Petition to the New York City Board of Correction
For Adoption of Rules Regarding the Use of Isolated Confinement

I. Proposed Rules

This request for rulemaking proposes that the Board of Correction add a Chapter 5 to its Minimum Standards as follows:

CHAPTER 5
ISOLATED CONFINEMENT MINIMUM STANDARDS

CONTENTS

§ 5-01 Disciplinary System.

Isolated confinement causes serious physical and psychological harm and has limited value for reducing violence. To prevent the use of isolated confinement as a punishment, the New York City Department of Correction shall design and implement a disciplinary system to do the following:

(a) Provide incentives for positive behavior;

(b) Offer out-of-cell programming tailored to the needs of each person; and

(c) Establish alternative sanctions for behavior that violates disciplinary rules.

Under no circumstances shall an incarcerated individual be required to remain confined to his or her cell for more than twenty hours per day.

§ 5-02 Use of Isolated Confinement.

(a) *Policy*.

Isolated confinement can cause serious physical and psychological harm and should only be used as a last resort to prevent immediate violence. The Department of Correction shall develop and implement policies and procedures to restrict the use of isolated confinement.

(b) *Definition.*

For the purposes of this Chapter, "isolated confinement" shall mean the involuntary confinement of a person to a cell for twenty or more hours per day. Any such involuntary confinement of a person shall constitute isolated confinement, irrespective of whether that person is confined to a cell alone or with others.

(c) *Isolated confinement shall be the most restrictive housing classification.*

Isolated confinement shall be the most restrictive housing classification. The Department of Correction shall not cause a person to be held in isolated confinement for a period of time greater than twenty hours per day.

(d) *Standard.*

No person shall be placed in isolated confinement unless:

(1) That person has caused another person to sustain serious physical injury as a result of violent conduct or has presented an imminent risk of causing serious physical injury through violence;

(2) That person presents a continuing and ongoing threat of physical violence against another person; and

(3) All other less restrictive alternatives have been shown to be inadequate to prevent that person from presenting an imminent risk of serious physical injury.

(e) *Hearing*.

The Department of Correction shall design and implement a hearing process for placing people in isolated confinement. The hearing shall:

(1) Be conducted by a trained independent and impartial hearing officer who is not employed by the Department of Correction;

(2) Be conducted within twenty-four hours after notice of the hearing or any final determination of non-disability. Notice to the person facing a possible penalty of isolated confinement shall be provided at least twenty-four hours prior to the hearing;

(3) Allow the person facing a possible penalty of isolated confinement to present evidence, and call and cross-examine witnesses; and

(4) Offer the person facing a possible penalty of isolated confinement the services of an attorney or a trained and competent advocate familiar with the disciplinary hearing process and not employed by the Department of Correction.

(f) *Determination of non-disability*.

In any case in which a person facing a possible penalty of isolated confinement has received a determination of non-disability following a reconsideration of disability status, as described in § 4-03(d) of this Chapter, a licensed mental health services clinician or an appropriately trained and licensed medical clinician from the Department of Health and Mental Hygiene shall give testimony regarding the non-disability of the person facing a possible penalty of isolated confinement. The person facing the possibly penalty shall have the right to cross-examine this clinician.

(g) *Appeal*.

Any person placed in isolated confinement shall have the right to appeal this determination. The record of the hearing described in paragraph (e) of this section shall be reviewed by an independent hearing officer other than the hearing officer who conducted the hearing. This review shall be completed no more than five days after a person requests an appeal under this section.

(h) *Hearing record.*

(1) The hearing officer shall generate a written and recorded record of any hearing held pursuant to paragraphs (e) and (f) of this section, and shall, within three business days of the hearing, make that record available and accessible to the person placed in isolated confinement, that person's advocate, the Commissioner of the Department of Correction, and the Board of Correction.

(2) Following any hearing held pursuant to paragraphs (e) and (f) of this section, the hearing officer shall issue a written decision based on the standard in paragraph (d) of this section regarding the necessity for placement in isolated confinement. Such decision shall consist of a narrative description of the need to use isolated confinement and the reasons that less restrictive alternatives were rejected, and a detailed description of the evidence upon which the decision was based.

(i) *Time limitations*.

(1) At the end of a maximum sentence of fifteen consecutive days, a person assigned to isolated confinement shall be released unless necessity to extend the period of isolated confinement is clearly demonstrated.

(2) The Department of Correction may not exceed the fifteen-day limit on isolated confinement unless:

(i) At the end of each fifteen-day period, an independent hearing officer, following the procedures described in paragraph (e) of this section, finds

that a person continues to represent an immediate threat of physical harm to others;

(ii) After an evaluation by a mental health clinician, it has been determined that the individual has suffered no negative psychological effects from the segregation; and

(iii) The Commissioner of the Department of Correction has personally authorized the extension of the segregation period and has given written narrative reasons for the extension.

(3) Under no circumstances shall a person be placed in isolated confinement for a period longer than sixty consecutive days. Under no circumstances shall a person be placed in isolated confinement for more than sixty days in any one hundred and eighty-day period.

(j) *Out of cell activities.*

The Department of Correction shall design and implement policies to offer out-of-cell programming to people placed in isolated confinement. Such programming shall:

(1) Be based on an individualized action plan;

(2) Be designed to reduce violent behavior; and

(3) Not be punitive in nature.

(k) *Documentation.*

(1) The Department of Correction shall issue a monthly report describing the number of people placed in isolated confinement; the mean, median, and mode, by hours, including hours spent out of cell, that people were kept in isolated confinement; and a complete list of the conduct that led to such restrictions. This report shall be posted on the Department of Correction's website.

(2) The Department of Correction shall issue a written report to the Board of Correction each time a person is placed in isolated confinement. This report shall include the name of the person placed in isolated confinement, the length of time imposed at the initial hearing, a narrative description of the behavior that led to the penalty of isolated confinement, and a narrative description of the less restrictive alternatives that the Department attempted to use to prevent the person from causing harm. Confidentiality of private information shall be maintained in accordance with state and federal law.

(3) The Commissioner of the Department of Correction shall issue a written report to the Board of Correction each time the Commissioner approves an extension of an

isolated confinement placement beyond fifteen consecutive days. This report will include the name of the person in isolated confinement, a narrative description of the reasons for the extension, and a narrative description of why less restrictive alternatives would not be sufficient to prevent the person from causing harm. Confidentiality of private information shall be maintained in accordance with state and federal law.

(l) *Non-interference with access to courts and visitation.*

Isolated confinement shall not interfere with a person's right to access the courts under § 1-08 of these Minimum Standards and other relevant law. Isolated confinement shall not interfere with a person's right to visitation under § 1-09 of these Minimum Standards and other relevant law.

§ 5-03 Exclusion of People with Disabilities and Serious Injuries from Isolated Confinement.

(a) *Policy.*

Isolated confinement represents a serious and immediate threat to the psychological and physical health of people with disabilities. The New York City Department of Correction and the New York City Department of Health and Mental Hygiene shall develop and implement procedures to exclude people with disabilities and people with serious injuries from isolated confinement.

(b) *Definitions.*

(1) For the purposes of this chapter, a "disability," with respect to an individual, shall mean:

(i) A physical or mental impairment that substantially limits one or more major life activities of such individual;

(ii) A record of such an impairment; or

(iii) Being regarded as having such an impairment.

(2) The term "disability," when referring to a mental disability and with respect to an individual, shall include but not be limited to:

(i) One or more of the following types of Axis I diagnoses, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including but not limited to symptoms related to such diagnoses:

(a) Schizophrenia (all sub-types),
(b) Delusional disorder,
(c) Schizophreniform disorder,

(d) Schizoaffective disorder,
(e) Brief psychotic disorder,
(f) Substance-induced psychotic disorder (excluding intoxication**)**,
(g) Psychotic disorder not otherwise specified,
(h) Major depressive disorder,
(i) Major anxiety disorder,
(j) Autism spectrum disorder,
(k) Post-traumatic stress disorder, or
(l) Bipolar disorder I and II;

(ii) Active suicidality or a history of serious suicide attempt(s);

(iii) A mental condition that is frequently characterized by breaks with reality, or perceptions of reality, that lead the individual to experience substantial functional impairment that has a seriously adverse effect on life or on mental or physical health;

(iv) An intellectual or developmental disorder that has resulted in substantial functional impairment;

(v) An Axis II diagnosis, as described by the most recent Diagnostic and Statistical Manual of Mental Disorders, of a personality disorder that is manifested by frequent episodes of psychosis or depression, or results in a substantial functional impairment that has a seriously adverse effect on life or on mental or physical health;

(vi) An Axis III diagnosis, as described by the most recent Diagnostic and Statistical Manual of Mental Disorders, that has resulted in a substantial functional impairment or any substantial vulnerability; or

(vii) Any substantial mental or emotional deterioration caused by isolated confinement and resulting in substantial functional impairment or any behavior that has a serious adverse effect on mental or physical health.

