and essential human rights.

Prisons are institutions remote from public view, rendering prisoners particularly vulnerable to mistreatment and abuse. They are "persons who most of us would rather not think about ... [b]anished" to a "shadow world that only dimly enters our awareness."[169] If prisons are opaque, the SHUs are virtual black boxes. It is no surprise, then, that the confluence of misguided approaches to criminal justice has manifested itself most demonstrably in the SHUs.

The mistakes we have made in subjecting so many to extreme isolation now offer us a critical opportunity. The NYCLU hopes this report, documenting the complex human experience in New York's SHUs, will engender serious debate and ultimately lead to reform of extreme isolation. If we can bring light into the Box and fix the darkest corners of our prisons, we can surely replicate that success – using humane and effective evidence-based approaches – in other parts of our criminal justice system. ■

ENDNOTES

1 "DOCCS Daily Population Capacity Report – 06/11/12," obtained through the New York Freedom of Information Law (FOIL) and on file with the NYCLU (reporting 55,969 prisoners under DOCCS custody). The NYCLU's original FOIL request and documents produced by DOCCS are available online at www.nyclu.org/boxedin.

2 Paul Guerino, Paige M. Harrison and William J. Sabol, *Prisoners in 2010* (Washington: U.S. Department of Justice, 2011) 24 (reporting 25,481 prisoners released from New York state prisons in 2009 and 25,365 prisoners released in 2010).

3 *The Price of Prisons: What Incarceration Costs Taxpayers*, Vera Institute of Justice, Jan. 2012: 8, 10.

4 "DOCCS Daily Population Capacity Report – 06/11/12," obtained through FOIL and on file with the NYCLU.

5 DOCCS operating costs broken down by facility as of March 3, 2011, obtained through the New York State Assembly Committee on Correction and on file with the NYCLU.

6 "DOCCS Dispositions with SHU Sentences – 01/01/2007-12/31/2011: Number of SHU Sentences by Year and Original Length of Sentence," obtained through FOIL and on file with the NYCLU.

7 "DOCCS Dispositions with SHU Sentences – 01/01/2007-12/31/2011: Length of SHU Sentence by Incident Year," obtained through FOIL and on file with the NYCLU.

8 "DOCCS Summary of Inmates Released 01/01/2008-12/31/2011 Statewide from SHU," obtained through FOIL and on file with the NYCLU.

9 *See, e.g.*, Jeanmarie Evelly, "Solitary Confinement on the Rise at Rikers," *City Limits*, 27 Mar. 2012.

10 *See, e.g., Custody and Control: Conditions of Confinement in New York's Juvenile Prisons for Girls*, American Civil Liberties Union and Human Rights Watch, Sept. 2006: 105-113 (discussing the "isolated confinement" of girls in two New York juvenile facilities).

11 Nina Bernstein, "Move Across Hudson Further Isolates Immigration Detainees," *New York Times*, 16 Mar. 2010 (noting that New York immigration detainees held in New Jersey's Hudson County Correctional Center were "punished with isolation").

12 Men make up roughly 99% of the total number of prisoners in extreme isolation. "DOCCS Daily Population Capacity Report – 06/11/12," obtained through FOIL and on file with the NYCLU. But the NYCLU recognizes that women are also held in extreme isolation in New York prisons and that their experiences, while equally harrowing, may be distinct to that of men.

13 The NYCLU submitted a FOIL request for DOCCS records on December 9, 2011. The request sought comprehensive and detailed information on how DOCCS uses extreme isolation, including information regarding the number of prisoners placed in extreme isolation, the reasons for their placement, and the length of their isolated confinement. On April 2, 2012, the NYCLU submitted an administrative appeal to DOCCS challenging its failure to produce a substantive response to the majority of the request. On May 10, 2012, after failing to receive a response to the administrative appeal, the NYCLU communicated to DOCCS that it would seek court-ordered document production. From May to July 2012, DOCCS produced records partially responsive to the FOIL request. At the time this report went to print, the NYCLU was still waiting for DOCCS to produce records responsive to several items in the original FOIL request.

14 "DOCCS Daily Population Capacity Report – 06/11/12," obtained through FOIL and on file with the NYCLU.

15 Harry Elmer Barnes, "The Historical Origin of the Prison System in America," *Journal of the American Institute of Criminal Law & Criminology* 12 (1921): 53.

16 Gustave de Beaumont and Alexis de Tocqueville, *On the Penitentiary System in the United States and Its Application in France*, trans. Francis Lieber (Philadelphia: Carey, Lea & Blanchard, 1833) 5-6.

17 Pennsylvania constructed one of the first U.S. prisons – the Eastern Penitentiary – dedicated to housing prisoners in extreme isolation. Charles Dickens famously toured the Penitentiary in 1842 and concluded: "The system here, is rigid, strict, and hopeless solitary confinement. I believe it, in its effects, to be cruel and wrong." Based on interviews with

several prisoners, Dickens described those effects as a "slow and daily tampering with the mysteries of the brain ... immeasurably worse than any torture of the body." He further disputed the Penitentiary's rehabilitative purpose, observing that "independent of the mental anguish it occasions – an anguish so acute and so tremendous, that all imagination of it must fall far short of the reality – it wears the mind into a morbid state, which renders it unfit for the rough contact and busy action of the world." Charles Dickens, *American Notes for General Circulation* (New York: D. Appleton & Co., 1868) 43-48. Pennsylvania abandoned extreme isolation in the post-Civil War period. Harry Elmer Barnes tracked the adoption and abandonment of extreme isolation across half a dozen other states as follows:

STATE	ADOPTED	ABANDONED
Maine	1824	1827
Maryland	1809	1838
Massachusetts	1811	1829
New Jersey	1820	1828
	Reintroduced in 1833	1858
Rhode Island	1838	1844
Virginia	1824	1833

Barnes, *supra* note 15, at 56 n. 54.

18 *In re Medley*, 134 U.S. 160, 168 (1890).

19 *See* Craig Haney and Mona Lynch, "Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement," *N.Y.U. Review of Law & Social Change* 23 (1997) 485-88 (discussing the general trend towards circumscribing the use of extreme isolation in the late 19th and early 20th centuries).

20 Stephen C. Richards, "USP Marion: The First Federal Supermax," *The Prison Journal* 88 (2008) 10. In 2007 the federal government converted USP Marion into a medium-security prison, ending its permanent lockdown status. *Id.* at 18.

21 *Prison Conditions in the United States*, Human Rights Watch, 1991: 3. *See also* Russ Immarigeon, "The Marionization of American Prisons," *National Prison Project Journal* (Fall 1992) 1. Marion emulated the model established by Alcatraz, a federal correctional facility opened in 1934, where the "most troublesome prisoners" were concentrated "in a place of draconian isolation." Haney and Lynch, "Regulating Prisons of the Future," *supra* note 19, at 488. The federal government shuttered Alcatraz in 1963 after years of controversy. David A. Ward and Allan F. Breed, *The United States Penitentiary, Marion, Illinois: A Report to the Judiciary Committee, U.S. House of Representatives*, 98th Cong., 2nd Sess., 1984: 1 ("Alcatraz, it was charged, was America's Devil's Island, it was 'Hellcatraz' – a place where convicts slowly went insane from the tedium and hopelessness of endless years on 'the Rock.'").

