



MEMORANDUM OF SUPPORT A1346A (O'Donnell) & A1347 (Rozić)

April 3, 2015

On behalf of Brooklyn Defender Services (BDS), I write in strong support of A.1346A (O'Donnell) & A.1347 (Rozić). BDS is a public defense office that represents half of the people who are arrested in Brooklyn annually, providing innovative, multi-disciplinary, and client-centered criminal defense, family defense, immigration, civil legal services, social work support and advocacy to more than 45,000 indigent Brooklyn residents every year. Of this annual caseload, approximately 6,000 are incarcerated at some point during the pendency of the case and brought into the custody of the New York City Department of Correction (DOC). Those who are sentenced serve time in Department of Corrections and Community Supervision (DOCCS) prisons or, for certain shorter sentences, on Rikers Island.

Together, A.1346A & A.1347 would prohibit the use of segregated confinement for juveniles under the age of twenty-one, people with mental illness or developmental disabilities, people who are pregnant, or who have given birth within the past eight weeks, and mothers living with infants in prison nursery programs. A.1346A would further establish segregated confinement as a measure of last resort, allowable only under the supervision of the Commissioner, and only for “the minimal period as may be necessary for maintenance of order or discipline.” It would also direct the Commissioner of DOCCS to compile and publish disaggregated data on the use of segregated confinement, including related suicide attempts and self-harm, on a quarterly basis.

Enactment of these bills would be important step toward ending a shameful chapter in New York, namely the explosive growth in the use of segregated confinement. I thank the sponsors for their efforts on behalf of the rights and well-being of incarcerated people—our society's most marginalized population—and I respectfully urge you to support these bills.

The need for this legislation is clear. There is a large body of research demonstrating the pernicious effects of segregated confinement on vulnerable individuals as well as the entire jail and prison population. To be sure, this research has found that nobody can rightfully be found fit to safely endure days, weeks, or months in a cell the size of an elevator with calculated sensory deprivation, little or no programming, and, at most, one hour per day of highly-restricted recreation. It has also demonstrated that solitary is particularly damaging to young people, those with mental illness or

developmental disabilities, and others with acute medical needs such as pregnant individuals and recent mothers.

Background

Correctional facilities were never intended to function as primary mental health treatment providers, yet they currently house overwhelmingly large populations of individuals with serious mental illness and complicated health needs. Treating and stabilizing serious mental illness is a delicate medical process that is deeply compromised by jail and correctional environments, which frequently trigger and exacerbate many common symptoms of a variety of mental illnesses. Confinement is not therapeutic. Jails are not hospitals, triage or respite centers, or by their very nature, therapeutic environments. Comprehensive and individualized care is not provided to detained BDS clients as it would be in the community at a hospital, mental health clinic, or treatment program, and our clients with serious mental illness or other acute health needs suffer tremendously as a result. Psychotropic medication has become the default treatment method in city jails. However, medication management without the supplement of supportive mental health services (i.e. individual or group therapies, case management services, supportive housing) that exist in the community is not medically sufficient care. This is a phenomenon experienced across the country, but it is especially true here in the New York City jails, including Rikers Island. In the absence of adequate care and support, and in extremely harsh environments like prisons and jails, people with mental illness often fall into a devastating cycle decompensation, rules infractions, and punitive segregation.

There is a comparatively long history of correctional facilities serving as adolescent detention centers, but their inefficacy in this role similarly demands fundamental reform. Young people also tend to act out in tightly regimented, hostile environments, and they, too, often fall into a cycle of punitive segregation. Improving prison and jail conditions, expanding programming, and augmenting health care screening and services are all important goals. However, the primary driver of reform must be restricting the use of correctional facilities to a measure of last resort and reinvesting the savings produced by declining jail populations into the communities from which our clients come. By reducing the number of people incarcerated in jails and prisons, our City and State can redirect scarce resources to education, community programs, infrastructure and employment to meet the needs of this population. To be sure, thanks in part to reforms enacted by the State Legislature, the prison population is down more than 28 percent since its peak in 1999, and New York City has reduced its jail population by more than 60 percent since 1991. But these figures obscure the reality that incarceration rates throughout the United States continue to be nearly unparalleled worldwide. New York should be a leader in the decarceration movement, rather than a stalwart of antiquated, misguided policies that deny our neighbors basic human rights.