(3) For the purposes of this chapter, a "serious injury," with respect to an individual, shall mean a physical injury that includes:

(i) A substantial risk of death or disfigurement;

(ii) Loss or impairment of a bodily organ;

(iii) A fracture or break to a bone, excluding fingers and toes;

(iv) An injury defined as serious by a physician; and

(v) Any additional serious injury as defined by the Department of Correction.

(c) *Screening.*

(1) A screening process shall be developed and implemented by the New York City Department of Health and Mental Hygiene for use prior to any hearing that could result in placement in isolated confinement.

(2) The screening process shall be administered by a licensed mental health services clinician or by an appropriately trained and licensed medical clinician. The screening shall be of sufficient length to obtain a reliable diagnosis of disability or serious injury.

(3) The screening process shall be designed to identify any disability as defined in paragraph (b) of this section.

(4) The New York City Department of Health and Mental Hygiene shall develop and implement policies and procedures to receive medical information about persons in its care from that person's family members, medical care providers, attorneys, and other advocates.

(5) The screening process shall be developed, implemented, and overseen exclusively by the New York City Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene will maintain the confidentiality of any medical or mental health diagnoses in accordance with good clinical practice and governing law.

(6) The clinicians conducting the screenings shall record their findings on a standard, written disability determination form, which the Department of Health and Mental Hygiene shall develop for the purposes of this screening.

(7) If a person in the custody and care of the New York City Department of Correction is determined to have a disability or serious injury, then that person shall not be placed in isolated confinement.

(d) *Right of reconsideration.*

(1) A person in the custody and care of the New York City Department of Correction shall have the right to request reconsideration of a determination of non-disability following the screening described in paragraph (c) of this section and prior to the disciplinary hearing described § 4-02(d). Such a reconsideration will consist of a second screening, to be conducted by a different clinician.

(2) Any person who is found to be disabled or seriously injured following this second screening shall be excluded from isolated confinement.

(3) Any person requesting reconsideration of a determination of non-disability may present documentary and/or testimonial evidence in support of such reconsideration.

(4) The determination of such reconsideration must be rendered within twenty-four hours of the reconsideration screening.

(e) *Pre-hearing detention.*

(1) No person who is currently receiving medical treatment for a disability or who has received medical treatment for a disability during a past incarceration shall be held in isolated confinement, or pre-hearing detention, while awaiting a disability screening or while awaiting a reconsideration of disability status, prior to a disciplinary hearing.

(2) No person who has requested a disability screening prior to a disciplinary hearing may be held in isolated confinement, or pre-hearing detention, for more than twenty-four hours while awaiting a disability screening or for more than a total of forty-eight hours while awaiting reconsideration of a non-disability determination.

§ 5-04 Alternative Safety Restrictions for People with Disabilities and Serious Injuries.

(a) *Policy.*

The Department of Correction and the Department of Mental Health and Hygiene shall develop and implement a written policy describing alternative safety restrictions for people with disabilities and serious injuries who represent an immediate threat to the physical safety of others.

(b) *Standard.*

No person with a disability or serious injury shall be placed in alternative safety restriction unless:

(1) That person has caused another person to sustain serious physical injury as a result of violent conduct or presents an imminent risk of causing serious physical injury through violence;

(2) That person presents a continuing and ongoing threat of physical violence against another person; and

(3) All other less restrictive alternatives have been shown to be inadequate to prevent that person from causing serious physical injury.

(c) *Restrictions.*

Any alternative safety restriction shall be:

(1) The least restrictive means of preventing the person with disabilities from causing harm;

(2) Designed and implemented consistent with a long-term therapeutic plan; and

(3) Based on positive reinforcement of behavior and not punitive in nature.

(d) *Time Limitations.*

(1) No person shall be kept in alternative safety restrictions any longer than necessary to prevent harm to others and no longer than fourteen consecutive days and no more than fourteen total days in any thirty-day period.

(2) Under no circumstances shall a person with a disability or serious injury be confined involuntarily to a cell for more than sixteen hours in any given twenty-four hour period.

(e) *Hearing.*

(1) No person with a disability or serious injury shall be placed in an alternative safety restriction for more than twenty-four hours without a hearing.

(2) Such a hearing will be conducted in accordance with the procedure described in § 4-02(d) of this Chapter.

(f) *Documentation*.

(1) The Department of Correction shall issue a monthly report describing the number of people placed in alternative safety restrictions; the mean, median, and mode, by hours, that people were kept in alternative safety restrictions; and a complete list of the conduct that led to such restrictions. This report shall be posted on the Department of Correction website.

(2) The Department of Correction shall issue a report to the Board of Correction every time it places a person in an alternative safety restriction. This report shall include the name of the person placed under restriction, the length of time that the restriction was used, a narrative description of the behavior that led to the restriction, and a narrative description of the less restrictive alternatives that the Department attempted to use to prevent the person from causing harm. Confidentiality of private information shall be maintained in accordance with state and federal law.

(g) *Non-interference with and access to courts and visitation.*

No alternative safety restriction shall interfere with a person's right to access the courts under § 1-08 of these Minimum Standards and other relevant law. No alternative safety restriction shall interfere with a person's right to visitation under § 1-09 of these Minimum Standards and other relevant law.

§ 5-05 Exclusion of Adolescents and Young Adults from Isolated Confinement.

(a) *Policy.*

Isolated confinement represents a serious threat to the physical and psychological health of adolescents and young adults. Isolated confinement also represents a threat to the developmental health of adolescents that can lead to permanent and irreversible damage. The New York City Departments of Correction, Education, and Health and Mental Hygiene shall develop and implement procedures to exclude adolescents and young adults from isolated confinement.

(b) *Definition.*

(1) For the purposes of this Chapter, "young adult" shall mean a person aged nineteen or older but younger than twenty-five years old.

(2) For the purposes of this Chapter, "adolescent" shall mean a person under the age of nineteen years old.

§ 5-06 Alternative Restrictions for Adolescents and Young Adults.

(a) *Policy.*

The Departments of Correction, Education, and Mental Health and Hygiene shall develop and implement a written policy describing alternative safety restrictions for adolescents and young adults who represent an immediate threat to the physical safety of others.

(b) *Standard.*

No adolescent or young adult shall be placed in an alternative safety restriction unless:

(1) That person has caused another person to sustain serious physical injury as a result of violent conduct or presents an imminent risk of causing serious physical injury through violence;

(2) That person presents a continuing and ongoing threat of physical violence against another person; and

(3) All other less restrictive alternatives have been shown to be inadequate to prevent that person from causing serious physical injury.

(c) *Restrictions.*

Any alternative safety restriction shall be:

(1) The least restrictive means of preventing the adolescent or young adult from causing harm; and

(2) Based on the positive reinforcement of behaviors and not punitive in nature.

(d) *Time Limitations.*

(1) No person shall be kept in alternative safety restrictions any longer than necessary to prevent harm to others and no longer than fourteen consecutive days and no more than fourteen total days in any thirty-day period.

(2) Under no circumstances shall an adolescent or young adult be confined involuntarily to a cell for more than sixteen hours in any given twenty-four hour period.

(e) *Hearing.*

(1) No adolescent or young adult shall be placed in an alternative safety restriction for more than twenty-four hours without a hearing.

(2) Such a hearing will be conducted in accordance with the procedure described in § 4-02(d) of this Chapter.

(f) *Non-interference with education.*

Adolescents and young adults receiving classroom education while in the custody of the Department of Correction shall be permitted to continue to attend classes notwithstanding their placement in an alternative safety restriction.

(g) *Non-interference with access to courts and visitation.*

No alternative safety restriction shall interfere with an adolescent or young adult's right to access the courts under § 1-08 of these Minimum Standards and other relevant law. No alternative safety restriction shall interfere with an adolescent or young adult's right to visitation under § 1-09 of these Minimum Standards and other relevant law.

(h) *No commingling*

Young adults shall be housed separate and apart from adolescents notwithstanding any placement in an alternative safety restriction.

(i) *Adolescents and young adults with disabilities.*

Adolescents and young adults with disabilities shall continue to receive medical treatment and accommodations notwithstanding their placement in an alternative safety restriction.

(j) *Documentation*.

(1) The Department of Correction shall issue a monthly report describing the number of adolescents and young adults placed in alternative safety restrictions; the mean, median, and mode, by hours, that people were kept in alternative safety restrictions; and a complete list of the conduct that led to such restrictions. This report shall be posted on the Department of Correction's website.