22 *Prison Conditions in the United States, supra* note 21, at 4. Some dispute exists as to the precise number of states that were constructing or repurposing facilities entirely dedicated to extreme isolation in the 1980s and 1990s. In a 1996 survey conducted by the National Institute of Corrections, 32 states reported having such facilities. U.S. Department of Justice, National Institute of Corrections, *Supermax Housing: A Survey of Current Practice* (Washington: U.S. Department of Justice, 1997) 7. The accuracy of that figure is in serious doubt. New York, for example, reported having no such facilities despite its operation of prisons with "the design characteristics and many of the operating procedures of what other states defined as supermax." Roy D. King, "The Rise and Rise of Supermax," *Punishment and Society* 1 (1999) 173.

23 Daniel P. Mears, *Evaluating the Effectiveness of Supermax Prisons*, Urban Institute Justice Policy Center, Mar. 2006: 4.

24 Rachael Kamel and Bonnie Kerness, *The Prison Inside the Prison: Control Units, Supermax Prisons, and Devices of Torture*, American Friends Service Committee, 2003: 2.

25 John J. Gibbons and Nicholas de B. Katzenbach, *Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons*, Vera Institute of Justice, June 2006: 52, citing James J. Stephan and Jennifer C. Karberg, *Census of State and Federal Correctional Facilities, 2000* (Washington: U.S. Department of Justice, 2003).

26 Tracy L. Snell, *Correctional Populations in the United States, 1993* (Washington: U.S. Department of Justice, 1995) iii; Patrick A. Langan et al., *Historical Statistics on Prisoners in State and Federal Institutions, Yearend 1925-1986* (Washington: U.S. Department of Justice, 1988) 15. The prison population continued to increase, hitting a peak of roughly 1.52 million in 2009, and declining slightly since then. Lauren E. Glaze, *Correctional Population in the United States, 2010* (Washington: U.S. Department of Justice, 2011) 3. These figures exclude the number of individuals incarcerated in jails.

27 Chase Riveland, *Supermax Prisons: Overview and General Considerations* (Washington: U.S. Department of Justice, 1999) 5 ("As correctional populations have escalated in recent years, prison crowding has become the norm in most jurisdictions. Most prisons across the country have been operating at well over 100% of design capacity. This crowding aggravated by the increase in street gang members, drug offenders, mentally ill, and youthful offenders has stressed the prisons and corrections systems. ... One response on the part of prison officials in many jurisdictions, in attempting to maintain control, has been the introduction of supermax units or facilities.").

28 Leena Kurki and Norval Morris, "The Purposes, Practices, and Problems of Supermax Prisons," *Crime & Justice* 28 (2001) 390; Jesenia M. Pizarro, Vanja M. K. Stenius and Travis C. Pratt, "Supermax Prisons: Myths, Realities, and the Politics of Punishment in American Society," *Criminal Justice Policy Review* 17 (2006) 8-9.

29 Riveland, *supra* note 27, at 5.

30 Kurki and Morris, *supra* note 28, at 391.

31 Timothy Hughes and Dora James Wilson, *Reentry Trends in the United States: Inmates Returning to the Community After Serving Time in Prison* (Washington: U.S. Department of Justice 2004) 1.

32 "Trying to Economize, New York Creates Its Own Alcatraz," *New York Times* 20 Feb. 1991: B1.

33 The section of the New York Codes, Rules and Regulations, which compiles state agency rules and regulations, addressing the operation of SHUs was first adopted in 1970. N.Y. Comp. Codes R. & Regs. tit. 7, ch. 6 ("Special Housing Units"). New York prison litigation in the 1970s and 1980s featured complaints about the conditions in various SHUs. *See, e.g., Sostre v. McGinnis*, 442 F.2d 178 (2d Cir. 1971) (discussing conditions in the SHU at Green Haven Correctional Facility); *Frazier v. Ward*, 426 F.Supp. 1354 (N.D.N.Y. 1977) (discussing conditions in the SHU at Clinton Correctional Facility).

34 *Lockdown New York: Disciplinary Confinement in New York State Prisons*, Correctional Association of New York, 2003: 9-10. The Correctional Association refers to the SHU 200s as "S-Blocks."

35 The medium-security correctional facilities are Cayuga, Collins, Fishkill, Gouverneur, Greene, Lakeview, Marcy, Mid-State, and Orleans. *Id.* In 2008 the SHU 200 at Marcy was converted from an extreme isolation facility to a "Residential Mental Health Unit," providing heightened mental health services to prisoners subject to disciplinary lockdown. The conversion was one of the settlement terms achieved in a lawsuit by prisoners' rights advocates against DOCCS and OMH challenging the inadequate provision of mental health care. *Marcy Correctional Facility*, Correctional Association of New York, April 2008: 1.

36 Upstate was originally designed to house all prisoners in extreme isolation in double cells. In December 2001, 160 of the cells were reclassified as single cells, giving Upstate the capacity to house 1,040 men – 880 in double cells and 160 in single cells. "New Concept in Disciplinary Housing: Upstate," *DOCS Today*, Apr. 2003, 15.

37 *Inmates Under Custody at End of Calendar Year: New York State Department of Correctional Services 1950-2003*, Correctional Association of New York, Mar. 2012.

38 Judith Greene and Marc Mauer, *Downscaling Prisons: Lessons from Four States*, The Sentencing Project, 2010: 6.

39 *Trends in New York State Prison Commitments*, Correctional Association of New York, 2009.

40 Kevin Sack, "Agreement on Revisions in Sentencing," *New York Times* 25 May 1995: B1.

41 Raymond Hernandez, "Assembly Passes Pataki's Measure to Limit Parole," *New York Times* 30 July 1998: A1.

42 Sarah Metzgar, "A Future Crowded with Fears: 'We're Jamming People In – People Who Have Nothing Left to Lose. That's Tinder for an Explosion.'," *Albany Times Union* 10 Sept. 1996: A1.

43 Paula M. Ditton and Doris James Wilson, *Special Report: Truth in Sentencing in State Prisons* (Washington: U.S. Department of Justice, 1999) 1; *Lockdown New York, supra* note 34, at 13.

44 U.S. General Accounting Office, *Truth in Sentencing: Availability of Federal Grants Influenced Laws in Some States* (Washington: United States General Accounting Office, 1998) 6.

45 *Lockdown New York, supra* note 34, at 13-14.

46 Stuart Grassian, "Psychopathological Effects of Solitary Confinement," *American Journal of Psychiatry* 140 (1983) 1450.

47 *E.g.*, S.L. Brodsky & F.R. Scogin, "Inmates in Protective Custody: First Data on Emotional Effects," *Forensic Reports* 1 (1988); Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Washington University Journal of Law & Policy* 22 (2006); Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *Crime and Delinquency* 49 (2003); Haney and Lynch, "Regulating Prisons of the Future," *supra* note 19; Holly A. Miller and Glenn R. Young, "Prison Segregation: Administrative Detention Remedy or Mental Health Problem?," *Criminal Behavior and Mental Health* 7 (1997); Peter Scharff Smith, "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature," *Crime and Justice* 34 (2006).

