THE WALLS ARE CLOSING IN ON ME

Suicide and Self-Harm in New York State's Solitary Confinement Units, 2015-2019



A Report by the #HALTsolitary Campaign
May 2020

HALTsolitary
NEW YORK CAMPAIGN FOR ALTERNATIVES TO ISOLATED CONFINEMENT

"I tried to kill myself twice last year within a short time. I had just finished a more than four-year SHU sentence, and I was being brought back to Elmira prison. Somebody asked me to pass over a wick (a piece of string used to light cigarettes) to the next guy. I tossed it over and a guard saw me throw something. We both got searched, they found nothing on me, but they discovered a marijuana cigarette on the guy I was passing the wick to. They believed that I was the one who passed him the pot, and I got sent back to the SHU for another eight months. I also lost a year of visitation and a year of good time. So I never made it back to general population and now, I have done almost five straight years in the box. I was just about to leave solitary, and instead I was immediately sent right back over a piece of string. I am in my early thirties right now. I consider myself a strong individual. Not a quitter. I thought only weak people would lose their minds and attempt suicide but getting sent back so quickly pushed me over the edge. Being in solitary is like sitting in your bathroom for almost 24 hours a day for years straight. You are stuck here. You start hearing voices and you argue more easily. **You go crazy like an animal in a cage…. I often feel extremely enclosed, as if the walls are closing in on me, suffocating me.**"

–Anonymous, *Solitary at Southport*, Correctional Association of NY

"[Our son] Ben could no longer endure the violence, brutality, inhumanity and loneliness of prison life. He had experienced and witnessed too many horrible events. On Oct. 30, 2014, while in solitary confinement, Ben hanged himself. He was 21 years old…. If HALT had been law, Ben would still be alive today."

—Alicia Barraza and Doug van Zandt, *Albany Times Union*

INTRODUCTION

In the U.S. criminal legal system, individuals sentenced to prison are required to relinquish their liberty as redress for the crimes for which they have been convicted. They are not supposed to also give up their humanity, their physical and mental health, or their lives. Yet in New York's state prisons, these are the terrible prices many incarcerated people end up paying.

Some of the incidents of suicide and self-harm in the state's prisons may be beyond the control of the New York State Department of Corrections and Community Supervision (DOCCS). But there can be no doubt that prison conditions profoundly affect the level of suffering and despair felt by incarcerated people, and that inhumane conditions often lead to desperate responses.

This report provides hard evidence, drawn from data provided by DOCCS and other state agencies, that the rate of suicides in New York's prisons far exceeds the national prison average. It also establishes an undeniable link between the use of solitary confinement and higher rates of suicide, suicide attempts, and self-inflicted injury.

Taken together, these numbers demand immediate and drastic change in DOCCS policies and practices in relation to solitary confinement. They demand that New York's lawmakers put an end to preventable suffering, self-harm, and death in our prisons by enacting the HALT Solitary Confinement Act, A.2500/S.1623.[1] Preventing self-injury and suicide by enacting HALT is even more imperative now, as COVID-19 increases the levels of anxiety, fear, and risk of self-harm for people in solitary during the pandemic.

[1] This report was prepared by members of the #HALTsolitary Campaign (a project of the New York Campaign for Alternatives to Isolated Confinement). For more information, contact vpate@nycaic.org. Learn more at www.nycaic.org.

Cover photographs: left, Kalief Browder, who committed suicide after his release from Rikers Island, where he spent nearly two years in solitary confinement; center and right: Ben van Zandt and Cachin Anderson, both of whom took their own lives while in solitary confinement in New York's prisons. RIP.

OVERVIEW

In 2019, 18 people died by suicide in New York state prisons. This was the highest rate of suicide in New York prisons since 2000. It was also **88% higher than the average rate of suicide in prisons across the country.** Already in 2020, as of the end of April, there have been at least five deaths by suicide. For the past two decades, rates of suicide in New York prisons have frequently been higher than the national prison suicide rate. During the last four years (2016-19), New York's prison suicide rate was 46% higher than the national rate.[2]

Equally disturbing is the clear link between prison suicides and the use of solitary confinement in New York. During the period 2015 through 2019, **the rate of suicide by persons in solitary confinement was more than five times the rate for the rest of the New York prison population**. In 2019, at least one third of all suicides occurred in solitary confinement and **the rate of suicides in solitary in our state prisons was ten times the national prison suicide rate.** Many of these deaths were preventable. Half of the people who died by suicide in solitary were young people in their twenties and 65% were People of Color, rates dramatically higher than the rates of suicide by these groups in the rest of the prison population, indicating how much of a direct role solitary played in many people's deaths.

In addition, many more people in New York's prisons are involved in acts of self-harm, including suicide attempts and less serious incidents of self-inflicted injuries. **With 688 suicide attempts during the period January 2015 through April 2019, nearly every other day, someone in a New York prison carries out a suicide attempt.**

Not surprisingly, the rate of suicide attempts is also much higher for people who experience solitary confinement. From January 2015 through April 2019, 43% of all suicide attempts occurred in a Special Housing Unit (SHU), one of several forms of solitary confinement used by DOCCS. Compared with the rest of the New York prison population,

[2] For national prison suicide data, *see* Carson, A. & Cowhig, M., Mortality in State and Federal Prisons, 2001-2016 – Statistical Tables, U.S. Department of Justice, Bureau of Justice Statistics, Table 4, Feb. 2020, NCJ 251920, *available at*: https://www.bjs.gov/content/pub/pdf/msfp0116st.pdf; Noonan, M., Mortality in State Prisons, 2001-2014 - Statistical Tables, U.S. Department of Justice, Bureau of Justice Statistics, Dec. 2016, NCJ 250150, *available at*: https://www.bjs.gov/content/pub/pdf/msp0114st.pdf.

excluding patients in disciplinary residential mental health units (another form of isolated confinement), **the suicide attempt rate for those in SHU was 12 times higher**.