(2) The Department of Correction shall issue a report to the Board of Correction every time it places an adolescent or a young adult in an alternative safety restriction. This report shall include the name of the person placed under restriction, the length of time that the restriction was used, a narrative description of the behavior that led to the restriction, and a narrative description of the less restrictive alternatives that the Department attempted to use to prevent the person from causing harm. The report shall include a certification from a staff member of the Department of Correction and a certification from a staff member of the Department of Education that the alternative safety restriction does not interfere with the adolescent's education. Confidentiality of private information shall be maintained in accordance with state and federal law.

§ 5-07 Training of Staff.

(a) *Policy.*

All correction officers and medical services personnel shall receive training in the implementation of the standards in this Chapter. Nothing in this section shall abridge or reduce the training mandated by § 2-02 of the Mental Health Minimum Standards.

(b) *Non-punitive use of isolated confinement.*

All correction officers and medical services personnel shall receive training that emphasizes the non-punitive nature of isolated confinement. All correction officers and medical services personnel shall be trained in the proper use of positive reinforcement methods to reduce violence.

(c) *Patient privacy.*

All correction officers and medical services personnel shall receive training in the proper handling of confidential information about a person's medical diagnosis, symptoms and treatment. This training will emphasize relevant legal constraints on the handling of confidential medical information, the goal of maintaining and respecting the private nature of confidential

information as well as the importance of confidentiality to good clinical practice and to institutional security.

(d) *Conflict reduction and safety.*

All correction officers shall receive continuing training on methods to reduce conflicts between incarcerated people and between correction officers and incarcerated people. This training shall be coupled with training emphasizing officer and medical personnel safety.

(e) *Additional training for staff serving in isolated confinement housing areas.*

In addition to the training described in paragraphs (b)–(d) of this section, correction officers and medical services personnel serving in isolated confinement housing areas shall receive eight additional hours of conflict reduction training and eight additional hours of training on mental illness and traumatic brain injury during each year they work in the isolated confinement housing areas.

(f) *Additional training for staff serving in alternative safety restriction housing.*

In addition to the training described in paragraphs (b)–(d) of this section, correction officers and medical services personnel serving in posts implementing alternative safety restrictions shall receive eight additional hours of conflict reduction training and twelve additional hours of training on adolescent development, mental illness, disability accommodation, and traumatic brain injury during each year they work in such posts.

II. Statement of Board's Authority to Promulgate the Proposed Rules

The New York City Charter vests the Board of Correction (Board) with authority to promulgate "minimum standards for the care, custody, correction, treatment, supervision, and discipline of all persons held or confined" by the Department of Correction (DOC).[1] This authority gives the Board the power to regulate the Department of Correction's segregation practices, which are central to the "care, custody, correction, treatment, supervision, and discipline" of the people the Department incarcerates. The Board currently exercises this power to establish the maximum period of time a person can be held involuntarily in a cell.[2] Accordingly, the Board also has the authority to specify how long incarcerated people may be held in particular custodial settings, including all forms of punitive segregation and isolated confinement.

Furthermore, the Board has already exercised its power over "discipline" to set limitations on disciplinary punishments. For example, the Minimum Standards ensure that people in segregation units receive recreation and access to congregate religious services.[3] The Minimum Standards limit the DOC's authority to restrict recreation as a form of punishment,[4] and mandate mental health services for people confined in punitive segregation cells.[5]

State law does not constrain the Board of Correction from promulgating the rules proposed in this petition. The proposed rules would exercise the broad discretion that the State Commission of Correction (SCOC) has bestowed on local municipalities to develop their own systems of discipline.[6]

III. Arguments in Support of Adoption of These Rules

The Department of Correction's current system of punitive segregation harms people in its care and custody without providing any penological benefit.

The Board should limit the DOC's reliance on the psychological and physical torment of long-term isolated confinement as a response to minor misbehavior. The Board should promulgate minimum standards that require DOC to use isolated confinement only as a last resort and only to prevent reasonably certain prospective violence. These standards should limit the circumstances under which people may be placed in isolated confinement and the amount of time they may be kept there.

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[1] N.Y.C. CHARTER § 626.

[2] N.Y.C. RULES & REGS. tit. 40, § 1-05(b). This regulation does not apply to people who are in punitive segregation or confined in contagious diseases units. *See id.* at § 1-05(a).

[3] *Id.* § 1-06(g) (recreation); *Id.* § 1-07 (access to congregate religious services).

[4] *Id.* § 1-06(h).

[5] *Id.* § 2-08(b).

[6] N.Y. Comp. Codes R. & Regs. tit. 9 § 7006.

Young adults, adolescents, and people with disabilities are especially vulnerable to the effects of isolated confinement. The Board should exclude these people from isolated confinement and require the DOC to develop "alternative safety restrictions" to prevent violence and minimize harm.

The DOC must develop new practices to maintain security and ensure compliance with facility rules without resorting to lengthy isolation. Improved training and oversight of staff, including instruction in dispute resolution techniques and improved interpersonal communication skills, must come first. The DOC should provide positive incentives for good behavior and tools for incarcerated people to manage conflicts without resorting to violence.

A. Punitive segregation harms people in DOC custody.

Punitive segregation, the involuntary confinement of incarcerated people in cells for twenty-two to twenty-four hours a day, causes serious physical, psychological, and developmental harm and cannot be justified. Punitive segregation fosters violence in DOC facilities and exacerbates threats to institutional security. The Board must act quickly to end the harmful effects of punitive segregation and to reduce current endemic violence in DOC facilities.

Contrary to the national trend to reduce the harmful use of isolation in jails and prisons, the DOC expanded its punitive segregation capacity by twenty-seven percent in 2011, and another forty-four percent in 2012. This expansion left New York City with one of the highest rates of punitive segregation in the country, comparable to the rate in New York State prisons.[7] DOC has more punitive segregation cells than it did in the 1990s, when it housed many thousands more people than it does today.

New York City currently places people in punitive segregation based on a finding of a jail rules infraction at a disciplinary hearing.[8] The DOC does not limit punitive segregation penalties to violent jail infractions. Instead, the DOC sends people to punitive segregation for minor jail misbehavior and violent offenses alike.[9] Each disciplinary infraction has an assigned grade that specifies the length of permissible punitive segregation penalties. Penalties for Grade I offenses range from a minimum of twenty-one days to a maximum of ninety days; Grade II penalties range from eleven to twenty days; and Grade III penalties have a maximum of ten

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[7] Approximately eight percent of the average daily jail population of 12,700 inmates is in twenty-three-hour-a-day lockdown. This rate equals the rate of disciplinary segregation in New York State prisons, where 4,500, or approximately eight percent, of the 56,000 people in New York state custody are held in isolation. SCARLET KIM ET AL, BOXED IN: THE TRUE COST OF EXTREME ISOLATION IN NEW YORK 1 (2012).

[8] *See* DOC Directive 6500-R-B (listing disciplinary offenses and the permissible range of punishments).

[9] Offenses run a wide gambit from "destruction of city property with a value of less than $10" to "arson"; from "extra amounts of city-issued property" to "contraband weapons." DOC Directive 6500-R-B.

days.[10] DOC charges multiple infractions arising from the same incident and requires people to serve segregation penalties consecutively. This system of punishment results in excessive penalties that take no account of the damaging effects of isolation and have no relationship to valid security interests.

Indeed, punitive segregation serves no clear security purpose. Experience suggests no valid safety benefit from the current practice. In 2012, just as correction officers pressured DOC to expand its segregation beds to prevent a "backlog" of people assigned to punitive segregation from overrunning the jails.[11] People assigned to punitive segregation remained in general population, but jail incidents did not increase. DOC's failure to segregate its "backlog" demonstrates how it has not tailored punitive segregation to meet legitimate objectives.[12]

The Board should promulgate rules that tailor isolated confinement to legitimate security objectives by using it only to prevent reasonably certain violence.

1. DOC harms people in punitive segregation through violence, neglect, and isolation.

Violence pervades DOC's punitive segregation units. DOC staff uses the threat of frequent cell searches—sometimes three per day amid a population that rarely leaves its cells—and abusive and taunting language to keep people in a constant state of fear. These interactions are the cause of frequent confrontation and unnecessary cell extractions that result in serious bodily injury to incarcerated people. Incarcerated people consistently report experiencing or witnessing brutal assaults in parts of the punitive segregation housing areas. The "mini-clinics" in the Central Punitive Segregation Unit (CPSU) and the Mental Health Assessment Unit for Infracted Inmates (MHAUII), which lack security cameras, are the frequent settings of horrific staff violence.

People in punitive segregation suffer neglect from correction and medical staff. Part of the reason is logistical. Segregation unit staff must escort incarcerated people wherever they go,

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[10] DOC Directive 6500-R-B.