48 *E.g.*, Sasha Abramsky and Jamie Fellner, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, Human Rights Watch, 2003: 145-68; Kristin G. Cloyes et al., "Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample, *Criminal Justice and Behavior* 33 (2006) 760, 773-74; Grassian, "Psychiatric Effects of Solitary Confinement," *supra* note 47, at 332, 348; Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *supra* note 47.

49 *Hutto v. Finney*, 437 U.S. 678, 685 (1978).

50 In *Turner v. Safly*, 482 U.S. 78 (1987), the Supreme Court formally articulated a standard of deference, known as the rational basis test. Under this standard, "when a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests." *Id.* at 89. This standard has subsequently been applied to uphold a wide range of prison restrictions affecting fundamental constitutional rights. *See, Beard v. Banks*, 548 U.S. 521 (2006) (access to publications); *Overton v. Bazzetta*, 539 U.S. 126 (2003) (visiting); *Washington v. Harper*, 494 U.S. 210 (1990) (administration of psychotropic medication); *O'Lone v. Estate of Shabazz*, 482 U.S. 342 (1987) (religious exercise).

51 A prisoner challenging conditions of confinement must demonstrate both a "sufficiently serious" deprivation (i.e. objective standard) and that officials acted with a "sufficiently culpable state of mind" (i.e. subjective standard). *Wilson v. Seiter*, 501 U.S. 294, 298 (1991).

52 Pub. L. No. 104-134, 110 Stat. 1321 (1996) (codified as amended at 18 U.S.C. §3626, 28 U.S.C. §1915, 28 U.S.C. §1346, 42 U.S.C. §1997e, and other scattered sections). The Prison Litigation Reform Act (PLRA) requires prisoners, *inter alia*, to exhaust administrative remedies and demonstrate physical injury. For more information on the harmful consequences of the Prison Litigation Reform Act and the reasons it should be significantly amended, see SAVE Coalition, Prison Litigation Reform Act (PLRA): Myths and Facts, http://www.savecoalition.org/myths.html.

53 *See, Jones'El v. Berge*, 164 F. Supp. 2d 1096, 1116-1126 (W.D. Wis. 2001); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999), *rev'd on other grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F. Supp. 2d 975 (S.D. Tex. 2001) ("Conditions in [extreme isolation] units clearly violate constitutional standards when imposed on the subgroup of the plaintiffs' class made up of mentally-ill prisoners"); *Madrid v. Gomez*, 889 F. Supp. 1146, 1265-66 (N.D. Cal. 1995). Several of these same courts have also observed, in dicta, the toll that extreme isolation takes on all individuals, regardless of their mental stability. *See, Jones'El*, 164 F. Supp. 2d at 1101 ("Confinement in a supermaximum security prison such as Supermax is known to cause severe psychiatric morbidity, disability, suffering and mortality. Prisoners in segregated housing units who have no history of serious mental illness and who are not prone to psychiatric decompensation (breakdown) often develop a constellation of symptoms known as 'SHU Syndrome.'"); *Ruiz*, 37 F. Supp. 2d at 907 (describing extreme isolation units as "virtual incubators of psychoses-seeding illness in otherwise healthy inmates"); *Madrid*, 889 F. Supp. at 1235, 1267 (observing that "many, if not most inmates in [extreme isolation] experience some degree of psychological trauma in reaction to their extreme social isolation and the severely restricted environmental stimulation," and that the regime "may press the outer bounds of what most humans can psychologically tolerate"). Recently, a federal district court held that a New York state prisoner, who was placed in the SHU for over two years after a cell search revealed papers prohibited under prison rules, stated a plausible claim under the Eighth Amendment. *Peoples v. Fischer*, No. 11 Civ. 2694, 2012 WL 2402593, at *1 (S.D.N.Y. June 26, 2012) ("Leroy Peoples was housed in [the SHU] for over two years, even though there was never any finding that he posed a threat to the safety of others or the security of the prison. His placement in the SHU for such a time period was grossly disproportionate to the non-violent violation that he was found to have committed. He has therefore stated a plausible claim that defendants violated his Eighth Amendment right to be free from cruel and unusual punishment.").

54 N.Y. Comp. Codes R. & Regs. tit. 7, §§ 253.7, 254.7 (disciplinary segregation), 301.4 (administrative segregation), and 330.2 (protective custody). Prisoners in protective custody are generally permitted three hours per day of out-of-cell time, including an hour for recreation, and may take two meals per day outside their cells. They are also permitted phone calls and personal property. Id. §§ 330.4-330.5.

55 "DOCCS Summary of Inmates Newly Placed into SHU Cells – 01/01/07-12/31/11" and "DOCCS Dispositions with SHU Sentences – 01/01/2007-12/31/2011: Number of SHU Sentences by Year and Original Length of Sentence," obtained through FOIL and on file with the NYCLU.

56 N.Y. Comp. Codes R. & Regs. tit. 7, § 270.2.

57 *Id.*

58 Select disciplinary records for infractions discussed throughout the report are available at www.nyclu.org/boxedin.

59 N.Y. Comp. Codes R. & Regs. Tit. 7, §§ 251-1.6, 253.7, 254.7.

60 *Id.* § 253.7. According to DOCCS regulations governing "keeplock admission" to the SHU: "An inmate in a medium or minimum correctional facility or Upstate Correctional Facility may be housed in a special housing unit for reasons such as, but not limited to, the following: … (2) for confinement pursuant to a disposition of a disciplinary (Tier II) or superintendent's (Tier III) hearing." *Id.* § 301.6.

61 "DOCCS Dispositions with Keeplock Sentences – 01/01/2007-12/31/2011," obtained through FOIL and on file with the NYCLU.

62 "Table 4-7: Selected Offender Populations in SHU – DOCCS Under Custody Pop. Jan. 1, 2012," obtained through FOIL and on file with the NYCLU.

63 N.Y. Comp. Codes R. & Regs. tit. 7, § 251-3.1.

64 *Id.* § 251-1.5.

65 *Id.* § 251-3.1.

66 *Id.* § 251-2.2.

67 *Id.* § 253.7. *See* note 60 (discussing DOCCS regulations governing "keeplock admission" to the SHU).

68 *Id.* § 254.7.

69 DOCCS, *Prison Safety in New York* (Albany: Department of Correctional Services, 2006) 17 (emphasis added).

70 N.Y. Comp. Codes R. & Regs. tit. 7, § 270.2.

71 Percentage calculated from "DOCCS Disciplinary Charge File Analysis – Incidents Occurring between 01/01/2007 and 12/31/2011," obtained through FOIL and on file with the NYCLU.