Segregated Confinement

As you may know, people in segregated confinement in our prisons and jails spend 22 to 24 hours a day locked in a cell the size of a parking spot. They are required to receive one hour of exercise alone in a cage, though this accommodation is often denied.¹ They do not receive any meaningful programs or therapy, and, in state prisons, cannot make phone calls. They do not have access to commissary, and thus cannot purchase additional food to supplement their reduced food allotment, or

¹ Staff Report, Barriers to Recreation at Rikers Island's Central Punitive Segregation Unit (New York City Bd. of Corr. 2014).

hygiene products. Those of our clients who are in segregated confinement consistently report to our Jail Services Coordinator that they are deprived of, among other things, showers, food, mental health services, medical services, opportunities to practice their religions, opportunities to receive education, and sanitary living conditions. This deprivation, lack of normal human interaction, and extreme idleness can cause immense psychological damage and suffering, as well as sickness and death.²

There are currently hundreds of inmates in punitive segregation on Rikers Island, most of whom reside in the Central Punitive Segregation Unit (“CPSU”) at the Otis Bantum Correctional Center. The average length of CPSU confinement is approximately 50 days, more than three times longer than the duration that the United Nations Special Rapporteur on Torture defines as “torture.”³ In 2013, the New York City Board of Correction (BOC), which is charged with overseeing DOC, issued a report detailing the experiences of three mentally ill adolescents (ages 16-18) who were sentenced to more than 200 days in punitive segregation at Rikers.⁴ Those adolescents described their experiences as torturous, with virtually no opportunity for mental or physical stimulation and significant deprivation of essential services—including complete cessation of their special education services, no meaningful recreational services, no meaningful mental health services, and inadequate medical care.⁵

Crucially, reductions in solitary have a direct impact on reducing violence. For example, Mississippi, working with the National Institute of Corrections, reduced its solitary population by more than 75%, resulting in a 50% reduction in prison violence.⁶

Segregated Confinement of Individuals with Mental Illness

According to the American Psychiatric Association, prolonged isolation “may produce harmful psychological effects,” including “anxiety, anger, cognitive disturbance, perceptual distortion, obsessive thoughts, paranoia, and psychosis. For persons with serious mental illness, these effects may exacerbate underlying psychiatric conditions, such as schizophrenia, bipolar disorder, and major depressive disorder.”⁷ In *Madrid v. Gomez*, the U.S. District Court found that “placing [people with mental illness or developmental disabilities] in the SHU is the mental equivalent of putting an asthmatic in a place with little air to breathe.”⁸

According to a September 5, 2013 report to the BOC by Dr. James Gilligan and Dr. Bandy Lee, experts in the field of mental health in prisons, “the proportion of mentally ill inmates in the New York City jail population is larger than ever before and growing.”⁹ Indeed, Rikers Island is the

² Michael Schwartz & Michael Winerip, Gross Incompetence Cited in Rikers Island Death, *The New York Times*, Jan. 22, 2015.

³ The Solitary Project, *Voices from the Box* (The Bronx Defenders 2014).

⁴ Staff Report, *Three Adolescents with Mental Illness in Punitive Segregation at Rikers Island* (New York City Bd. of Corr. 2013).

⁵ *Ibid.*

⁶ U.S. Senator Dick Durbin, *Durbin Statement on Federal Bureau of Prisons Assessment of Its Solitary Confinement Practices* (2013).

⁷ James H. Scully, Jr., M.D., *Testimony Before the U.S. Senate Subcommittee on the Constitution, Civil Rights, and Human Rights* (The Am. Psychiatric 2012).

⁸ *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995)

⁹ James Gilligan, M.D. and Bandy Lee, M.D., *Report to the New York City Board of Correction* (New York City Bd. of Corr. 2013).

largest provider of mental health services in the state, though its infrastructure and personnel are entirely ill-equipped and unqualified to work with this population. According to the New York City Department of Health and Mental Hygiene (DOHMH), about 25 percent of the City jail intakes present with some kind of mental illness, including about 5 percent who present with serious mental illness such as schizophrenia. (This tracks, generally, the overall population). Our experience leads us to believe that the incidence of mental illness is actually much greater than DOHMH's data, an understanding supported by off-line conversations with medical staff in city jails who report a serious problem with identifying health and mental health needs upon intake. Furthermore, many otherwise healthy people develop mental health symptoms such as depression, suicidality and trauma while incarcerated, in addition to communicable illness.