This rate would undoubtedly be even higher if it included suicide attempts that took place in other forms of solitary confinement, such as keeplock in one's own cell.[3] Unfortunately, this information is not available from DOCCS records. Even beyond keeplock, when other forms of isolated confinement are factored in — including disciplinary residential mental health units and crisis units for those with suicidal thoughts or experiencing significant mental health deterioration – the percentage of all suicide attempts that took place in isolation rose to well over 50% of all suicide attempts.

Also common in New York's prisons are self-inflicted injuries that are classified by DOCCS as less serious than suicide attempts. From January 2015 through April 2019, there were 420 such incidents. Again, **the rate of such injuries for those in solitary and the disciplinary residential mental health units was more than seven times** greater than the rate in the remainder of the prison population.

The direct relationship between suicidal and self-injurious behavior and the state's infliction of solitary confinement is as predictable as it is unconscionable. Solitary confinement has long been known to lead to self-mutilation, suicide attempts, and death by suicide. For example, a 2014 study conducted in New York City jails, written by experts affiliated with the New York City Department of Health and Mental Hygiene, and published in the *American Journal of Public Health*, found that people who were held in solitary confinement were nearly seven times more likely to harm themselves and more than six times more likely to commit potentially fatal self-harm than their counterparts in general population, after controlling for length of jail stay, serious mental illness status, age, and race/ethnicity.[4]

[3] Keeplock is used extensively in DOCCS as punishment for rule violations. Persons in keeplock in their own cells remain in their housing units but are locked in their cells all day, 23-24 hours per day, for many days, weeks, and even months per year, without any meaningful human contact or programs. More than 30,000 keeplock sentences are issued annually, and we estimate that more than 1,000 persons are in keeplock at any time.

[4] Kaba, F., et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, Am J Public Health. March 2014; 104(3): 442–447, *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3953781/.

In the midst of COVID-19, there is increased risk of self-harm and other negative health consequences for people in solitary. Being in solitary during the pandemic, without the possibility of seeing family and with the fear of contracting or dying from the virus alone in a solitary cell, can increase levels of anxiety and depression. Moreover, health experts have been warning that solitary worsens the spread and harm of COVID by (1) weakening people's overall condition and immunity, (2) forcing contact between officers and the people in solitary they have to escort to showers or recreation, and (3) discouraging people from reporting symptoms because they know they will likely end up in a solitary cell rather than receiving quality medical treatment and care.[5]

"Solitary confinement induces the bleakest depression, plunging despair, and terrifying hallucinations. The Mental Health Department looms large in these units, doling out antidepressants, antipsychotics, and mountains of sleeping pills. If these [people] didn't have mental health issues before they entered solitary, they do now. But even the most potent medications can only do so much, and when they give out—when human behavior deteriorates into frantic scenes of self-mutilation and makeshift nooses—we're called to a cell door."

—Mary Buser, *Lockdown on Rikers*

Furthermore, the rates of suicide and suicide attempts carried out in solitary confinement do not fully capture the harm caused by solitary. Evidence shows that the effects of solitary are lasting and sometimes permanent and can lead to suicide and self-

[5] *See. e.g.*, Dr. Homer Venters, *Coronavirus behind bars: 4 priorities to save the lives of prisoners*, The Hill, March 23, 2020, *available at*: https://thehill.com/opinion/criminal-justice/488802-coronavirus-behind-bars-4-priorities-to-save-the-lives-of-prisoners; Vera Institute for Justice and Community Oriented Correctional Health Services (COCHS), *Guidance for preventive and responsive measures to coronavirus for jails, prisons, immigration detention and youth facilities*, March 18, 2020, *available at*: https://www.vera.org/downloads/publications/coronavirus-guidance-jails-prisons-immigration-youth.pdf; David Cloud, Dallas Augustine, Cyrus Ahalt, & Brie Williams, *The Ethical Use of Medical Isolation – Not Solitary Confinement –to Reduce COVID-19 Transmission in Correctional Settings*, AMEND: Changing Correctional Culture, April 9, 2020, *available at:* https://amend.us/wp-content/uploads/2020/04/Medical-Isolation-vs-Solitary_Amend.pdf.

harm after a person is returned to the general prison population or even released to the outside community.

In the past year alone, two studies have concluded that solitary confinement dramatically increases the risk of death by suicide and other causes after a person is released from prison. Specifically, new U.S. academic research found that even a few days in solitary confinement can significantly heighten the risk of death by suicide, as well as by accident, violence, and other causes, for people who have returned to the community.[6] Similarly, an international study found that solitary led to dramatically increased rates of death by suicide, as well as overdose, after a person was released from prison, with the risks increasing the more time the person had spent in solitary.[7]

Utilizing the most up-to-date data available, this report provides an in-depth analysis of suicide, suicide attempts, and self-inflicted injuries and their connection to New York's use of solitary confinement.

METHODOLOGY FOR ANALYZING SUICIDE AND SELF-HARM DATA

Suicide Analysis

In order to assess the number and location of suicides and other forms of self-harm in New York prisons, we analyzed electronic records from several New York agencies including DOCCS, NYS Office of Mental Health (OMH), NYS Commission of Correction (SCOC), and the NYS Justice Center for the Protection of People with Special Needs (Justice Center).