72 N.Y. Comp. Codes R. & Regs. tit. 7, §§ 253.5-253.6, 254.5-254.6. The prisoner must be served with the misbehavior report at least 24 hours in advance of the hearing. Tier III hearings have additional procedural safeguards for prisoners whose "mental state or intellectual capacity is at issue." In these circumstances, the hearing officer must investigate evidence concerning the prisoner's mental condition or intellectual capacity at the time of the incident. The hearing officer may, on the basis of this evidence, adjourn the hearing or request an assistant for the prisoner. If the hearing officer proceeds with the hearing and finds the accused prisoner guilty, the officer may, in light of the prisoner's mental condition or intellectual capacity, dismiss the charge.

73 *Id.* §§ 154.8, 253.8.

74 In the prison litigation context, claims of government misconduct and abuse often rest on the plaintiff prisoner's word against that of defendant corrections officers. In such cases, prisoners typically find their testimony viewed with skepticism by both judges and juries. *See* Margo Schlanger, "Inmate Litigation," *Harvard Law Review* 116 (2003) 1555, 1615 & n. 177 (observing that "both judges and juries tend to find convicted criminals unappealing and unbelievable witnesses" and extrapolating from studies that "find that, all else equal, jurors are more likely to convict a defendant if they know that he has a prior conviction").

75 "Inmate Disciplinary System – Count of Tier 3 Hearings: 2007-2011," obtained through FOIL and on file with the NYCLU.

76 *Id.*

77 DOCCS, "Guidelines for Disciplinary Dispositions," July 2005, obtained through FOIL and on file with the NYCLU.

78 DOCCS, *Prison Safety in New York, supra* note 69, at 19.

79 Jean Casella and James Ridgeway, "New York's Black Sites," *The Nation* 30 July 2012.

80 Percentages calculated from "Inmate Disciplinary System – Count of Tier 3 Hearings: 2007-2011," obtained through FOIL and on file with the NYCLU.

81 "DOCCS Dispositions with SHU Sentences – 01/01/2007-12/31/2011: Number of SHU Sentences by Year and Original Length of Sentence," obtained through FOIL and on file with the NYCLU. DOCCS permits discretionary time cuts to SHU sentences under its "Progressive Inmate Movement System" (PIMS), which is a three-level system of graduated privileges in the SHU. Prisoners on Level I, which is the most restrictive, can graduate to Level II after a minimum of 30 days without a disciplinary infraction. Similarly, prisoners on Level II can graduate to Level III after a minimum of thirty days without a disciplinary infraction. Prisoners on Levels II and III who commit a disciplinary infraction drop back to Level I. These levels are pegged to potential SHU time cuts. A "Disciplinary Review Committee" (DRC) reviews the case of each prisoner halfway between his date of arrival and date of release from the SHU. Level I and II prisoners are eligible to receive a time cut of up to 1/2 the amount of SHU time remaining. Level III inmates are eligible to receive a time cut of up to 2/3 the amount of SHU time remaining. The issuance of a time cut is up to the discretion of the DRC, just as the determination of tier ratings and whether misbehavior warrants a SHU sentence is up to the discretion of corrections officials.

82 For more information on DOCCS' placement of substance abusers in extreme isolation, see *Barred from Treatment: Punishment of Drug Users in New York State Prisons*, Human Rights Watch, Mar. 2009: 35-51. Drug-related rules include 113.14 ("An inmate shall not possess outdated or unauthorized types of quantities of medication, nor shall an inmate sell, exchange or provide any medication to anyone.); 113.24 ("An inmate shall not use or be under the influence of any narcotics or controlled substances unless prescribed by a health service provider and then only in the amount prescribed."); 113.25 ("An inmate shall not make, possess, sell or exchange any narcotic, narcotic paraphernalia, controlled substance or marijuana. An inmate shall not conspire with any person to introduce such items into the facility."); 180.14 ("An inmate shall comply with and follow the guidelines and instructions given by staff regarding urinalysis testing pursuant to the requirements of departmental Directive No. 4937 (N.Y. Comp. Codes R. & Regs. tit. 7, part 1020). This includes providing a urine sample when ordered to do so."). N.Y. Comp. Codes R. & Regs. tit. 7, § 270.2.

83 Percentages calculated from "Inmate Disciplinary System – Count of Tier 3 Hearings: 2007-2011," obtained through FOIL and on file with the NYCLU.

84 Percentages calculated from "DOCCS Disciplinary Charge File Analysis – Incidents Occurring between 01/01/2007 and 12/31/2011," obtained through FOIL and on file with the NYCLU.

85 *Id.*

86 DOCCS, "Guidelines for Disciplinary Dispositions," *supra* note 77.

87 "DOCCS Disciplinary Charge File Analysis, Table 3 – Charge by Year of Incident by Facility," obtained through FOIL and on file with the NYCLU.

88 For a discussion of the unique dangers that extreme isolation poses for juveniles, see Amy Fettig, "Teenagers Too Often End Up in Solitary," *New York Times*, 5 June 2012, http://www.nytimes.com/roomfordebate/2012/06/05/when-to-punish-a-young-offender-and-when-to-rehabilitate/the-dangers-of-juveniles-in-solitary-confinement; Human Rights Watch, "US: Look Critically at Widespread Use of Solitary Confinement," 18 June 2012, http://www.hrw.org/news/2012/06/18/us-look-critically-widespread-use-solitary-confinement. For a discussion of the particular vulnerabilities of elderly prisoners in extreme isolation, see James Ridgeway, "The Graying of America's Prisons," *The Crime Report*, 7 Dec. 2009, http://www.thecrimereport.org/viewpoints/the-graying-of-americas-prisons.

89 *See At America's Expense: The Mass Incarceration of the Elderly*, American Civil Liberties Union, June 2012: v ("There is an overwhelming consensus among correctional experts, criminologists, and the National Institute of Corrections that 50 years of age is the appropriate point marking when a prisoner becomes 'aging' or 'elderly.' The lack of appropriate healthcare and access to healthy living prior to incarceration, added to the heavy stresses of life behind bars, accelerates the aging process of prisoners so that they are actually physically older than average individuals."); *Old Behind Bars: The Aging Prison Population in the United States*, Human Rights Watch, Jan. 2012: 17 ("In the community, age 50 or 55 would not be considered 'older.' But incarcerated men and women typically have physiological and mental health conditions that are associated with people at least a decade older in the community. This accelerated aging process is likely due to the high burden of disease common in people from poor backgrounds who comprise the majority of the prison population, coupled with unhealthy lifestyles prior to and during incarceration. These factors are often further exacerbated by substandard medical care either before or during incarceration. The violence, anxiety, and stress of prison life, isolation from family and friends, and the possibility of spending most or all of the rest of one's life behind bars can also contribute to accelerated aging once incarcerated.").

90 "Table 3B and 3F: Age by Facility for Offenders Housed in SHU – DOCCS Under Custody Pop. Jan. 1, 2012," obtained through FOIL and on file with the NYCLU.

91 DOCCS, *Identified Substance Abuse* (Albany: Department of Correctional Services, 2007) i.

92 Percentages calculated from "Table 16D: Self-Report Substance Abuse for Southport CF, Upstate CF and SHU 200 Facilities – DOCCS Under Custody Pop. Jan. 1, 2012," obtained through FOIL and on file with the NYCLU.