Those of our clients who have a mental illness almost always fare poorly in jail. Many of them end up in solitary confinement as a punishment for actions and behaviors related to their mental illness—mostly for disobeying orders, not acts of violence. In our City jails, there is a punitive segregation unit reserved for those with mental illness who infract called the Restricted Housing Unit (RHU). It did not surprise us, then, to read in the Gilligan and Lee report that, as the mentally ill population in the City jail system grew, the total number of inmates in punitive segregation grew, too—increasing 61.5% between 2007 June 2013.¹⁰ Once isolated and deprived in this way, individuals with mental illness rapidly deteriorate. Indeed, Gilligan and Lee note, “From a medical/psychiatric standpoint, no one should be placed in prolonged solitary confinement, as it is inherently pathogenic—it is a form of causing mental illness.”¹¹

In 2008, New York State enacted the SHU Exclusion Law, which mandates that people with a “serious mental illness” (SMI) who face disciplinary confinement that could exceed 30 days be diverted to a Residential Mental Health Treatment Unit. The law represented an important acknowledgement of the dangers of extreme isolation, and spared many people the compounding misery of enduring serious mental illness in the Box. However, it left behind the vast majority of SHU residents, including many with debilitating mental illnesses not designated SMI. Furthermore, the statutory definition of SMI allows ample space for correctional health staff to underdiagnose, and data suggests this to be the case. Crucially, A.1346A establishes a more inclusive standard and a more comprehensive exclusion, but advocates and legislators will have to monitor DOCCS and local corrections agencies to ensure that the subject populations are actually protected as the law intends.

Segregated Confinement of Juveniles

Much like individuals with mental illness, young people often exhibit behaviors, relating to their brain chemistry, that result in sentences of punitive segregation. It is said in our office that our young clients will be in solitary within a month unless we find a way to get them out of jail. This is because they are routinely penalized for actions that are typical of teenagers. Indeed, BOC has found that more than a quarter of all juveniles in Rikers are in punitive segregation.¹² U.S. Attorney Preet Bharara found “DOC relies far too heavily on punitive segregation as a disciplinary measure [for young people], placing adolescent inmates—many of whom are mentally ill—in what amounts to

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² Staff Report, Three Adolescents with Mental Illness in Punitive Segregation at Rikers Island (New York City Bd. of Corr. 2013).

solitary confinement at an alarming rate and for excessive periods of time.”¹³ Once in isolation, most of these young people start showing signs of serious mental problems. They tend to get so distraught over being left alone with their thoughts for so many hours that they do self-destructive things that increase their time in solitary. (Failure to obey an order is among the most common infractions leading to solitary sentences for all populations statewide.) Thus begins the cycle of solitary in which many become trapped. All too often, young people find only one way to escape; a study conducted by DOHMH found far higher incidences of suicide and other self-harm among juveniles who had been in solitary confinement in Rikers.¹⁴ A 2012 task force convened by U.S. Attorney General Eric Holder also linked solitary confinement of juveniles to higher rates of suicide.¹⁵ The United Nations Special Rapporteur on Torture has called for an outright prohibition of the practice for juveniles.¹⁶

The adverse impacts of placing vulnerable individuals—and, indeed, anybody—in segregated confinement extend far and wide. Concomitant with the rise in the disciplinary use of solitary in our City jails has been a rise in violence inside those same institutions. For example, Gilligan and Lee found that, between 2004 and 2013, as the number of people in solitary sharply increased, the rate of use of force incidents tripled.¹⁷ In particular, U.S. Attorney Bharara found “that a deep-seated culture of violence is pervasive throughout the *adolescent* facilities at Rikers [italics added].”¹⁸ While tragic, this rise in violence is not surprising to those of us who have witnessed the effects of extreme isolation. Moreover, these facts directly contradict the common refrain that DOC’s discretionary use of solitary is necessary to ensure the safety of inmates and staff.

Gilligan and Lee add that this data must be viewed in the context of a decline in the overall jail population and in violent crime across the City. In what is often called “the safest big city in the world,” Rikers is an island of violence, trauma, and despair. That said, we know the impacts of isolation do not end at the fortified perimeter. 25,000 people are released from New York State prisons every year, including 2,000 who are released directly from solitary—many without any rehabilitation programs and services.