In analyzing suicides in DOCCS and utilizing data from each of these state agencies, we were able to identify the names of 74 of the 75 persons who died by suicide from January 2015 through April 2020, and were able to compile extensive information about each

[6] Wildeman, C. & Anderson, L., *Solitary confinement placement and post-release mortality risk among formerly incarcerated individuals: a population-based study*, The Lancet Public Health Volume 5, Issue 2, Feb. 2020, pages e107-e113, *available at*: https://www.sciencedirect.com/science/article/pii/S2468266719302713.

[7] Brinkley-Rubinstein, L., Sivaraman, J., et al., *Association of Restrictive Housing During Incarceration With Mortality After Release*, JAMA Netw Open. 2019;2(10):e1912516., Oct. 4, 2019, *available at*: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2752350.

person, including demographic data, such as age and race/ethnicity, and criminogenic data, such as the prison in which the persons were housed, how long they were in DOCCS custody prior to their death, and their maximum sentences. Because we had very limited data about the locations in which persons who died by suicide in 2020 were housed, we limited our analysis to the five-year period January 2015 through December 2019.

To complete our suicide analysis, however, we also needed to determine whether persons were in some form of isolation at the time of their death. This was challenging because electronic records from DOCCS and most other state agencies do not generally indicate the type of housing a person resided in at the time of their death. For example, if a person was in a typical Special Housing Unit in most prisons, this would not be indicated in the DOCCS records.

Moreover, DOCCS records never denote if a person was in keeplock, a form of solitary confinement in which the person is locked in their general population cell for 23-24 hours per day for intervals that can extend for many days, weeks, or even months at a time. With more than 1,000 individuals in keeplock on a given day in DOCCS and more than 30,000 keeplock sentences imposed each year through the disciplinary process, we know that incidents of suicide occur while individuals are in keeplock.

Fortunately, for most years during the five-year study period, OMH summary records sometimes contained a general description of the location where a suicide occurred, including whether the person died while in a SHU, long-term keeplock unit, or keeplock. This data, however, was not always accurate or complete, and in 2018, OMH did not provide any location description in the summaries it provided. In some cases, we were able to determine that a person who died by suicide was in some form of isolation from other DOCCS, SCOC or Justice Center records. But we strongly suspect that we have not been able to identify all persons who died by suicide in isolation during the five-year period.

Suicide Attempts and Self-Inflicted Injuries Analysis

The methodology for assessing suicide attempts and self-inflicted injuries was more limited. Primarily, we relied upon summaries of all DOCCS Unusual Incident Reports (UIRs) for the period from January 1, 2015 through April 30, 2019. DOCCS separates UIR incidents of self-harm into three categories: suicides, suicide attempts, and self-inflicted injuries.

The UIR summaries include the prison or sometimes the residential unit where the incident occurred, the date and time of the incident, a general description of the location where the incident occurred (such as cell, Special Housing Unit, medical or mental health area), the type of unusual incident that occurred, and very limited information about the job titles and actions of staff. No identifying information is provided about the incarcerated persons or staff members involved in the incident. From this data, we can sometimes ascertain if the incident occurred in a Special Housing Unit in the prison, one form of solitary confinement imposed by DOCCS, or in one of the residential medical or mental health units in the prisons. The UIR summaries do not indicate, however, whether at the time of an incident, the person was in keeplock. Therefore, we could not include in our solitary computation any self-harm that occurred while persons were in keeplock.

Another challenge we encountered in determining whether self-harm injuries involved persons who had been in solitary confinement arose when reviewing UIR summaries that indicated that an incident happened in an area of the prison where persons can be held temporarily, such as a mental health unit or a medical area. We expect that some of the people who self-harmed in these temporary locations had been placed there directly from solitary confinement.

The UIR data demonstrates that many incidents of self-harm involved people who had mental health needs. A significant number of incidents occurred in one of the disciplinary residential mental health treatment units (RMHTUs), consisting of the Bedford Hills Therapeutic Behavioral Unit, Great Meadow Behavioral Health Unit, Marcy Residential Mental Health Unit (RMHU), Five Points RMHU, and Attica RMHU (closed in 2017), which have a combined capacity for about 225 patients. Since we could determine if people were living in an RMHTU when they self-harmed, and we discovered that many incidents of self-harm occurred on these units, we analyzed the rate of self-harm for RMHTU patients. Similarly, we could identify if people who self-harmed were in a non-punitive residential mental health treatment unit, including the 17 DOCCS Intermediate Care Programs.

But some persons involved in self-harm were not in one of the residential mental health units. In such cases, the designation of a mental health location most likely referred to people in a Residential Crisis Treatment Program (RCTP) unit, a separate unit in the prisons where people are sent who express an intent to self-harm or who have self-harmed. Such individuals could have been in solitary confinement immediately before being sent to the

RCTP. In our analysis of self-harm, we have attempted to identify the number of incidents that could fall into this category.

Similarly, some persons were identified as engaged in self-harm and their UIR location was apparently in a medical area, such as an infirmary. It should be noted that persons who express an intention to self-harm or have actually attempted self-harm are frequently sent for monitoring to an infirmary in prisons that do not have an RCTP, which includes most prisons in the state. Such persons may have been in solitary confinement prior to this temporary transfer to the infirmary and will remain there until they are released back to their original housing location or sent to an RCTP. Again, we have attempted to identify the number of incidents that could fall into this category — in which we do not know where the person was housed prior to their act of self-harm.