93 Percentage calculated from "Active Mental Health Inmate-Patients Housed in Segregated Confinement, First Quarter 2012," obtained through FOIL and on file with the NYCLU.

94 Percentage calculated from "CNYPC Net Facility Caseload Census as of May 31, 2012," obtained through FOIL and on file with the NYCLU.

95 Percentage calculated from "Active Mental Health Inmate-Patients Housed in Segregated Confinement, First Quarter 2012," obtained through FOIL and on file with the NYCLU. For an explanation of mental health classifications, see New York State Commission on Quality of Care and Advocacy for Persons with Disabilities, *Review of Residential Crisis Treatment Programs (RCTPs)* (Schenectady: N.Y. State Commission on Quality of Care and Advocacy for Persons with Disabilities, 2010) 1.

96 Prisoners designated as seriously mentally ill are those: (1) exhibiting nine types of Diagnostic and Statistical Manual IV Axis I diagnoses – schizophrenia (all sub-types), delusional disorder, schizophreniform disorder, schizoaffective Disorder, brief psychotic disorder, substance-induced psychotic disorder (excluding intoxication and withdrawal), psychotic disorder not otherwise specified, major depressive disorders, bipolar disorder I and II; (2) "actively suicidal or [who have] engaged in a recent, serious suicide attempt;" or (3) who commit acts of self-harm motivated by breaks or perceived breaks with reality, or caused by an organic brain syndrome, psychosis or depression. N.Y. Correct. Law. § 137.6 (McKinney 2011).

97 As New York expanded its use of extreme isolation, reports of the startling number of prisoners with serious mental illness held in these units began to surface. See Mary Beth Pfeiffer, "A Death in the Box," *New York Times* 31 Oct. 2004: 48; Jennifer Gonnerman, "Suicide in the Box," *Village Voice* 23 Dec. 2003: 40. In 2003, 20 percent of prisoners in extreme isolation were receiving mental health treatment. Roughly half of these prisoners were diagnosed with a major or serious mental illness. One grim barometer of the number of seriously mentally ill prisoners in extreme isolation was the suicide rate in the SHU. Between 1998 and 2004, 34 percent of prisoner suicides occurred among individuals in the SHU, while comprising 7 percent of the total prison population. *Mental Health in the House of Corrections: A Study of Mental Health Care in New York State Prisons*, Correctional Association of New York, June 2004: 48, 57.

98 Complaint at 12-13, *Disability Advocates, Inc. v. New York State Office of Mental Health*, No. 02-CV-4002 (S.D.N.Y. May 28, 2002) ("Inadequate mental health treatment in the prisons results in prisoners with mental illness suffering psychiatric deterioration and engaging in symptomatic behaviors which ... violate DOCS rules for prisoner conduct. Prisoners with mental illness are frequently sentenced to periods of isolated confinement for engaging in such symptomatic conduct. … Once punished with confinement in a twenty-three hour isolated confinement housing area, many prisoners with mental illness become even less able to conform to prison rules because their mental conditions worsen. As a result, many prisoners with mental illness, who are suffering from their illnesses and who are serving time in isolated confinement, become subject to additional disciplinary sanctions including additional consecutive periods of isolated confinement.").

99 Private Settlement Agreement, *DAI v. OMH*, 02-CV-4002 (S.D.N.Y. Apr. 27, 2007), available at http://www.disability-advocates.org/complaints/DAIvOMHSettlement.pdf. A history of legal challenges to inadequate mental health treatment in specific SHUs (resulting in settlements) preceded the DAI lawsuit. *See* Private Settlement Agreement, *Anderson v. Goord*, No. 87-CV-141 (N.D.N.Y. Dec. 16, 2003); Stipulation, *Eng v. Goord*, No. 80-CV-385S (W.D.N.Y. June 12, 2000); *Stipulation, Langley v. Coughlin*, No. 84-CV-5431 (S.D.N.Y. July 23, 1987).

100 SHU Exclusion Law of 2008, codified as amendments to N.Y. Mental Hyg. Law § 45 (McKinney 2011) and N.Y. Correct. Law. §§ 2, 137.6, 401, 401-a (McKinney 2011).

101 N.Y. Correct. Law §§ 137.6(d), 2.21 (McKinney 2011). The law does, however, provide a loophole to diversion in two "exceptional circumstances." First, "when … 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." Second, "when the mental health clinician determines that such placement is in the inmate's best interest 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."

102 Percentages calculated from "DOCCS Ethnic Breakdown of Employees by Facility from Data as of 01/07/2012" and "Table 3H: Race/Ethnic for Offenders Housed in SHU – DOCCS Under Custody Pop. Jan. 1, 2012," obtained through FOIL and on file with the NYCLU.

103 See **Section II**, *Building the Box*.

104 *See supra* note 46-47.

105 *See supra* note 48.

106 *See* William D. Bales and Daniel P. Mears, "Inmate Social Ties and the Transition to Society: Does Visitation Reduce Recidivism?," *Journal of Research in Crime and Delinquency* 45 (2008) (studying the relationship between visitation and recidivism in Florida and concluding that visitation reduces and delays recidivism); Creasie Finney Hairston, "Family Ties During Imprisonment: Do They Influence Future Criminal Activity?," *Federal Probation* 52 (1988) (discussing five empirical studies indicating that maintenance of family and community ties is positively related to lower recidivism); Norman Holt and Donald Miller, *Explorations in Inmate-Family Relationships*, Research Report No. 46 (Sacramento: California Department of Corrections, 1972) ("The central finding of this research is the strong and consistent positive relationship that exists between parole success and maintaining strong family ties while in prison."); Minnesota Department of Corrections, *The Effects of Prison Visitation on Offender Recidivism* (St. Paul: Minnesota Department of Corrections, 2011) ("Using multiple measures of visitation … and recidivism, … the study found that visitation significantly decreased the risk of recidivism …."); Marta Nelson, Perry Deess, and Charlotte Allen, *The First Month Out: Post-Incarceration Experiences in New York City*, Vera Institute of Justice, Sept. 1999 (reporting results of study tracking prisoners returning from New York jails and prisons and concluding that prisoners with stronger familial support had greater success reintegrating).

107 "DOCCS Daily Population Capacity Report – 06/11/12," obtained through FOIL and on file with the NYCLU.

108 DOCCS, *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2011* (Albany: Department of Corrections and Community Supervision, 2011) 4.

109 Reading is one of the few real activities available to prisoners in the SHU, despite DOCCS statistics that document low literacy among a significant percentage of prisoners: One in three state prisoners (34 percent) read below the eighth-grade level, including roughly one in five (19 percent) who read below the sixth-grade level. Literacy appears to be lower still in extreme isolation facilities: A quarter of prisoners housed at Upstate and Southport read below the sixth-grade level. DOCCS, Hub System: Profile of Inmate Population Under Custody on January 1, 2008 (Albany: Department of Correctional Services 2008) 45, 47.