[11] Jeanmarie Evelly, *Solitary Confinement on the Rise at Rikers*, CITY LIMITS (Mar. 27, 2012), http://www.citylimits.org/news/article_print.cfm?article_id=4559.

[12] Efforts in other states demonstrate no increase in violence connected to reform of punitive segregation. Mississippi reduced its isolated confinement population in its prisons by more than seventy-five percent since 2007, when its officials revised segregation policies to include only the most serious disciplinary infractions. Violent jail incidents declined by fifty percent during the same period. 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. Judiciary Comm., 112th Cong. (2012) (statement of Christopher Epps, Comm'r, Miss. Dep't of Corrections). Maine reduced its isolated confinement population by seventy percent after revising its classification criteria and categorically excluding people with mental illness. Maine reports no increase in prison violence as a result. Lance Tapley, *Reducing Solitary Confinement*, THE PORTLAND PHOENIX, Nov. 2, 2011.

which requires intensive manpower and great cost.[13] Escorts are not always available in sufficient numbers, and people in segregation report routine difficulties with obtaining needed medical aid or making family or attorney visits.

People in punitive segregation endure twenty-two to twenty-four hours of lonely idleness in a small cell that admits little or no natural light in housing areas that smell of body odor and human waste. Communication between cells requires yelling. Recreation, when provided, is taken alone in a small pen. Frequently, correction officers withhold recreation and other privileges as a means to punish or harass people. The CPSU resembles what is known as a "supermax" facility. The doors are solid with only a small window and a slot with a hatch where food trays are passed in and out. The slot in the door is also used for conversations with medical, security, and other staff.

This isolation from human contact can cause severe physical and psychological harm, which has been well known for over a century. In 1890, the United States Supreme Court assessed the nation's original experiment with solitary confinement and described its harmful 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."[14]

When New York tried a similar form of solitary confinement, Gustav Beaumont and Alexis de Tocqueville reported that it "devours the victim incessantly and unmercifully; it does not reform, it kills. The unfortunate creatures submitted to this experiment wasted away…."[15]

Modern courts have reiterated these consequences when addressing present-day forms of solitary confinement.[16] In 1988, the Seventh Circuit observed, "the record shows, what anyway

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[13] Although the DOC does not release specific figures describing the relative cost of solitary confinement, a recent report from the New York City Office of Management and Budget revealed that the DOC will save $323,000 annually by converting one adolescent punitive segregation unit into a general population housing area. NEW YORK CITY OFFICE OF MGMT. AND BUDGET, AGENCY GAP CLOSING PROGRAMS 3 (2012).

[14] In re Medley, 134 U.S. 160, 168 (1890). The court concluded that solitary confinement "is itself an infamous punishment." *Id.* at 169. *See also* CHARLES DICKENS, AMERICAN NOTES FOR GENERAL CIRCULATION 68 (1842) ("I hold this slow daily tampering with the mysteries of the brain to be immeasurably worse than any torture of the body…").

[15] TORSTEN ERIKSSON, THE REFORMERS, AN HISTORICAL SURVEY OF PIONEER EXPERIMENTS IN THE TREATMENT OF CRIMINALS 49 (1976). *See also* W. DAVIS LEWIS, FROM NEWGATE TO DANNEMORA: THE RISE OF THE PENITENTIARY IN NEW YORK, 1796–1848, at 17–21 (1965).

[16] Jones'El v. Berge, 164 F. Supp. 2d 1096, 1101 (W.D. Wisc. 2001) (isolated confinement is "known to cause severe psychiatric morbidity, disability, suffering and mortality [even among

seems pretty obvious, that isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total."[17]

Psychiatrists have concluded that isolation causes "hyperresponsivity to external stimuli," "perceptual distortions, illusions, and hallucinations" "panic attacks," "difficulties with thinking, concentration, and memory," "intrusive obsessional thoughts," "overt paranoia," and "problems with impulse control."[18] This psychological damage exacerbates problems within the jailhouse—

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those] who have no history of serious mental illness and who are not prone to psychiatric decompensation."); Koch v. Lewis, 216 F. Supp. 2d 994, 1001 (D. Ariz. 2001) (experts agreed that extended isolation causes "heightened psychological stressors and creates a risk for mental deterioration"); Ruiz v. Johnson, 37 F. Supp. 2d 855, 907 (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) (the court described administrative segregation units as "incubators of psychoses-seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from mental infirmities"); Langley v. Coughlin, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (citing expert's affidavit regarding effects of SHU placement on individuals with mental disorders); Baraldini v. Meese, 691 F. Supp. 432, 446–47 (D.D.C. 1988) (citing expert testimony on sensory disturbance, perceptual distortions, and other psychological effects of segregation), *rev'd on other grounds sub nom*. Baraldini v. Thornburgh, 884 F.2d 615 (D.C. Cir. 1989); Bono v. Saxbe, 450 F. Supp. 934, 946 ("Plaintiffs' uncontroverted evidence showed the debilitating mental effect on those inmates confined to the control unit."), *aff'd in part and remanded in part on other grounds*, 620 F.2d 609 (7th Cir. 1980); Madrid v. Gomez, 889 F. Supp. 1146, 1235 (N.D. Cal. 1995) (concluding, after hearing testimony from experts in corrections and mental health, that "many, if not most, inmates in the SHU experience some degree of psychological trauma in reaction to their extreme social isolation and the severely restricted environmental stimulation in the SHU"), *rev'd in part on other grounds*, 190 F.3d 990 (9th Cir. 1999).

[17] Davenport v. DeRobertis, 844 F.2d 1310, 1313 (7th Cir. 1988). In *Davenport*, the court recognized that "there is plenty of medical and psychological literature concerning the ill effects of solitary confinement (of which segregation is a variant) . . ." *Id.* at 1316 (citing Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. PSYCHIATRY 1450, 1450–54 (1983)). Other courts have made similar observations. Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995). *See also* McClary v. Kelly, 4 F. Supp. 2d 195, 208 (W.D.N.Y. 1998) (the fact that "prolonged isolation from social and environmental stimulation increases the risk of developing mental illness does not strike this Court as rocket science").

[18] Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J. L. & POL'Y 325, 335–36 (2006). Grassian based his findings on his own observations of patients who had endured solitary confinement and on the recorded observations of others who had studied people who had endured various other types of limitations on environmental stimulation. *See also* Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQUENCY 124 (2003); Craig Haney & Mona Lync, *Regulating Prisons of the Future: A Psychological Analysis of Supermax & Solitary Confinement*, 23 N.Y.U. J. L. & SOC. CHANGE 477 (1997); Kristin G. Cloyes et al., *Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample*, 33 CRIM. J. & BEHAVIOR 760 (2006).

hyperresponsive people with low impulse control are likely to act out when they return to general population. These symptoms have a profound ripple effect when people are released directly from isolation to the free world, where their impaired abilities leave them liable to return to previous patterns of destructive behavior, such as crime and drug abuse.[19]

Punitive segregation damages the ability of some pretrial detainees, to participate in their own criminal defense. The negative psychological effects of punitive segregation may adversely affect the ability of these individuals to communicate effectively with counsel, understand court proceedings, and participate in their defense. Additionally, people in punitive segregation report missing court dates because of transportation delays.

Isolated confinement causes harm, and the Board should promulgate rules that reduce that harm.

2. People with mental disabilities must be excluded from punitive segregation.

People with mental disabilities are particularly prone to the ill-effects of isolation. One court found that confining a person with mental illness to segregation "is the mental equivalent of putting an asthmatic in a place with little air to breathe."[20] Isolating people with mental illness can exacerbate their symptoms or lead to decompensation.[21] It conflicts with sound medical practice and challenges the medical ethics of mental health practitioners in jails and prisons.[22]

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[19] *See* Terry Kupers, *Prison and the Decimation of Pro-Social Life Skills*, *in* THE TRAUMA OF PSYCHOLOGICAL TORTURE, 127, 131, 135 (Almerindo E. Ojeda ed., 2008).

[20] Madrid, 889 F. Supp. at 1261.

[21] HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 145–68 (2003). In their amicus brief in *Wilkinson v. Austin*, leading mental health experts summarized the clinical and research literature about the effects of prolonged isolated confinement and concluded: "No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects" (Statement of Interest of Amici, p. 4). Brief of *Amici Curiae* Professors and Practitioners of Psychology and Psychiatry, Wilkinson v. Austin, 545 U.S. 209 (2005) (No. 04-4995). See also Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUST. 441 (2006).

[22] *See* Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCH. L. 104, 105 (2010) (concluding that "[m]ental health professionals are often unable to mitigate fully the harm associated with isolation" due to limited access to medicine and limited opportunities for therapeutic interaction).