SUICIDES

From January 2015 through April 2020, there were 75 suicides in DOCCS prisons. The table on page 12 summarizes DOCCS suicides and suicide rates, and the U.S. prison suicide rates, from 2000 through April 2020. The DOCCS suicide rate has exceeded the national prison suicide rate for every year in the past two decades, except for three years (2001, 2004, and 2006).[8] The most recent national prison suicide rate, released in February 2020 by the U.S. Department of Justice, Bureau of Justice Statistics, is 21 deaths per 100,000 residents, based upon 2016 national data.[9] During the past four years (2016-19), the rate of suicides in NY prisons was 30.8 deaths per 100,000 incarcerated persons, a rate **46% higher** than the national average for all U.S. prisons. The 18 suicides in 2019 represent a rate of 39.4 suicides per 100,000, which is **88% higher** than the national rate.

[8] The national suicide rate for all U.S. citizens is 14 persons per 100,000 individuals. Xu, J., et al., Mortality in the United States, 2018, U.S. Department of Health and Human Services, Center for Disease Control and Prevention, Jan. 2020, *available at*: https://www.cdc.gov/nchs/data/databriefs/db355-h.pdf. The rate inside U.S. prisons is 50% higher than the rate in the community, and DOCCS' 2019 rate is 181% higher than the community suicide rate.

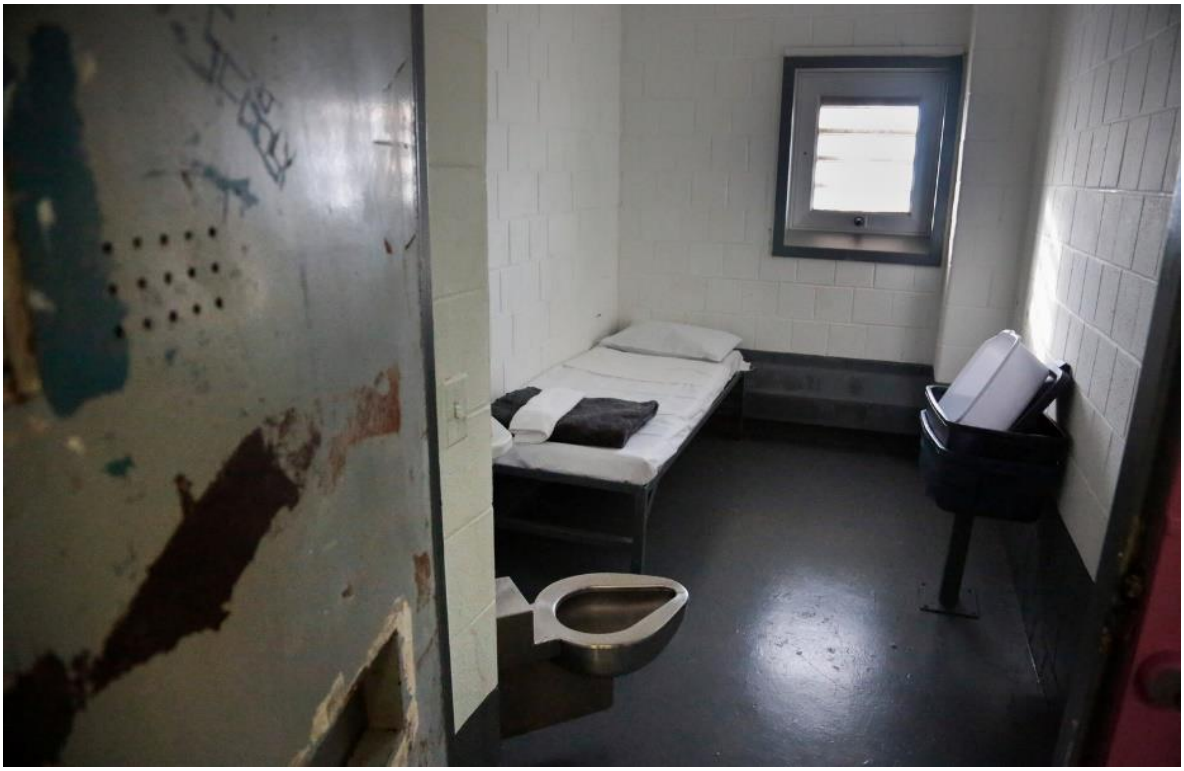
[9] Carson, A. & Cowhig, M., Mortality in State and Federal Prisons, 2001-2016 – Statistical Tables, U.S. Department of Justice, Bureau of Justice Statistics, Table 4, Feb. 2020, NCJ 251920, *available at*: https://www.bjs.gov/content/pub/pdf/msfp0116st.pdf.

The limited data for 2020 suggests that it too will result in a rate that is substantially higher than the national prison suicide rate and only slightly lower than the rate in 2019.

"I attempted suicide at least five times during [a six-month] time period. I didn't want to live. The SHU really brings out the worst in me. I hung myself innumerable times. Each time I hung myself with sheets, someone alerted staff to cut me down. Even while in a preventive suicide unit, I hung myself by a towel. Other times, I swallowed my inhaler, paperclips, and zippers. I have been sent to the mental health crisis observation units numerous times."

—Anonymous, *Solitary at Southport*, Correctional Association of NY

Our data includes the prisons at which persons died by suicide for 74 deaths from January 2015 through April 2020. These deaths were concentrated in maximum-security prisons, with the highest numbers of suicides occurring at: Attica (7); Coxsackie (6); Elmira (9); Great Meadow (7); Green Haven (7); and Wende (6). These six maximum-security prisons accounted for **57%** of all suicides during this 64-month period. The rate at these prisons was **six times** the suicide rate in the other 46 DOCCS prisons and nearly **four times** the national prison suicide rate.