110 *See supra* note 81 for a discussion of PIMS, a three-level system of graduated privileges in the SHU. At Southport, Level I prisoners receive two showers per week and must remain in restraints during recreation and visits. They are permitted 5 books or magazines. Level II prisoners may exercise and conduct visits without restraints. They receive headphones and a state-issued winter coat. They are permitted 5 additional books or magazines and have limited commissary privileges, restricted primarily to writing materials and toiletries. Level III prisoners receive three showers per week. They are permitted one pair of personal sneakers and shorts, and they may purchase candy from the commissary. PIMS operates similarly at Upstate, although the physical design of the cells, which are directly connected to recreation pens, obviates the need for restraints during recreation on Level I. Prisoners on Levels I and II receive three showers per week, whereas prisoners on Level III receive four showers per week. "Southport Correctional Facility SHU Staff and Inmate Orientation Manual" and "Upstate Correctional Facility SHU Inmate Orientation Manual," obtained through FOIL and on file with the NYCLU.

111 Prisoners must be on PIMS Levels II or III to obtain the GED packet and must be on Level III to obtain the substance abuse or aggression management packets. *Id.*

112 "DOCCS Summary of Inmates Released 01/01/2008-12/31/2011 Statewide from SHU," obtained through FOIL and on file with the NYCLU.

113 N.Y. Comp. Codes R. & Regs. tit. 7, § 270.2.

114 "DOCCS Daily Population Capacity Report – 06/11/12," obtained through FOIL and on file with the NYCLU.

115 *See, e.g., Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Subcommittee on the Constitution, Civil Rights, and Human Rights of the Senate Committee on the Judiciary*, 112th Congress (2012) (statement of Craig Haney, Professor of Psychology, University of California, Santa Cruz) ("[Double-celled prisoners] are ... simultaneously isolated and overcrowded. They … really can't relate in any meaningful way with whom they're celled, and so they basically develop a kind of within cell isolation of their own. And it adds to the tension, and the tensions then can get acted out on each other. It creates hazards for the people who are forced to live that way. It creates hazards for the correctional officers who have to deal with prisoners who are living under those kinds of pressures."). In *Madrid v. Gomez*, a case examining conditions of extreme isolation at California's Pelican Bay State

prison where "[r]oughly two-thirds of the inmates [were] double celled," the court cited testimony from Professor Haney and Dr. Stuart Grassian in observing:

> [Double-celling] does not compensate for the otherwise severe level of social isolation .... The combination of being in extremely close proximity with one other person, while other avenues for normal social interaction are virtually precluded, often makes any long-term normal relationship with the cellmate impossible. Instead, two persons housed together in this type of forced, constant intimacy have an 'enormously high risk of becoming paranoid, hostile, and potentially violent towards each other.' The existence of a cellmate is thus unlikely to provide an opportunity for sustained positive or normal social contact.

889 F. Supp. 1146, 1229-30 (N.D. Cal. 1995) (internal citations omitted).

116 N.Y. Comp. Codes R. & Regs. tit. 7, § 305.2 (a).

117 *Id.* § 305.2(e).

118 *Id.* § 304.2(b).

119 *Id.* § 304.2(f).

120 *Id.* § 304.2(b).

121 *Id.* § 304.2(c).

122 In 2003 the Correctional Association surveyed 238 prisoners in the SHU, a significant number of whom reported "never or rarely" attending recreation. Psychiatrists, who accompanied the Correctional Association on site visits to the SHUs, "pointed out that refusing recreation often indicates clinical depression, over-medication and/or listlessness brought on by social isolation and reduced stimulation." *Lockdown New York, supra* note 34, at 19, 35-36.

123 "Southport Correctional Facility SHU Staff and Inmate Orientation Manual," obtained through FOIL and on file with the NYCLU.

124 The Correctional Association's survey of prisoners in the SHU, see note 122, included 88 prisoners at Southport, nearly 40 percent of whom reported "never or rarely" attending recreation. The "most common reason cited was fear of harassment by correction officers, around whom they feel particularly vulnerable while wearing mechanical restraints." *Lockdown New York, supra* note 34, at 36.

125 See Abramsky and Fellner, supra note 48, at 154-160; Jamie Fellner and Joanne Mariner, *Cold Storage: Super-Maximum Security Confinement in Indiana*, Human Rights Watch, Oct. 1997: 115-120; *Reassessing Solitary Confinement: Hearing Before the Subcommittee, supra* note 115 (statement of Physicians for Human Rights).

126 *See* Abramsky and Fellner, *supra* note 48, at 156; Fellner and Mariner, *supra* note 125, at 119; Sharon Shalev, *A Sourcebook on Solitary Confinement*, Mannheim Centre for Criminology, London School of Economics and Political Science, Oct. 2008: 63-64.

127 Percentage calculated from "Active Mental Health Inmate-Patients Housed in Segregated Confinement, First Quarter 2012," obtained through FOIL and on file with the NYCLU.

128 There is evidence to suggest that placing prisoners in extreme isolation increases their risk of recidivism after release. In Washington state, researchers tracked re-arrest rates among prisoners released over two years. The study found that prisoners who had spent at least three continuous months in extreme isolation were somewhat more likely to commit new felonies. Moreover, among those prisoners who experienced extreme isolation, those who were released directly from extreme isolation had a higher rate of recidivism than those who had returned to the general prison population prior to their release. David Lovell and Clark Johnson, "Felony and Violent Recidivism Among Supermax Prison Inmates in Washington State: A Pilot Study" (2004), available at http://www.son.washington.edu/faculty/fac-page-files/Lovell-SupermaxRecidivism-4-19-04.pdf. The Commission on Safety and Abuse in America's Prisons has cited to these findings as suggesting "a link between recidivism and the difficult living conditions in [extreme isolation], where good rehabilitative and transitional programming are less available." Gibbons and Katzenbach, *supra* note 25, at 55.

129 Terry A. Kupers, et al., "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," 36 *Criminal Justice and Behavior* 1037, 1039-1041 (2009); Erica Goode, "Prisons Rethink Isolation, Saving Money, Lives and Sanity," *New York Times* 10 Mar. 2012: A1.

130 *Final Report of Review of Due Process Procedures in Special Management Units at the Maine State Prison and the Maine Correctional Center*, March 2011, available at http://www.aclu.org/files/assets/maine_-_final_doc_report_on_smus.pdf (last visited 31 Aug. 2012); Lance Tapley, "Reform Comes to the Supermax," *Portland Phoenix*, 25 May 2011.

131 James Austin and Emmitt Sparkman, *Colorado Department of Corrections Administrative Segregation and Classification Review* (National Institute of Corrections, Oct. 2011), available at http://www.ccjrc.org/pdf/2011_Solitary_Confinement_Report.pdf (last visited 31 Aug. 2012).

132 Emmit Sparkman, "Mississippi DOC's Emmitt Sparkman on Reducing the Use of Segregation in Prisons," 31 Oct. 2011, http://www.vera.org/blog/mississippi-docs-emmitt-sparkman-reducing-use-segregation-prisons.

133 Kupers, *supra* note 129, at 1041.

134 *Final Report of Review of Due Process Procedures in Special Management Units at the Maine State Prison and the Maine Correctional Center*, *supra* note 130, at 4-6.