Thus, the American Bar Association,[23] the American Psychiatric Association,[24] the United Nations,[25] religious organizations,[26] and non-governmental organizations[27] are nearly unanimous in their recommendation that people with mental illness and other mental disabilities be categorically excluded from isolated confinement.

New York and other states have taken steps, because of litigation or independently, to exclude people with serious mental illness from some isolated confinement settings and to increase mental health services in restricted settings.

Courts have approved remedies, many in the form of settlement agreements,[28] for people with mental illness in isolation. In New Jersey, people with a history of mental illness *must* be

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[23] ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS No. 23-2.8(a) (2010) ("No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing") [hereinafter ABA STANDARDS].

[24] *See* American Psychiatric Association, *Position Statement on Segregation of Prisoners With Mental Illness* (2012) ("Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted.").

[25] *See, e.g.*, Interim Rep. of the Spec. Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc. A/66/268 at 21 (Aug. 5, 2011) ("given their diminished mental capacity and that solitary confinement often results in severe exacerbation of a previously existing mental condition…its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment") [hereinafter U.N. Solitary Report].

[26] *See, e.g.*, THE RABBINICAL ASSEMBLY, RESOLUTION ON PRISON CONDITIONS AND ISOLATION (2012) (calling upon prison officials to "analyze this data supporting ending…the use of solitary confinement for mentally ill prisoners"); NEW YORK STATE COUNCIL OF CHURCHES, RESOLUTION OPPOSING THE USE OF PROLONGED SOLITARY CONFINEMENT IN THE CORRECTIONAL FACILITIES OF NEW YORK STATE AND NEW YORK CITY (2012).

[27] *See, e.g.*, SHARON SHALEV, A SOURCEBOOK ON SOLITARY CONFINEMENT 30 (2008) ("those suffering from mental illness must not be placed in solitary confinement and under no circumstances should the use of solitary confinement substitute for appropriate mental health care"); COMM'N ON SAFETY AND ABUSE IN AM.'S PRISONS, CONFRONTING CONFINEMENT 59 (2006) (declaring that "[p]risoners with a mental illness that would make them particularly vulnerable to conditions in segregation must be housed in secure therapeutic units").

[28] *See, e.g.*, Letter Agreement from Joe R. Williams, Secretary of Corrections for the State of New Mexico, Nick D'Angelo, General Counsel, and Robert T. Booms, Counsel for Defendants to Mark Donatelli, Peter Cubra, Sophie Cooper, and Jane Yee, Counsel for Petitioners in *Ayers v. Perry* and other individual habeas actions pending in New Mexico State Court 18-19 (May 20, 2003); Settlement Agreement, State of Connecticut Office of Protection & Advocacy for Persons

released from administrative segregation if it appears that ongoing confinement there would harm them.[29] A federal court ordered the Mississippi Department of Correction to provide yearly assessments and better mental health care for people on death row, who were subject to conditions of isolation.[30] In California, a federal judge ordered that people with serious mental illness be excluded from the Pelican Bay SHU.[31] In Connecticut, a settlement called for exclusion of people with serious mental illness from the Northern Correctional Institution, a high-security prison.[32] A federal judge ordered Ohio to exclude people with serious mental illness from the Ohio State Penitentiary, a supermax.[33] In Wisconsin, a settlement agreement excluded prisoners with serious mental illness from supermax housing.[34] Litigation has also resulted in state regulations that require that mental illness be taken into consideration during prison disciplinary hearings.[35]

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with Disabilities v. Choinski, No. 3:03 CV 1352 (D. Conn. Mar. 8, 2004); Private Settlement Agreement, Mast v. Donahue, No. 2:05-cv-00037 (S.D. Ind. Jan. 23, 2007); Private Settlement Agreement, Disability Advocates, Inc. v. NYS Office of Mental Health, et al., No. 02 Civ. 4002 (S.D.N.Y. April 27, 2007); Settlement Agreement, Disability Law Center, Inc. v. Massachusetts Dep't of Correction, No. 07-10463 (D. Mass. Apr. 12, 2012), Settlement Agreement, Katka v. State of Montana, Cause No. BDV 2009-1163, at 4 (D. Mont. Apr. 12, 2012). Recently, following litigation, the Michigan legislature proposed a bill to exclude people with mental disabilities from solitary confinement in Michigan's state prisons. *See* Mental Health Association of Michigan, *An Important Message on Solitary Confinement of Michigan Prisoners with Mental Disorders*, MHA-MI.COM (Sept. 6, 2012), http://www.mha-mi.com/2012/09/an-important-message-on-solitary-confinement-of-michigan-prisoners-with-mental-disorders/.

[29] D.M. v. Terhune, 67 F. Supp. 2d 401, 403 (D.N.J. 1999).

[30] Gates v. Cook, 376 F.3d 323, 342 (5th Cir. 2004) (ordering mental health examinations and care for death row prisoners).

[31] Madrid, 889 F. Supp. at 1265.

[32] Connecticut Office of Protection & Advocacy for Persons with Disabilities v. Choinski, Civ. No. 3:03 CV 1352 (RNC) (U.S.D.C. Conn.).

[33] Austin v. Wilkinson, Civ. No. 01 CV 071 (U.S.D.C. N. Ohio).

[34] Jones'El v. Berge, 164 F. Supp. 2d 1096, 1125–26 (W.D. Wis. 2001) (granting preliminary injunction requiring removal of those with serious mental illness from "supermax" prison, which isolates prisoners).

[35] Anderson v. Goord, 87-CV-141 (N.D.N.Y. 2003) (private settlement agreement required amendments to state-wide regulations that identified specific circumstances when mental health must be considered during a disciplinary hearing to assist in determining the appropriate penalty, if any, and established case management committees to review the status of SHU prisoners with mental illness and make recommendations for restoration of privileges, time cuts, and housing reassignments); 7 N.Y.C.R.R. §§ 251.2, 254.6, 254.7, and 310; D.M. v. Terhune, 67 F. Supp. 2d 401, 403 (D.N.J. 1999) (requiring that hearing officers are informed whether inmates are receiving treatment, and requiring removal from disciplinary detention if mental health status deteriorates).

In New York, litigation[36] and a simultaneous effort of a broad coalition of prisoner and mental health advocates, formerly incarcerated people, and family members worked together to successfully alter the use of isolated confinement for imprisoned people with mental illness in New York State prisons. As litigation progressed in federal court, the coalition, Mental Health Alternatives to Solitary Confinement (MHASC), worked on state legislation to end isolated confinement for people with serious mental illness in New York State prisons altogether.[37]

The private settlement agreement that resulted from the *DAI v. OMH* litigation required a minimum of two hours per day of out-of-cell treatment or programming for people with serious mental illness confined in punitive segregation and the creation of residential mental health units which provided *four* hours of out-of-cell treatment where people with serious mental illness would be housed instead of punitive segregation.[38] Legislative efforts were also successful; through the efforts of MHASC, the Special Housing Unit (SHU) Exclusion Law was passed.[39] The SHU Exclusion Law expands on some of the provisions of the private settlement agreement entered in the *DAI v. OMH* litigation and adopts other provisions without modification. It defines "serious mental illness," provides for people with serious mental illness to be diverted or removed from segregated confinement (punitive segregation) to residential mental health units, and provides them with improved mental health care. The passage of this state law made restrictions on housing people with mental illness in isolated confinement permanent.

Although DOC does operate a separate residential unit specifically for people with mental illness sentenced to punitive segregation called the Mental Health Assessment Unit for Infracted Inmates (MHAUII), MHAUII does not offer any respite from punitive segregation.[40]

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[36] Disability Advocates Inc. v. New York State Office of Mental Health, et al, No. 1:02-cv-04002 (S.D.N.Y.) (*DAI v. OMH)*.

[37] Assembly Mental Health Corrections Committee Chair Jeffrion Aubry drafted and introduced the legislation in the State Assembly. It was later co-sponsored in the State Senate by then Senate Corrections Committee Chair Michael Nozzolio.

[38] The settlement agreement also provided universal and improved mental health screening of all people upon admission to the state prison system, creation and expansion of numerous residential mental health programs, required and improved suicide prevention assessments upon admission to punitive segregation, improved treatment and conditions for people in psychiatric crisis in observation cells, and modifications to the disciplinary process. A stated goal of the agreement was to treat rather than isolate and punish people with serious mental health needs. Disability Advocates, Inc. v. New York State Office of Mental Health, No. 1:02-cv-04002 (S.D.N.Y. 2007) (private settlement agreement).

[39] Provisions of the law are codified as amendments to N.Y. MENTAL HYG. LAW § 45.07(z) (McKinney 2011) and N.Y. CORRECT. LAW §§ 2, 137.6, 401, 401-a (McKinney 2011).