Suicide Rates per 100,000 People in DOCCS and U.S. Prisons, 2000 - 2020

Year	Average Population	Suicides	NY Rate	U.S. Rate
2000	71,172	16	22.5	N/A
2001	69,157	7	10.1	14
2002	67,117	12	17.9	14
2003	66,050	14	21.2	15
2004	64,659	8	12.4	16
2005	63,357	18	28.4	17
2006	63,318	8	12.6	17
2007	63,507	18	28.3	16
2008	61,724	10	16.2	15
2009	59,471	10	16.8	15
2010	57,229	20	34.5	16
2011	55,979	11	19.7	14
2012	54,865	14	25.5	16
2013	54,142	13	24.0	15
2014	53,103	12	22.6	20
2015	52,344	10	19.1	18
2016	51,466	16	31.1	21
2017	50,271	13	25.9	N/A
2018	47,459	13	27.4	N/A
2019	45,663	18	39.4	N/A
4/2020	43,141	5	34.7	N/A

Our analysis focused on comparing persons who died by suicide who were in some form of solitary to those who died by suicide but were not apparently in solitary at the time of their death. During the five-year period January 2015 through December 2019, we were able to determine the names of 69 of the 70 persons who died by suicide. Although we could not definitively determine the status of each person in terms of whether they were in solitary at the time of their death, we were able to identify at least 20 persons who died by suicide in solitary during the five-year period. The remaining 49 deaths we analyzed as if they did not occur in isolation, although we strongly suspect that some may have.

A Latinx man in his fifties died by suicide the day after a disciplinary hearing for allegedly refusing to produce urine for a drug test. He had repeatedly been sent to solitary confinement for allegedly failing to produce urine, which he was unable to do because of medical reasons. According to the SCOC, the individual "had been a long time diabetic who had extensive neuropathy and reported that due to his neuropathy and taking prescription medication, he was unable to produce urine on demand. [His] condition qualified him for placement on the 'Shy Bladder' list." In a letter to OMH found in his cell following his suicide, he said, "I can't take the abuse anymore, the mental anguish of being locked up for urinalysis, while all along my system has been clean…. [Being in] the cold cell … which I'm forced to be in 24 hours a day it's as if I were dead already….

—2016 SCOC Medical Review of a DOCCS suicide in solitary confinement

The data demonstrates that suicides occur in solitary confinement at an unacceptably high rate, much higher than the rate in the rest of the prison population, and that the characteristics of those who died by suicide in solitary were significantly different than those who died by suicide elsewhere in DOCCS.

Using the likely undercount of 20 suicides in solitary in the five-year period, the suicide rate in solitary was **five times** the rate for the rest of the prisons. **It appears that suicides in solitary were the primary reason why NY prisons have a suicide rate substantially higher than the national prison rate for the past five years**. The situation was particularly egregious in 2019. One-third (6) of all the suicides in 2019 occurred in solitary confinement during a year with the highest suicide rate in the last two decades. Moreover, the rate of 2019 suicides in solitary (201 suicides per 100,000 persons) was nearly **ten times** the national prison suicide rate.

We examined the characteristics of those who died by suicide in solitary compared to persons who were not in isolation and found significant differences. Besides being more likely to die by suicide, persons in isolation were younger, were primarily Persons of Color, and had shorter lengths of time in DOCCS and shorter maximum sentences than those who died by suicide who were not in isolation.

The following tables detail the characteristics of the persons who died by suicide in solitary compared to those who appeared not to be in solitary at the time of their death.

COMPARE SUICIDES in ISOLATION to NON-ISOLATION - AGE AT DEATH				
	ISOLATION		NON-ISOLATION	
Age	Number	Percentage	Number	Percentage
20-29	10	50.0%	10	20.4%
30-39	5	25.0%	14	28.6%
40-49	2	10.0%	12	24.5%
50-59	3	15.0%	9	18.4%
60+	0	0.0%	4	8.2%
Total	**20**		**49**	

COMPARE SUICIDES in ISOLATION to NON-ISOLATION - RACE/ETHNICITY				
	ISOLATION		NON-ISOLATION	
Race	Number	Percentage	Number	Percentage
African American	7	35.0%	11	22.4%
Latinx	6	30.0%	12	24.5%
White	7	35.0%	25	51.0%
Other	0	0.0%	1	2.0%
Total	**20**		**49**	

COMPARE SUICIDES in ISOLATION to NON-ISOLATION - TIME IN DOCCS				
	ISOLATION		NON-ISOLATION	
Time in DOCCS	Number	Percentage	Number	Percentage
< 1 year	3	15.0%	21	42.9%
1 Yr and < 3 Yrs	7	35.0%	6	12.2%
3 Yrs and < 5 Yrs	4	20.0%	5	10.2%
5 Yrs and < 8 Yrs	3	15.0%	6	12.2%
8 Yrs and < 15 Yrs	3	15.0%	7	14.3%
15 Yrs and more	0	0.0%	4	8.2%
Total	**20**		**49**	

COMPARE SUICIDES in ISOLATION to NON-ISOLATION - MAX SENTENCE				
	ISOLATION		NON-ISOLATION	
Max Sentence	Number	Percentage	Number	Percentage
1 Yr and < 5 Yrs	3	15.0%	8	16.3%
5 Yrs and < 10 Yrs	4	20.0%	5	10.2%
10 Yrs and < 15 Yrs	3	15.0%	6	12.2%
15 Yrs and < 20 Yrs	3	15.0%	6	12.2%
20 Yrs and < 50 Yrs	3	15.0%	6	12.2%
50 yrs	0	0.0%	1	2.0%
Life	4	20.0%	17	34.7%
Total	**20**		**49**	

This data illustrates several significant differences between the group of persons in solitary who died by suicide as compared to those who were not isolated.