Segregated Confinement of New and Prospective Mothers

The argument against the use of punitive segregation for people before, during, and after childbirth is self-evident. Such segregation is inherently pathogenic, traumatizing and stress-inducing, and risks compromising the health and well-being of a newborn child, literally visiting the alleged sins of the mother upon her child. Stress and depression have been linked to premature births and low birthweights. Reproductive health can also be compromised by segregated confinement’s restrictions on access to OB/GYN care and exercise. In addition, the lack of privacy and confidentiality inherent to facilities in which all communication is made through corrections officers can discourage people

¹³ U.S. Attorney of the S. Dist. of NY, CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island (U.S. Dep’t of Justice 2014).

¹⁴ DOHMH, Solitary Confinement and Risk of Self-Harm Among Jail Inmates, 104 Am. J. of Pub. Health (2014).

¹⁵ Report of the Attorney General’s National Task Force on Children Exposed to Violence (U.S. D.O.J. 2012).

¹⁶ Juan E. Méndez, Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the United Nations 2011).

¹⁷ James Gilligan, M.D. and Bandy Lee, M.D., Report to the New York City Board of Correction (New York City Bd. of Corr. 2013).

¹⁸ U.S. Attorney of the S. Dist. of NY, CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island (U.S. Dep’t of Justice 2014).

from seeking treatment, especially for issues related to sexual health, risking adverse outcomes for both mother and child.

Notably, in contravention of New York’s 2009 Anti-Shackling Law, many women in DOCCS custody continue to be shackled before, during, and after childbirth, particularly in solitary. This abhorrent practice can cause physical harm to mother and child and inhibits the formation of a strong bond between them.¹⁹ The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders, known as the Bangkok Rules, prohibit the placement of pregnant or nursing women in solitary confinement. Under the terms of a 2014 interim settlement agreement in a federal civil rights law suit, *Peoples v. Fischer*, DOCCS agreed to a presumption against placing pregnant women in the Solitary Housing Unit, unless there are exceptional circumstances.²⁰ This bill would codify and expand that agreement to ensure that the state does not back slide, regardless of the final outcome of the case, and that local correctional facilities are covered by the policy. Our City and State must comply with international standards for human rights and commit in law to end solitary for all new and prospective mothers.

Experiences of BDS’s Clients and Staff

The experiences of BDS’s clients and staff plainly illustrate the horrors of our City’s and State’s use of solitary confinement. In considering their stories, it is critical to remember who we represent. Our representation begins at arraignment and extends throughout the pendency of the case. **By definition, our clients have yet to be convicted or sentenced and are thus presumed innocent of what they have been accused.** Nevertheless, thousands of them are incarcerated, due solely to the fact that they cannot post bail. In other words, they are in jail because they are poor. The presumed innocence of this population, a fundamental tenet of our justice system, is often forgotten in discussions about penology and jail conditions. This disregard is especially evident in State and City policies relating to the use of segregated confinement. The Gilligan and Lee report found the prolonged solitary confinement that is standard procedure at Rikers Island to be “one of the most severe forms of punishment that can be inflicted on human beings short of killing them.”²¹ The UN Special Rapporteur on Torture has called for a prohibition on punitive segregation for pre-trial detainees.

The following stories involve adolescents who would be protected from segregated confinement under this legislation.

Mr. S

Mr. S is a young person who suffers from schizoaffective disorder and a learning disorder. During his incarceration, Mr. S was the victim of stabbing and burning attacks when he resisted pressure to join gangs. After staff failed to de-escalate conflicts with Mr. S over issues like lost property, he was issued infractions for disobeying orders, and he was eventually placed in the RHU—a punitive segregation unit for people with mental illness. The isolation endured by Mr. S contributed to his decompensation, and he began to experience more regular auditory and visual hallucinations. Mr. S

¹⁹ Tamar Kraft-Stolar, *Reproductive Injustice* (Corr. 2015).