[40] People receiving mental health treatment can be confined in CPSU provided that mental health staff determines that they can "psychologically tolerate" the CPSU. Department of Health and Mental Hygiene Health Care Access and Improvement, Correctional Health Services, Mental Health Policies, MH 38.

People housed in MHAUII have the same restrictions on their movement and freedom and suffer the same abusive treatment as do people in other DOC punitive segregation units.[41]

MHAUII ostensibly provides mental health monitoring and treatment. However, people held in MHAUII routinely report that they do not actually receive adequate treatment. For example, they report not being allowed out of their cells to attend group therapy. Those who are permitted to attend group sessions must sit handcuffed to a wall.[42] Some people report that the security officers rarely move them from their isolation cells in MHAUII to the small room in the housing unit where medical staff should provide psychological services. Instead, these services are provided through the food slots in the doors of the cells, a situation that requires patients and therapists to yell at one another and affords no confidentiality of private mental health communications. MHAUII detainees spend a longer time in punitive segregation than their counterparts in other punitive segregation areas, at least in part because many MHAUII detainees accumulate additional infractions while in MHAUII because of symptomatic acting-out behavior, and are therefore unable to move from MHAUII to a less restrictive setting.

In 2012, Homer Venters, Department of Health and Mental Hygiene (DOHMH) Assistant Commissioner for Correctional Health Services, called MHAUII "a complete failure in meeting the needs of patients and the needs of DOC."[43] More recently, Dr. Venters has described how patients who thrive in less restrictive environments become violent and dangerous when placed in segregation at MHAUII.[44] The DOHMH admits that MHAUII harms people without any improvement in facility security. Even DOC Commissioner Dora Schriro has acknowledged the Department's frustration with the unit.[45]

The tragic stories of Aris Hiraldo and Jason Echevarria demonstrate how segregation in MHAUII fails to provide needed oversight and treatment for individuals with mental illness.

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[41] Deputy Warden Edwin Diaz held command over MHAUII until the Bronx District Attorney indicted him for assaulting an incarcerated person. *See* Kevin Deutsch, *Deputy Warden Pleads Not Guilty in Attack on Killer Who Punched Female Officer*, DAILY NEWS (N.Y.), Feb 9, 2012.

[42] New York City Council Member Kevin Dromm expressed his shock after witnessing a group therapy session in MHAUII during which the patients remained handcuffed to the wall. Joint Hearing, Comm. Fire & Crim. Just. Servs. & Comm. Mental Health, Mental Retardation, Alcoholism, Drug Abuse & Disability Servs., N.Y. City Council, "Examining New York City's Compliance with the Brad H. Settlement and Administration of Discharge Planning for People with Mental Illness in City Jails," October 26, 2012 (statement of Kevin Dromm).

[43] N.Y.C. Bd. of Correction, Minutes 9 (Mar. 12, 2012) (describing statement of Homer Venters).

[44] N.Y.C. Bd. of Correction, Minutes 10 (Jan. 14, 2013) (describing statement of Homer Venters).

[45] Preliminary Budget Hearing, Fire and Criminal Justice Services Committee (Mar. 7, 2013).

On February 3, 2011,[46] correction officers found the lifeless body of Aris Hiraldo hanging from a sprinkler head in his punitive segregation cell in MHAUII on Rikers Island. He died two months after he entered the care and custody of the DOC. Mr. Hiraldo had been on Rikers Island before, and his treatment needs were known. Nonetheless, in December 2010, the DOC screening procedures did not detect his mental illness and prior history in DOC. He was placed in general population housing. On December 27, Mr. Hiraldo received a disciplinary ticket after he refused a direct order to return to his cell. The disciplinary hearing resulted in a sentence to punitive segregation.

By January 7, ten days after Mr. Hiraldo's transfer to isolation, DOC staff noticed a "radical change in his behavior."[47] Mr. Hiraldo could not spend twenty-three hours alone in a locked room without human contact or environmental stimulation without psychiatric decompensation. DOC sent him to a mental health caseworker and moved him from the CPSU to MHAUII on January 17. In MHAUII, Mr. Hiraldo only received treatment from a pharmacy technician who oversaw both the administration of Mr. Hiraldo's psychotropic medicine and his observed therapy. Within a month, Mr. Hiraldo hanged himself. In its mortality investigation into Mr. Hiraldo's death, the SCOC determined that DOC and DOHMH should investigate Rikers medical care provider Corizon Health's "fitness to conduct prescription medication and directly observed therapy with needed psychotropic medications."[48]

The August 19, 2012 homicide of Jason Echevarria resulted from the most extreme harms of isolation in MHAUII—the conditions that drive individuals to commit desperate acts of self-harm and correction staff's neglect of medical necessity and utter disregard for human suffering. The DOC has issued no official account of all of the circumstances surrounding Mr. Echevarria's death. Instead, the public must rely exclusively on press accounts of the incident, which have included inaccurate information.[49] The one verified fact is that the city Medical Examiner ruled Mr. Echevarria's death a homicide because of neglect and the denial of medical care.

According to the most recent article concerning Mr. Echevarria's death, he ingested a toxic soap ball on August 18, 2012.[50] He requested medical attention from three jail staff and a captain, but his pleas for help were ignored. Correction Officer Castro stopped in front of Mr.

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[46] The description that follows derives from State Commission of Correction, In the Matter of the Death of Aris Hiraldo, an Inmate of the George R. Vierno Center (2012) [hereinafter SCOC Report on Aris Hiraldo].

[47] *Id.* at 4.

[48] *Id.* at 9–10.

[49] *Compare* Reuven Blau, *Father Demands Answers After His Son at Rikers Island Deliberately Swallows Soap, Dies*, DAILY NEWS (N.Y.), Oct 3, 2012 *with* Reuven Blau, *Bronx DA Will Not Prosecute Jail Guards in Inmate's Death Caused by "Neglect and Denial of Medical Care" After Eating Soap*, DAILY NEWS (N.Y.), Mar 24, 2013.

[50] The description that follows is based on the article Reuven Blau, *Bronx DA Will Not Prosecute Jail Guards in Inmate's Death Caused by "Neglect and Denial of Medical Care" After Eating Soap*, DAILY NEWS (N.Y.), Mar 24, 2013.

Echevarria's cell multiple times but took no action. Captain Terrence Pendergrass refused to send Echevarria to the medical clinic. No video recording of what occurred from midnight until 8:00 a.m. exists as a result of a power failure that affected only this jail. By the morning of August 19, Mr. Echevarria was dead as a result of the neglect and denial of medical care.

The conditions in MHAUII are not a viable alternative to punitive segregation for individuals with mental illness. MHAUII is "a complete failure in meeting the needs of patients and the needs of DOC."[51] MHAUII deprives people with mental illness of the social and psychological aid that they need to meet the basic necessities of life.

Isolated confinement wreaks terrible physical and psychological damage on people with mental disabilities, and the Board should categorically exclude such people from punitive segregation in all DOC facilities including MHAUII.

3. People with physical disabilities must be excluded from punitive segregation.

Punitive segregation also causes substantial harm to people with physical disabilities.

When placed in isolated confinement, people with disabilities do not have proper access to necessary medical care, accommodations, or peer assistance. People with physical disabilities are much more reliant on assistance from others when they are incarcerated, and isolating them makes it more difficult to receive that assistance.

As the *U.N. Handbook on Prisoners with Special Needs* explains, "the difficulties people with disabilities face in society are magnified in prisons," and people with physical disabilities need constant assistance to perform daily tasks.[52] Some individuals rely on the support of other incarcerated people on their cellblock for their daily functioning. However, many people with disabilities have persistent health care needs related to their disability that can only be addressed by a competent clinician.

Isolating people with physical disabilities jeopardizes their well-being. In punitive segregation, people with physical disabilities do not have ready access to medical professionals and are completely reliant on correction staff to communicate their need for medical treatment and to escort them to a treatment provider. Correction officers charged with maintaining security in segregation units are unlikely to provide reasonable accommodations and cannot offer disabled people the type of assistance they rely upon in general population.

People with physical disabilities are more prone to require sick call and special assistance from security staff and are thus more likely to file grievances or other complaints when security constraints, or, indeed a particular officer's lassitude, keeps them from getting the assistance they need. Reports from incarcerated people with physical disabilities indicate that some correction

[51] N.Y.C. Bd. of Correction, *supra* note 43, at 9 (describing statement of Homer Venters).

[52] UNITED NATIONS OFFICE ON DRUGS AND CRIME, HANDBOOK ON PRISONERS WITH SPECIAL NEEDS 44–45 (2009).

officers routinely punish people with physical disabilities with punitive segregation time in retaliation for their complaints about poor medical care.