- **Suicides in solitary involved persons much younger than the non-isolation group**. Half (50%) of the persons in isolation who died by suicide were between 20-29, more than double the percentage (20%) of suicide by persons of the same age who were not in isolation. Similarly, those 40 years or older accounted for only 25% of isolation-suicides, in contrast to 51% of non-isolation suicides who were 40 or older.
- **More People of Color died by suicide in solitary than similar persons who died by suicide who were not in isolation**. Sixty-five percent of the isolation-suicide group were Persons of Color, a rate more than a third higher compared to 47% of those who were not in isolation.[10]

[10] The rate of suicide by African American men in the community is significantly less than for White men. According to the latest data from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics, the suicide rate for African American men for 2017 of all ages, age-adjusted, was 11.0/100K compared to 25.1/100K for White men and 11.2/100K for Latino men. See U.S. Depart. Health & Human Serv., CDC, Natl. Center for Health Statistics, *Health, United States, 2018*, Table 9 Death rates for suicide, by sex, race, Hispanic origin, and age, 1950-2017 (2019). White men in the general community are approximately 2.3 times more like to die by suicide then African American or Latino men. Suicides in DOCCS follow this trend, with higher rates of suicide for White incarcerated men than incarcerated men who are People of Color. Overall, 46% of DOCCS suicides involve White incarcerated persons while 52% of suicides by People of Color.

- **A majority of suicides in solitary involved persons who had been in DOCCS for one to five years, an incarceration history that was much less present for those not in isolation.** Fifty-five percent of the suicides in solitary involved persons who had been in DOCCS for one year to less than five years. In contrast, only 22% of the non-isolation group of suicides fall within this period of incarceration. Moreover, 40% of all non-isolation suicides (21 deaths) happen during the first year of incarceration. Of that group, one-third happened in the first six weeks, and 76% were in less than six months from admission, representing 31% of all non-isolation suicides. Only 15% of suicides in solitary involved persons who have been incarcerated for less than one year.

- **Suicides of persons in solitary did not involve as many persons with long prison sentences in comparison to suicides by persons not in solitary.** Thirty-five percent of persons who died by suicides in isolation had sentences of one to 10 years; for those not in isolation, it was 27%. Conversely, 35% of isolation-suicide cases had a maximum sentence of 20 years to life; the comparable number for non-isolation-suicide cases was 49%, including more than one-third who had life sentences

An African American man in his thirties died by suicide in the SHU, even though two months prior to his death, according to the SCOC, he "was seen by DOCCS officers jumping from the sink in his cell head first to the floor…. [The patient] reported that 'he wanted to end it and go home.'… The Medical Review Board finds that RN … failed to notify DOCCS security staff regarding [the patient's] self-injurious behavior and refusal to speak. Based on [the patient's] past suicide attempt, self-injurious behavior, documented increased paranoia, and recent admission to the RCTP, he should have been placed on a one to one constant watch until he was seen and evaluated by OMH….The Medical Review Board has found that there were deficiencies in the mental health care and supervision provided him. Had appropriate safety measures been taken given [the patient's] recent suicidal threats and behavioral changes, his suicide may have been preventable."

— 2018 SCOC Medical Review of a DOCCS suicide in solitary confinement

The vast majority (82%) of persons who died by suicide while they were not in isolation were part of two groups: (1) people who had recently been incarcerated or (2) persons who faced very long sentences of 20 or more years or had been incarcerated for eight or more years. Only 55% of the persons who died by suicide in solitary were included in these categories.

In contrast, nearly two-thirds (65%) of the persons who died by suicide in solitary were in their twenties or had been incarcerated between one and three years. Only 29% of the persons who died by suicide who were not in isolation fell into these categories.

The significant distinctions between persons who died by suicide in solitary and those who were not in isolation, and considering that suicide rates in solitary are five times the rate elsewhere in DOCCS, lead us to conclude that it is likely that many of the deaths by suicide in solitary would not have occurred but for the trauma those persons experienced while in isolation. These suicides were preventable deaths that could have been avoided if long-term isolation had been eliminated.