²⁰ *Peoples v. Fischer*, 11-CIV-2694 (SAS)

²¹ James Gilligan, M.D. and Bandy Lee, M.D., Report to the New York City Board of Correction (New York City Bd. of Corr. 2013).

became increasingly depressed and hopeless while in the RHU. At one point he shared his sense of hopelessness with staff, and in response he was placed on suicide watch, in an empty cell, with nothing more than a smock. After coming off suicide watch, Mr. S was denied all out-of-cell time and access to privileges he had earned through program compliance for the next three weeks. In short, staff's response to a perceived suicidal statement was to categorically isolate Mr. S in his cell, 24 hours a day for a month. Mr. S discharged to the community directly from isolation.

Mr. F

Mr. F is a young man who suffers from paranoid schizophrenia. While incarcerated, Mr. F decompensated and began experiencing confrontations with custody staff, many of whom, lacking adequate training to de-escalate incidents involving individuals in his mental state, approached Mr. F aggressively. Mr. F received infractions during his incarceration and spent several months in the RHU at the George R. Vierno Center (GVRC) on Rikers Island. This isolation caused Mr. F to decompensate further, losing the few privileges he came to earn in the unit and lengthening his stay in the RHU. Eventually, Mr. F's condition worsened and he was transferred into another isolation unit, which housed mentally ill individuals deemed violent—12 Main at GRVC. In this unit, Mr. F was isolated further and experienced worsening depression, anxiety, anger, lethargy, loss of appetite, frustration, hopelessness, insomnia, physical pain, and hallucinations associated with his schizophrenia. He reported to our staff a feeling of being trapped. In no small part due to his prolonged isolation, Mr. F decompensated so profoundly that he was eventually found unfit to proceed in his criminal case and had to be hospitalized in order for him to move forward through the system. This case begs the question, what is the purpose of pre-trial detention if not to ensure people make it to court? 12 Main was depopulated recently after people isolated there smeared feces on the doors and walls of their cells and others lit cell fires.

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 or months on end. Our Jail Services Coordinator regularly brings back stories that shock the conscience. 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. These individuals are not afforded due process in the hearings on their alleged infractions. It is clear to us that the use of this extreme punishment constitutes a flagrant deprivation of our clients' civil rights—and their essential humanity.

Conclusion

In a way, it is almost frustrating to have to explain the ills of segregated confinement, given the tremendous amount research on its cruelty and inefficacy that already exists—dating back several centuries to the birth of the very concept of correctional facilities. As NYCLU's 2012 report on extreme isolation in New York, “Boxed In,” notes, Alexis de Tocqueville and Gustave de Beaumont toured Auburn state prison in the early 1820's and found its use of extreme isolation to be ruinous and counterproductive. “[I]n order to reform them,” they wrote, “[the prisoners] had been submitted to complete isolation; but this absolute solitude, if nothing interrupt it, is beyond the strength of man...it does not reform, it kills.” That prison closed its solitary cells two years after opening them. Of the 26 who were pardoned after serving in solitary, 14 soon returned to prison on new offenses. Perhaps more timely, as New York City tries to heal its rift as a “Tale of Two Cities,” is Charles Dickens' reaction to Pennsylvania's Eastern Penitentiary after touring the facility in 1842. He found

the extreme isolation system there to be “worse than any torture of the body...[I]t wears the mind into a morbid state, which renders it unfit for the rough contact and busy action of the world.”

Enacting the legislation in question would expand upon the limited protections set forth in the SHU Exclusion Law and send a message that New York State recognizes the potential harms of solitary confinement. However, we must not stop there. The provision in A.1346A governing the use of solitary for individuals who do not meet the criteria for exclusion permit total discretion on the part of the Commissioner of the corrections agency with jurisdiction. This bill should be strengthened to comply with the United Nations Committee Against Torture’s standard limiting solitary sentences to 15 days or fewer and prohibiting the practice for those in pre-trial detention. It should also specify the types of infractions that can result in such sentences, and stipulate clear measures for ensuring due process in the meting out of this uniquely traumatic punishment. Lastly, both bills should explicitly include RHU’s and Enhanced Supervision Housing units in their definitions of segregated confinement, as they are essentially disciplinary segregation units but might be construed otherwise by DOC. Ultimately, the City and State should stop placing anybody in solitary confinement until the conditions of this 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 positively impact future behavior in jail is established by concrete evidence. Again, the primary path to reform must be dramatically reducing incarceration and refocusing our resources on opportunity over punishment.

Thank you for your consideration of my comments.

Sincerely,

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