People who suffer temporary disability because of serious injury face the same difficulties with daily functioning and require the same intensive medical attention.[53] They, too, endure dangerous neglect in isolated confinement.

The Board should exclude people with physical disabilities and serious injuries from isolated confinement to protect them from the serious health risks and humiliations that they would otherwise suffer in punitive segregation.

4. Adolescents and young adults must be excluded from punitive segregation.

Adolescents and young adults, like people with disabilities, are particularly vulnerable to the harms of punitive segregation. A growing number of authorities oppose placing young people in isolated confinement. At least two jurisdictions have introduced legislation to exclude adolescents from isolated confinement and one federal court settlement has imposed strict limitations.[54] The United Nations unequivocally opposed the practice as early as 1990.[55] A Joint Committee of the American Academy of Child and Adolescent Psychiatry distinguished between

[53] Consider the case of Billy Davis, a California prisoner who was sent to solitary confinement after three brain surgeries. According to his mother's testimony to the U.S. Senate, the time Mr. Davis spent in solitary disrupted his recovery from his surgeries and caused him to endure longer suffering and lifelong irreversible injury. *See* 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. Judiciary Comm., 112th Cong. (2012) (statement of Janet Davis).

[54] In February 2013, Florida introduced a bill to exclude youth from segregation except in emergencies. S.B. 812, 2013 Leg. (Fla. 2013), *available at* http://www.flsenate.gov/Session/Bill/2013/0812. The bill limits limit youth segregation to seventy-two hours. In 2012, California introduced similar legislation. S.B. 1363, 2012 Leg. (Cal. 2012), *available at* http://www.temple.edu/psychology/lds/documents/cognitiveandaffectivedevelopmenttics.pdf. In 2012, Montana entered into a federal court settlement that excluded adolescents from segregated confinement for periods longer than seventy-two hours except under certain circumstances. Settlement Agreement, Raistlen Katka v. State of Montana, Cause No. BDV 2009-1163, at 4 (D. Mont. Apr. 12, 2012).

[55] United Nations Rules for the Protection of Juveniles Deprived of Their Liberty, General Assembly Resolution 45/113 at IV(L)(66) (Dec. 14, 1990) ("All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.")

what it calls "seclusion," or extremely brief periods of isolation, and longer-term isolated confinement, and called for a categorical ban on the latter in juvenile facilities.[56]

Isolation alone compromises mental health. As one adolescent recounted, "When you're isolated from everybody else, you start to get some bad thoughts. I was bugging out."[57] These mental health effects can have fatal consequences. As with adults, the majority of suicides in juvenile correctional settings occur in isolation.[58] Cutting and other acts of self-harm are also prevalent among adolescents and young people in isolated confinement.[59]

In fact, in 2012, the DOC designed the Restrictive Housing Unit (RHU) to address the high rate of juveniles engaging in suicidal gestures and suicide attempts while in punitive segregation. Unfortunately the RHU perpetuates DOC's reliance on isolated confinement. For the first week, RHU participants receive no additional out-of-cell time, and even participants who advance to the highest level of the program receive only three hours of lock-out incentive time daily. Successful completion of all three levels of the program takes at least fifty days, almost as long as detainees' average length of stay in DOC custody. The RHU has not been implemented in a manner that offers any respite from the harmful isolation of punitive segregation.

Moreover, forty-eight percent of adolescents admitted to New York jails suffer from mental disabilities at the time of admission, and that number does not include adolescents whose mental disability has not yet become manifest.[60] Like adults with mental disabilities, adolescents with mental disabilities, especially undiagnosed mental disabilities, are at a higher risk of debilitation by isolated confinement.

An additional vulnerability of adolescents and young adults is that their brains are still developing.[61] According to a leading expert in adolescent brain biology, "there is considerable

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[56] JUVENILE JUSTICE REFORM COMMITTEE, AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY, SOLITARY CONFINEMENT OF JUVENILE OFFENDERS (April 2012), http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders [hereinafter AACAP STATEMENT]. The Committee specified, "seclusion should only be used for the least amount of time possible for the immediate physical protection of an individual, in situations where less restrictive interventions have proven ineffective." *Id.*

[57] Interview with M.W., Robert N. Davoren Center, Rikers Island.

[58] AACAP STATEMENT, *supra* note 56.

[59] HUMAN RIGHTS WATCH, GROWING UP LOCKED DOWN 29 (2012).

[60] *Id.* at 32–33. One study established that the mean age for the onset of symptoms of schizophrenia was nineteen. *See id.*; Nitgin Gogtay et al., *Age of Onset of Schizophrenia: Perspectives from Neuroimaging Studies*, 37 SCHIZOPHRENIA BULL. 504 (2011).

[61] Laurence Steinberg, *Cognitive and affective development in adolescence*, 2 TRENDS IN COGNITIVE SCIENCES 69 (2005), *available at* http://www.temple.edu/psychology/lds/documents/cognitiveandaffectivedevelopmenttics.pdf.

evidence that the second decade of life is a period of great activity with respect to changes in brain structure and function."[62] Subjecting young people to the harmful conditions of isolated confinement while such development is underway places them at great risk for psychological damage.

Adolescents and young people also suffer serious physical harm from segregation. Because their bodies are still growing, the forced idleness and poor nutrition available in punitive segregation can lead to permanent developmental damage.[63] The mandated hour of outdoor recreation is inadequate to meet the need for aerobic and muscle-strengthening activity that youth require for healthy development, especially as recreation in punitive segregation occurs in a cell alone without exercise equipment. One adolescent explained that commissary food, which he needed to supplement the meager meals offered in isolated confinement, was completely banned in segregation.[64] He abided a nearly constant feeling of hunger during his time in segregation.[65]

Adolescents in punitive segregation in DOC facilities consistently report disruptions to their education. Although most adolescents are required to receive educational services while incarcerated in DOC custody,[66] those services effectively end when adolescents enter punitive segregation. In their place is what the DOC calls "cell study," in which adolescents receive a packet of school materials to complete on their own and are given the option to speak on the phone with a teacher.[67]

The Board should exclude adolescents and young adults from isolated confinement to preserve their mental and physical health and to avoid irreversible damage to their development.

B. The proposed rules mitigate the harm to people in DOC custody by limiting the use of isolated confinement, excluding vulnerable populations, and improving due process.

Isolated confinement causes serious physical and psychological harm and should be used sparingly, if at all, as a tool of jail management. Isolated confinement should be conceived as a means of preventing violence rather than as a punishment for past behavior. Limiting the use of isolated confinement to situations when it is a tool to temporarily restrain prisoners from impending violence will accord with the recommendations of the American Bar Association,

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[62] *Id.* at 69.

[63] HUMAN RIGHTS WATCH, *supra* note 59, at 37–40.

[64] Interview with M.W., Robert N. Davoren Center, Rikers Island.

[65] *Id.*

[66] *See* DOC Directive #3503R (requiring educational services for all people eighteen and younger who have not received a high school diploma or equivalent held in DOC custody longer than ten days).

[67] HUMAN RIGHTS WATCH, *supra* note 59, at 43.

which recommends that "[s]egregated housing should be used for the briefest term and under the least restrictive conditions practicable."[68] It will also accord with the New York Constitution, which requires the DOC to balance "the harm to the individual resulting from the condition imposed against the benefit sought by the Government through its enforcement."[69]

1. The proposed rules predicate isolation on security objectives instead of punishment.[70]

Under the proposed minimum standards, a person can only be assigned to isolated confinement or alternative safety restrictions when he or she represents an ongoing threat to the physical safety of others.[71] The proposed minimum standard for assigning a person to isolated confinement requires a finding that no less restrictive alternatives would be effective.[72] The proposed minimum standards end the DOC's practice of using isolated confinement as a punishment for minor jail misbehavior and tailor isolation to safety and security objectives.[73]

2. The proposed rules limit the amount of time a person may be isolated.

The goal of isolated confinement should be to restrict a potentially violent person only as long as necessary to prevent violence. The proposed minimum standards limit the permissible length of an assignment to solitary confinement to fifteen days.[74]

The proposed minimum standards do allow for limited renewal of solitary confinement assignments based on a showing that a person represents a continuing threat of injury to others.[75] The proposal permits renewals limited to sixty days total—or four consecutive segregation assignments.[76] If a person continues to represent a threat of violent harm to others after sixty

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[68] ABA STANDARDS, *supra* note 23, at No. 23-2.6(a).

[69] Cooper v. Morin, 49 N.Y.2d 69, 79 (1979).

[70] Citations throughout this section are to the Proposed Isolated Confinement Minimum Standards in Section I of this document.

[71] *Supra* at §§ 5-02(d)(2), 5-04(b)(2), 5-06(b)(2).

[72] *Supra* at § 5-02(d)(3).