135 Lance Tapley, "Reducing Solitary Confinement," *Portland Phoenix* 2 Nov. 2011.

136 Austin and Sparkman, *supra* note 131, at 17.

137 Percentage calculated from comparing *id.* at 4 (identifying 1,552 prisoners in extreme isolation in October 2011) and Kirk Mitchell, "Colorado Prisons Turn Away from Heavy Use of Solitary Confinement," *Denver Post* 4 June 2012 (stating that as of April 2012 there were 1,012 prisoners in extreme isolation).

138 Sparkman, *supra* note 132.

139 *Id.*

140 Tapley, "Reducing Solitary Confinement," *supra* note 135.

141 Denise Maes, "Victory in Colorado: Closing Solitary Confinement Unit Good for Budget and Public Safety," *ACLU Blog of Rights*, 21 Mar. 2012, http://www.aclu.org/blog/prisoners-rights/victory-colorado-closing-solitary-confinement-unit-good-budget-and-public.

142 Gibbons and Katzenbach, *supra* note 25, at 14.

143 *Id.* (citing Chad S. Briggs, Jody L. Sundt and Thomas C. Castellano, "The Effects of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence," *Criminology* 41 (2003): 1341-76).

144 *Id.* (citing Peter C. Kratcoski, "The Implications of Research Explaining Prison Violence and Disruption," *Federal Probation* 52 (1988): 27-33).

145 *Id.*

146 Sparkman, *supra* note 132.

147 Rachel Alexander, "DOC Explains Closing CSP II," *Cañon City News* 21 Mar. 2012.

148 Alex Barber, "Less Restriction Equals Less Violence at Maine State Prison," *Bangor Daily News* 15 June 2012.

149 Vera Institute of Justice, Segregation Reduction Project, http://www.vera.org/project/segregation-reduction-project (last visited 31 Aug. 2012).

150 International Covenant on Civil and Political Rights, Dec. 16, 1966, S. Exec. Doc. E, 95-2, 999 U.N.T.S. 171 [hereinafter ICCPR]; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, S. Treaty Doc. No. 100-20, 1465 U.N.T.S. 85 [hereinafter CAT].

151 *See* ICCPR, *supra* note 150, art. 7 ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."); CAT, *supra* note 150, art. 2 ("Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction."); *id.* art. 16 ("Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture ....").

152 ICCPR, art. 10.1, states, "All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person." ICCPR, art. 10.3, states, "The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation.

153 U.S. Const. art. VI, cl. 2. The U.S. has signed and ratified both the ICCPR and CAT, but has placed significant restrictions on their enforceability in U.S. courts. The ICCPR is non-enforceable in U.S. courts because the U.S. ratified the treaty with an attached non-self-execution reservation. (A reservation is "a unilateral statement, however phrased or named, made by a State, when signing, ratifying, accepting, approving or acceding to a treaty, whereby it purports to exclude or to modify the legal effect of certain provisions of the treaty in their application to that State." Vienna Convention on the Law of Treaties art. 2(1)(d), May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679) The non-self-execution reservation is a statement to the effect that a treaty requires domestic implementing legislation to operate as binding domestic law; Congress has yet to pass legislation implementing the ICCPR. Both the ICCPR and CAT are further limited by reservations restricting the scope of their protection. The U.S. attached a reservation to article 7 of the ICCPR, binding it under that article only to the extent that any "cruel, inhuman or degrading treatment" amounts to treatment prohibited by the Fifth, Eighth, and Fourteenth Amendments to the Constitution. *International Convention on Civil and Political Rights: Hearing before the Senate Comm. on Foreign Relations*, 102d Cong., 1st Sess., 1991. The U.S. attached a similar reservation to article 16 of CAT, clarifying that any prohibited treatment is only that which is "cruel, inhuman or degrading" as interpreted via the Fifth, Eighth and Fourteenth Amendments. *Convention Against Torture: Hearing Before the Senate Comm. on Foreign Relations*, 101st Cong. 2nd Sess., 1990.

154 U.N. Human Rights Comm., *General Comment No. 20*, ¶ 6 (Oct. 3, 1992).

155 U.N. Human Rights Comm., *Concluding Observations of the Human Rights Committee: United States of America*, ¶ 32, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (Dec. 18, 2006).

156 U.N. Comm. Against Torture, *Conclusions and Recommendations of the Committee Against Torture: United States of America*, ¶ 36, U.N. Doc. CAT/C/USA/CO/2 (July 25, 2006).

157 *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Punishment or Treatment*, ¶ 70 U.N. Doc. A/66/268 (Aug. 5, 2011) [hereinafter *2011 Interim Report of Special Rapporteur*]; *see also Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Punishment or Treatment*, ¶¶ 77-85, U.N. Doc. A/63/175 (July 28, 2008) [hereinafter *2008 Interim Report of Special Rapporteur*].

158 *2011 Interim Report of the Special Rapporteur, supra* note 157, ¶¶ 77-78; *2008 Interim Report of the Special Rapporteur, supra* note 157, ¶¶ 80, 83 (citing to guidance from the Committee against Torture and the Committee on the Rights of the Child, as well as the Basic Principles for the Treatment of Prisoners).

159 *ABA Standards for Criminal Justice: Treatment of Prisoner*s 3d ed. (Washington: American Bar Association, 2011) Standard 23-1.2 Commentary.

160 *Id.* at Standard 23-3.8(b) "Segregated Housing" ("Conditions of extreme isolation should not be allowed regardless of the reasons for a prisoner's separation from the general population."); Standard 23-4.3(a) ("[Disciplinary] sanctions should never include: ... conditions of extreme isolation ....").

161 *Id.* at Standard 23-2.7(b) "Rationales for Long-Term Segregated Housing."

162 *Id.* at Standard 23-2.6(a) "Rationales for Segregated Housing."

163 *Id.*

164 *Id.* at Standard 23-2.8 "Segregated Housing and Mental Health". The Standards define "serious mental illness" as "a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the prison environment and is manifested by substantial pain or disability. It includes the status of being actively suicidal; severe cognitive disorders that result in significant functional impairment; and severe personality disorders that result in significant functional impairment and are marked by frequent episodes of psychosis, depression, or self-injurious behavior." *Id.* at Standard 23-1.0(s) "Definitions".

165 Gibbons and Katzenbach, *supra* note 25, at 52-60.

166 ACLU National Prison Project, Model Act: Improving Public Safety, Protecting Vulnerable Populations & Ensuring Process in Imposing Long-Term Isolated Confinement, available at http://www.aclu.org/files/pdfs/prison/model_stop_solitary_act_-_7-11.pdf (last visited 31 Aug. 2012).

167 Separation under the third prong – where there is specific and demonstrable evidence that the prisoner "poses a serious ongoing threat to prison safety and security" – can include separation for medical reasons, such as airborne contagion. *See, e.g.*, ABA Criminal Justice Standards on the Treatment of Prisoners, Standard 23.2.6(a) "Rationales for Segregated Housing;" 23-2.7(a)(iii) "Rationales for Long-Term Segregated Housing."

168 DOCCS should withhold personal identifying information of separated prisoners to protect individual privacy and safety.