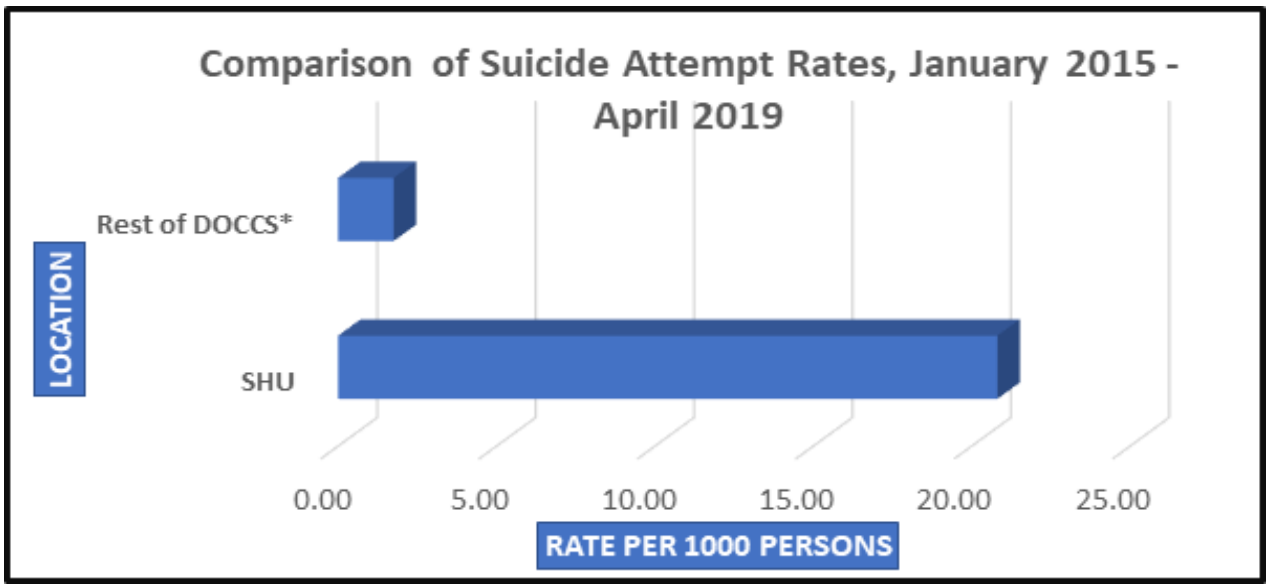
SUICIDE ATTEMPTS

During the 52-month period from January 2015 through April 2019, there were 688 suicide attempts in DOCCS, more than 13 per month, or **one suicide attempt every 2.27 days**. Of these, 295 occurred in a DOCCS Special Housing Unit, representing an astonishing 43% of all suicide attempts. The SHU suicide attempt rate was **12 times** the rate for the rest of the prison system, excluding the punitive residential mental health units discussed below.

"The depression I fight can at times be so oppressive that it takes a conscious effort to breathe, and feels as if my body is covered with the weight of a wet blanket."

— Letter from a DOCCS incarcerated person in solitary, 2019

The percentage of suicide attempts in 2015-16 was slightly higher (45%) than in 2017 through April 2019 (41%); but given the small reduction in the SHU population during the last two years, the rate of such attempts has remained approximately the same throughout the 52-month period.



* Rest of DOCCS includes all incarcerated persons except those in SHUs and RMHTUs.

The number of suicide attempts by people in other forms of punitive separation is also very high. As noted above, our number of SHU suicide attempts does not include those occurring in keeplock. Also, from January 2015 through April 2019, 38 people who attempted suicide were in one of DOCCS' disciplinary residential mental health treatment units. Many of those individuals had spent time in a SHU prior to their admission to an RMHTU, which is also a very restrictive environment where people are locked down between 19-24 hours a day. Given an average total RMHTU population of 198 patients, the suicide attempt rate on those units was more than double that in the SHU and was **26 times** the rate for the rest of the DOCCS population.

Finally, a significant number of people carried out suicide attempts in areas of the prison that likely were not their permanent housing locations. Specifically, 33 suicide attempts that did not involve a patient from a residential mental health treatment unit occurred in an area designated as a mental health location or in a mental health observation cell. Many of the RCTP patients had previously been in solitary confinement, so we would anticipate that several of these suicide attempts may have involved people who were transferred from, or were recently in, solitary confinement.

Similarly, 20 suicide attempts occurred in a location that was designated as an infirmary, hospital, or clinic area in the records, but the people who made these attempts were not housed in a residential medical unit. Again, we believe some of these suicide attempts

may have involved individuals who were transferred to one of these areas directly from solitary or who were recently in solitary confinement.

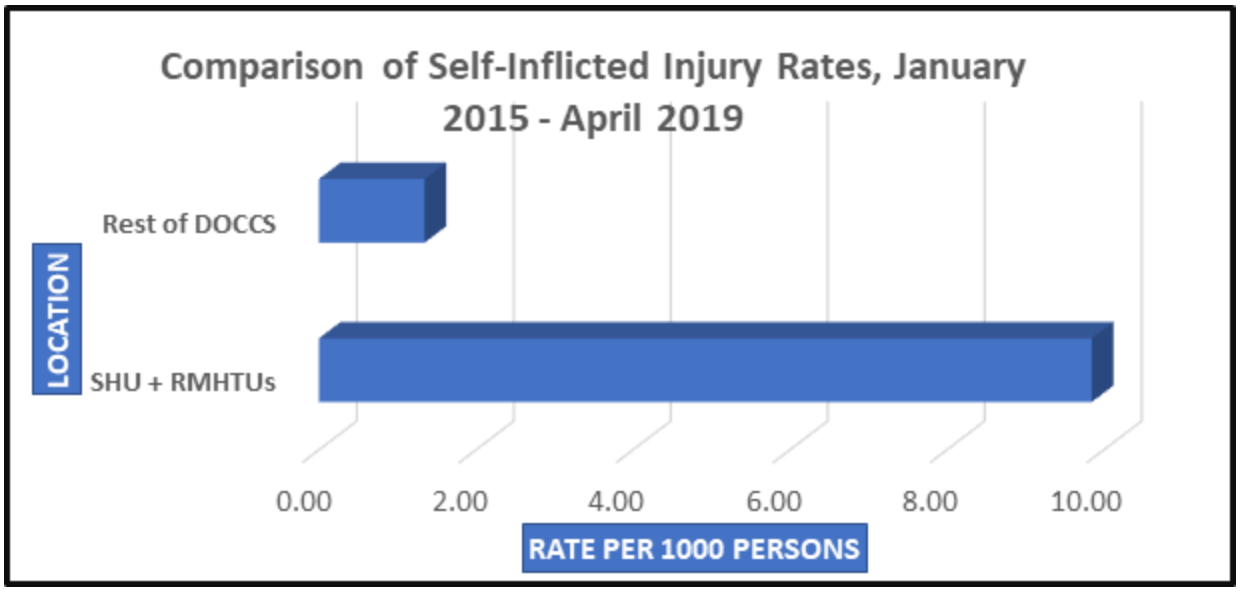
For these reasons, the high rate of suicide attempts in SHU likely do not reflect the full impact of solitary confinement in increasing suicidal behavior among incarcerated people.