[73] *See supra* at §§ 5-01, 5-02(a).

[74] *Supra* at § 5-02(i)(1). Fifteen days is the recommended maximum isolation assignment under the U.N.'s current standards. U.N. Solitary Report, *supra* note 25. Other jurisdictions have also begun to discuss serious limitations on the time that a person can be held in isolated confinement. In January 2013, Massachusetts introduced legislation that would limit disciplinary segregation sentences to two weeks in all cases and require the sentence be no longer than required to prevent threats to security. H.B. 1486, 188th Gen. Court (Mass. 2013), *available at* http://www.malegislature.gov/Bills/188/House/H1486.

[75] *Supra* at § 5-02(i)(2)(i).

[76] *Supra* at § 5-02(i)(3).

days in segregation, the DOC will be required to seek out alternatives to isolated confinement, such as assigning that person to a different housing area or providing that person with additional supportive programming or mental health services.

The proposed standards limit the aspects of solitary confinement that provoke violent behavior, including forced idleness and deprivation of human contact.[77] The rules require isolated confinement to include a minimum of four hours out of cell each day.[78] The time out of cell will alleviate isolation and permit people to interact with others to the extent practicable.[79] The proposal requires the DOC to offer out-of-cell activities designed to reduce idleness and teach the skills necessary to resolve conflicts without resorting to violence.[80]

The proposed minimum standards require that the conditions of confinement in isolated confinement be as similar as possible to the conditions of confinement in general population housing.

3. The proposed rules exclude vulnerable groups from isolation.

The proposal excludes vulnerable groups from isolation[81] and establishes a system of alternative safety restrictions.[82] The proposed standards limit harm to young people and people with disabilities while still allowing the DOC to maintain security and safety in its housing areas. The alternative safety restrictions must be: (1) no more restrictive than necessary to prevent violence; (2) not punitive in nature; and (3) based on the positive reinforcement of behaviors.[83] Restrictions should be limited to those necessary to restrain violence; any additional restriction would be punitive, not preventative. Restrictions for people with disabilities must also be consistent with a long-term therapeutic plan designed to address the underlying disability.[84]

Punishing symptoms of mental disability or adolescence will do nothing to stop future violence. Alternative safety restrictions must be designed to prevent incarcerated people from acting out violently by addressing the root cause of violent conduct through therapy and education. The DOC should collaborate with the Department of Health and Mental Hygiene and the Department of Education to learn best practices for preventing violence.

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[77] *See supra* at§ 5-02(j).

[78] *Supra* at § 5-02(c).

[79] *See* ABA STANDARDS, *supra* note 23, at No. 23-3.8(c).

[80] *Supra* at § 5-02(j).

[81] *Supra* at §§ 5-03(a), 5-05(a).

[82] *Supra* at §§ 5-04(a), 5-06(a).

[83] *Supra* at §§ 5-04(c), 5-06(c).

[84] *Supra* at § 5-04(c)(2).

A well-designed alternative safety restriction will preserve continuity of care, advance therapeutic goals, and provide people with new tools to shape their behavior that will, in turn, aid them in remaining free from incarceration.

4. The proposed rules improve the due process required to place a person in isolated confinement.

The proposed rules improve due process protections for people the DOC charges with violating rules. Currently, the DOC provides a skeletal hearing process that results in numerous successful court challenges for procedural violations. The proposed rules improve this hearing process in four ways.

First, under the proposed rules, the disciplinary hearing will be overseen by an independent and impartial hearing officer who is not employed by the DOC.[85] Allowing correction officers to serve as hearing officers raises unnecessary questions about the partiality of the disciplinary process. By employing a neutral decision maker to oversee the disciplinary hearings, the minimum standards will help ensure that assignments to isolated confinement are based only on the threat an incarcerated person represents to the safety of others and are not retributory.

Second, the proposed rules will require incarcerated people to have assistance of a trained and competent advocate who is familiar with the DOC's disciplinary procedures.[86] Current regulations do not allow incarcerated people to benefit from such assistance.[87] The addition of a competent advocate would help focus the hearing on the nature and severity of the ongoing threat of violence.

Third, the proposed rules will require a representative of DOHMH to testify at disciplinary hearings when a person has disputed an adverse disability determination.[88] The DOHMH clinician will provide testimony concerning whether the individual has a disability to ensure that the screening requirements have been met. The DOHMH clinician will be required to describe the disability interview that "cleared" the person for segregation as well as any additional opinions offered after reconsideration of an initial decision. The person facing disciplinary sanction will have the right to cross-examine the DOHMH clinician. The hearing officer will be able to exclude a person from segregation for reasons of disability if the testimony of the DOHMH clinician fails to convince her that the individual is not disabled.

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[85] *Supra* at § 5-02(e)(1).

[86] *Supra* at § 5-02(e)(4).

[87] The U.S. Constitution and the State Commission of Correction each require due process prior to segregation, and the DOC's written procedures meet those minima. *See* Wolff v. McDonnell, 418 U.S. 539, 564–72 (1974); N.Y. Comp. Codes R. & Regs. tit. 9 § 7006.

[88] *Supra* at § 5-02(f).

Finally, the DOC will produce a record of the hearing, which it will provide to the person facing a disciplinary sanction for appeal and to the Board for oversight.[89] A person will have the right to appeal an assignment to isolated confinement.[90] The Board will receive detailed information describing the use of isolated confinement so that it can determine whether the DOC has properly limited its reliance on isolated confinement.[91] The DOC will also create reports for the general public that exclude the private personal information of incarcerated people. These reports will inform the public about the operations of DOC facilities and the Department's efforts to limit isolated confinement in the city jails.[92]

Conclusion

For the foregoing reasons, the Board of Correction should adopt the proposed rules as Minimum Standards for the Department of Correction.

IV. Period of Time Rules Should Be in Effect

These rules should take immediate effect upon the Board's action, and they should remain in effect indefinitely.

[89] *Supra* at § 5-02(h)(1).

[90] *Supra* at § 5-02(g).

[91] *Supra* at §§ 5-02(k)(2)-(3), 5-04(f)(2), 5-06(j)(2).

[92] *Supra* at §§ 5-02(k)(1), 5-04(f)(1), 5-06(j)(1).

V. Petitioners

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Tita Theodora Beal
John Boston
Nora Carroll
Megan Crowe-Rothstein
Mary Clare Dougherty
Marla Erlien
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Josh Tarjan
Gale Wiener
Hannah Wolfe

Declaration of Support

The following organizations and individuals believe that people incarcerated in New York City jails deserve appropriate and humane treatment. We oppose the Department of Correction's overuse of punitive segregation and call on the Board of Correction to adopt minimum standards that will:

• Limit the reasons for which a person can be placed in isolated confinement so that isolated confinement will only be used as a last resort to prevent violent conduct;

• Increase the amount of time that a person in isolated confinement is allowed to spend out of cell daily;

• Limit the number of days that a person can be held in isolated confinement;

• Exclude incarcerated people under 25 years old and people with mental or physical disabilities or serious injuries from isolated confinement;

• Require the creation of alternative safety restrictions to address violent conduct by these vulnerable populations in a therapeutic manner;

• Improve due process afforded to those at risk of being placed in isolated confinement; and

• Increase transparency by requiring DOC to report on its use of isolated confinement and alternative safety restrictions.

Association of Legal Aid Attorneys (AFL-CIO) – UAW Local 2325
Association of Pro-Inmate Rights Ñeta
Bronx Defenders
Brooklyn Defenders
Campaign for Alternatives to Isolated Confinement
Campaign to End the New Jim Crow
Center for Comprehensive Care
Center for Constitutional Rights
Children' Defense Fund – New York
Columbia University Mailman School of Public Health, Association for Public Health Action and Criminal Justice
Creating Law Enforcement and Responsibility (CLEAR) at CUNY School of Law
CUNY Law School, Criminal Defense Clinic
Five Borough Defenders
Fortune Society
Jews for Racial and Economic Justice
The Legal Aid Society
Metro NY Religious Campaign Against Torture
NAMI – East Flatbush
National Lawyers Guild
National Religious Campaign Against Torture
Neighborhood Defender Services
New York Association of Psychiatric Rehabilitation Services
New York Civil Liberties Union
New York State Prisoner Justice Network
Office of Appellate Defender
Prisoners' Legal Services of New York
Rights for Imprisoned People with Psychiatric Disabilities (RIPPD)
Social Justice Committee of the Unitarian Universalist Congregation at Shelter Rock
T'ruah: the Rabbinic Call for Human Rights
Urban Justice Center
Uri L'Tzedek
Venture House
VOCAL – NY
Women's Prison Association

Lauren Dammier
Sister Marion Defeis
George Davis
City Council Member Daniel Dromm
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