169 *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 354 (1987) (Brennan, J., dissenting).

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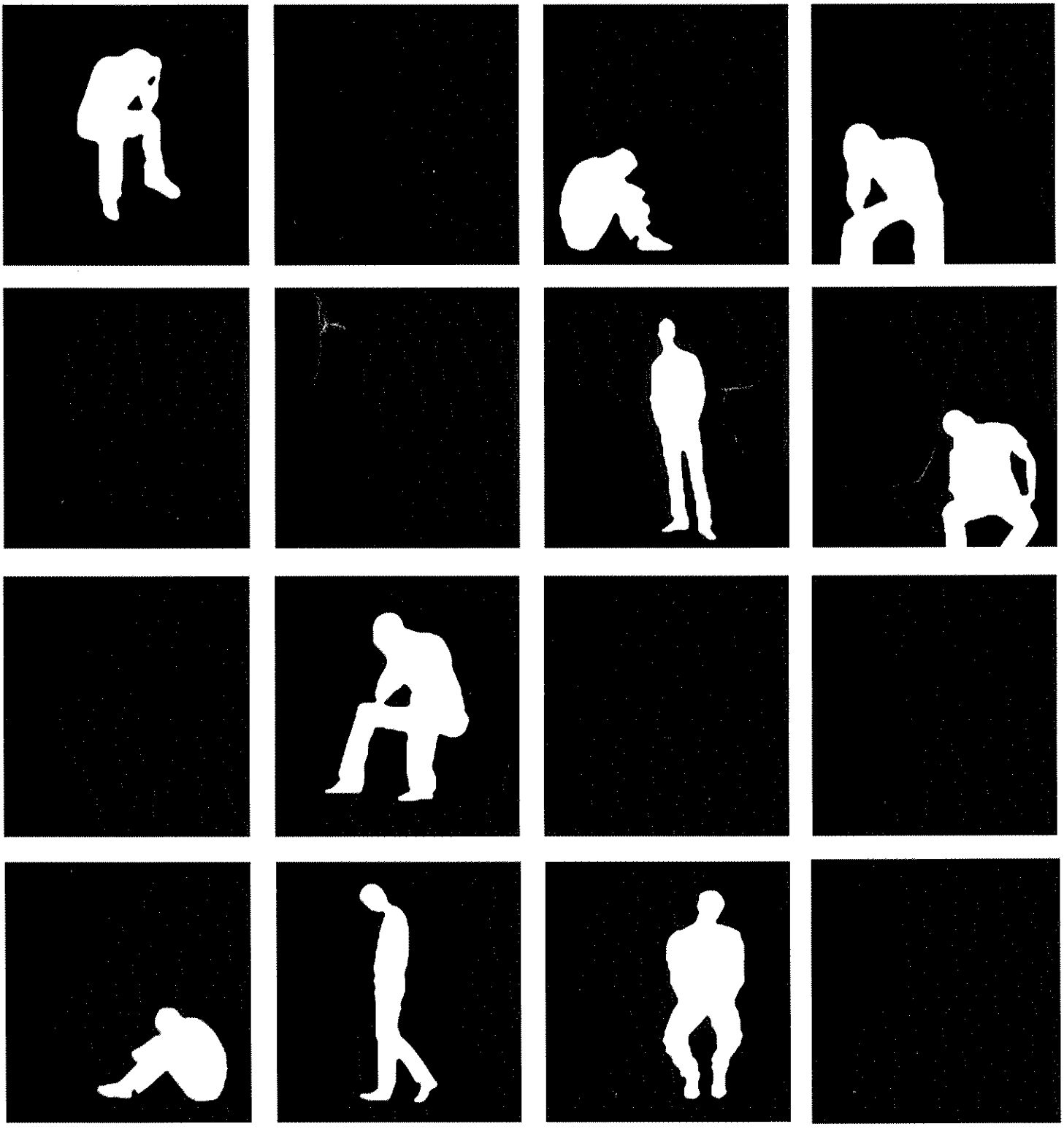

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DR. Amanda Parsons

Address: DOHMH

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DR. Homer Venters

Address: _____

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 292 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Nick Malinowski Brooklyn Defenders

Address: 177 Livingston St.

I represent: Brooklyn Defender Services

Address: 177 Livingston St.

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Five Muslimah Ale

Address: 1979 Cantlandt Ave BX NY 10453

I represent: Girls Active Coalition

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Deborah Hertz

Address: _____

I represent: TAILS Action Coalition

Address: 123 William St NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: SARAH KERR NEED TO LEAVE AT 4:20 PM

Address: 199 WATER ST

I represent: THE LEGAL AID SOCIETY

Address: 199 WATER ST

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0292-2014 Res. No. _____

☐ in favor ☐ in opposition

Date: June 12, 2014

(PLEASE PRINT)

Name: Dr. Kirk Anthony James

Address: Senior Director for Public Policy

I represent: The Fortune Society

Address: 29-76 Northern Boulevard

Long Island City, NY 11101

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 6/12/2014

(PLEASE PRINT)

Name: Skylar Albertson

Address: 360 East 161ST Bronx, NY 10451

I represent: The Bronx Defenders

Address: 360 East 161ST Bronx, NY 10451

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Dr. Henry Weinstein

Address: 1111 Park Ave NY NY

I represent: New York County Psychiatric Society

Address: 1001 Avenue Americas, Floor 11

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Erik Bechines, Deputy Commissioner

Address:

I represent: DOC

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Joseph Ponte, Commissioner

Address:

I represent: DOC

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Mary Bassett

Address:

I represent: DOHMH

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 292-2014 Res. No. _____

☑ in favor ☐ in opposition

Date: June 12, 2014

(PLEASE PRINT)

Name: MARY BETH ANDERSON

Address: 123 William St, NY NY

I represent: URBAN JUSTICE CENTER

Address: Mental Health Project
123 William

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Elizabeth Mayes

Address: 25 Central Park West

I represent: Jails Action Coalition

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Norman Seabrook

Address: _____

I represent: COBA

Address: 75 Broad St NYC 10004

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 292 Res. No. 292

☒ in favor ☐ in opposition

Date: June 12

(PLEASE PRINT)

Name: Shanna Miller

Address:

I represent: NYCLU

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Beth Powers

Address: 15 Maiden Lane NYNY

I represent: Children's Defense Fund - New York

Address: 15 Maiden Lane NYNY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 292 Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Michelle Bailhe

Address: 44 Berry Street Brooklyn NY

I represent: 1199 AC1 Heath Care (Connections)

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: June 12

(PLEASE PRINT)

Name: FRANK SPROSCIA

Address: _____

I represent: DOCTORS COUNCIL SEIU

Address: 50 BWAY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/12/14

(PLEASE PRINT)

Name: Maya Escalona

Address: 270 W. 73RD St #5

I represent: NYSNA

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 219-2014 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: James Gilligan

Address: 375 Sackett St, Bklyn, NY 11231

I represent: NYCLU

Address: 125 Washington St. E. 14th Floor NYC 10003

Please complete this card and return to the Sergeant-at-Arms