"I have attempted self-harm several times during my incarceration, including since I have been at Clinton. I have hung up and I have cut myself. I have harmed myself both when I was in the SHU and when I was in general population…. I spent almost five months in [Clinton's] solitary. The SHU is horrible. It is painful. I was stressing in there. It makes you depressed. I can see that the SHU could lead me down to a point where I might do something I don't want to do…. There have been times I wanted to kill myself. I was so depressed to the point that I didn't want no one to talk to me or call me, including the COs. There were moments when I didn't even know how much longer I could hold on. I tried to calm myself down. As more pressure built up, I felt I could snap at any moment. I tried to tell a mental health staff person, and she didn't want to listen. She just said she can't do anything and I need to keep holding on."

—Anonymous, Voices from Clinton, Correctional Association of NY.

SELF-INFLICTED INJURIES

The UIR category of "self-inflicted injuries" represents acts of self-harm that are less serious in nature than those designated as suicide attempts. There were 420 self-inflicted injuries in DOCCS prisons during the January 2015 through April 2019 period. Unlike the relatively consistent incidence of suicide attempts, self-inflicted injuries have **increased** throughout this period: In 2015 there were 73 incidents; in 2016 there were 78; in 2017 there were 113; in 2018 there were 116; and in the first four months of 2019 alone, there were 41, representing an annualized 2019 rate of 123. These incidents frequently occurred in the Special Housing Units, disciplinary residential mental health treatment units, non-punitive residential mental health Intermediate Care Program units, or temporary medical or mental health units holding patients from other locations in the prisons.



From the housing data, we could identify 86 incidents of self-inflicted injuries in a SHU, representing 20% of all such incidents. The number of such incidents in the SHUs increased substantially from 2015 but somewhat declined following the highest rate in 2017: in 2015 there were 9 incidents; in 2016 there were 23; in 2017 there were 31; in 2018 there were 19; and in the first four months of 2019 there were 4, annualized to 12. As noted above, this data does not include any individuals who were involved in self-harm and were in keeplock during or immediately prior to the incidents.

In addition, we are concerned that persons in solitary who were transferred to a mental health crisis unit may have experienced self-inflicted injuries. We were startled to learn that 49 persons not from a residential mental health treatment unit engaged in self-harm while in a temporary mental health unit or a mental health observation cell. From our experience, those who self-harm in these temporary mental health units often were sent there from solitary confinement. The UIR data also indicates there were 27 incidents of self-inflicted injuries occurring in locations identified in the records as an infirmary, hospital, or clinic area. Again, we believe some of the persons involved in this self-harm were in solitary confinement just prior to their transfer to these medical units.

We were also shocked to learn that there were 62 incidents of self-inflicted injuries in the disciplinary residential mental health treatment units: 41 in the Marcy RMHU; 6 in the Great Meadow BHU; 12 in the Five Points RMHU; and 3 in the Attica RMHU (which was closed in 2017); the disciplinary RMHTU self-inflicted injury data accounted for 15% of all such incidents. With an average of 198 patients in the disciplinary RMHTUs at any time,

62 incidents represents an extremely high rate of self-inflicted injuries for these patients. Similarly, 33 patients in a non-disciplinary residential mental health unit, such as Intermediate Care Programs, were involved in incidents of self-inflicted injuries.

Overall, the amount of self-inflicted injuries in disciplinary units, including SHUs and the disciplinary RMHTUs, is unacceptably high, **more than seven times** greater than the rate occurring in the rest of DOCCS prisons.

CONCLUSION

Data provided by DOCCS and other state agencies clearly shows a high number of suicides, suicide attempts, and other forms of self-harm in New York prisons, and an undeniable nexus between these desperate actions and the use of solitary confinement. Given these facts, it is crucial that the state immediately end the inhumane practice of using isolation as a means to respond to prison rule violations. As the data shows, reforms implemented thus far have failed to stem the tide of suffering and death in our prisons. Only by rejecting solitary confinement, a practice that has been proven both ineffective and inhumane, can New York end the tremendous psychological and physical self-harm that is occurring daily in our prisons and jails.

The Humane Alternatives to Long-Term (HALT) Solitary Confinement Act, A.2500/S.1623, would end solitary confinement beyond 15 days for all people, which is in line with international standards on the prevention of torture; ban any length of time in solitary for young people, people with mental health needs, and other special populations; create more humane and effective alternatives to solitary; and provide greater due process, transparency, and oversight.

With majority support in both houses of the legislature, the HALT Act offers a way to help stop the crisis of suicide and self-injury that pervades our prisons. Every day that goes by without HALT's passage places incarcerated New Yorkers at greater risk of suicide, attempted suicide, and self-harm. How many more people must die before change comes to our prisons? The answer now lies with New York's elected state lawmakers.

Akeem Browder, brother of the late Kalief, speaking at a #HALTsolitary rally with nearly 1,000 people in the NYS Capitol.

Alicia Barraza and Doug Van Zandt, parents of the late Ben Van Zandt, speaking at a press conference outside a replica SHU cell built by Doug and stationed inside the NYS Legislative Office Building.