UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

A.T., a minor, by and through his parent and natural guardian SHA-KEEMA TILLMAN; B.C., a minor, by and through KRISTI COCHARDO; on behalf of themselves and all others similarly situated, Plaintiffs, v. DAVID HARDER, Broome County Sheriff, in his official capacity, et al. Defendants.	:	17-CV-817 (DNH)(DEP)

DECLARATION OF ANDREA WEISMAN, Ph.D

DATED: February 6, 2018
Washington D.C.

I, Andrea Weisman, Ph.D, declare as follows:

INTRODUCTION

1. My name is Andrea Weisman, Ph.D. I have been retained by Plaintiffs' attorneys to provide an expert opinion regarding the psychiatric effects of solitary confinement generally, the particular vulnerabilities of juveniles, the special vulnerability of juveniles with a history of trauma or with pre-existing mental illness, and the application of these issues in the context of the policies and practices at the Broome County Correctional Facility in Dickinson, New York. The jail holds 16 and 17-year old juveniles.

QUALIFICATIONS

2. I am a licensed clinical psychologist in Washington, D.C. My experience as a clinical psychologist spans nearly 30 years. I have extensive experience evaluating juveniles who have been subjected to stringent conditions of confinement, a very large percentage of whom have experienced severe trauma or are diagnosed with mental or intellectual disabilities. I have evaluated several hundred juveniles during my career. This declaration is submitted in support of the motion for a preliminary injunction submitted by the plaintiffs. If called upon to testify I would do so competently as follows.

3. I have worked with juveniles in correctional settings for over 25 years. Most recently I served as the Chief of Health Services for the Department of Youth Rehabilitation Services (DYRS) in Washington. DC. While there I was responsible for the oversight of all medical and behavioral health programs and services for youth detained in or committed to DYRS facilities or in the community. The Agency had been under court order (*Jerry M.*) since 1987, in large part due to the inadequacy of medical and mental health services. During my tenure, both medical and behavioral health services came into

substantial compliance with the consent decree. In addition, I oversaw the development of specialized programs, including programs introducing trauma informed care.

4. From *December, 2004 – April, 2007,* I was Director of the Division of Behavioral Health Services for the Maryland Department of Juvenile Services in Baltimore, Maryland. I was responsible for the development, implementation and oversight of a continuum of behavioral health services (i.e., mental health and substance abuse) for youth in the 15 Department of Juvenile Services (DJS) facilities, both detention and commitment. DJS was under agreements with the U.S. Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA) in three facilities (Baltimore City Juvenile Justice Center, Cheltenham Youth Facility and Charles H. Hickey School). During my tenure, we came into partial or substantial compliance on most CRIPA-related indicators.

5. From *December, 1995 – July, 2000,* I was the Director of Mental Health Services at the Central Detention Facility (DC Jail) during the time it was under Federal Receivership (*Campbell v. McGruder*). Under my leadership the D.C. Jail developed protocols, procedures and policies that conformed with, and in many instances, went beyond the National Commission on Correctional Health Care standards.

6. I have been appointed to serve as the mental health expert for monitors of consent decrees involving reforms in the juvenile justice systems in California, Ohio, Maine and Georgia. In my role in Ohio I aided in the restructuring of the mental health system and revamping of the disciplinary process in the states' three secure juvenile facilities. Ohio's use of isolation and programmatic restraint was a central part of the litigation. *See S.H. v Reed* 2:04-cv-1206 (S.D. Ohio). In Georgia I assisted the Department of Justice in monitoring a memorandum of understanding they reached with the State. My focus was

on the conditions of confinement juveniles were subjected to and the adequacy of mental health services provided to the juveniles.

7. I have written and spoken extensively on the issues of isolation and mental health services for juveniles involved with the justice system. In 2007 I testified before Congress on mental health issues among youth in the juvenile justice system.

8. I obtained my Doctor of Philosophy (Ph.D), in clinical psychology from Clark University in 1988. I am a licensed clinical psychologist in Washington D.C.

9. I have included a copy of my curriculum vita as Exhibit A.

INVOLVEMENT IN THIS CASE

10. In this present case, I was retained by Legal Services of Central New York to perform professional services as an expert in connection with litigation challenging the use of solitary confinement on juveniles (16-and-17-year-olds) at the Broome County Correction Facility ("the Jail")

11. For the purpose of preparing this declaration I reviewed a number of documents regarding the Jail's policies, declarations of juveniles, data on the use of solitary confinement, disciplinary records of juveniles, and medical records of juveniles. The documents I reviewed are attached as Exhibit B.

12. I also visited the Jail; while there I toured the medical unit, the Segregation Housing Unit or SHU (D-Pod), and the juvenile pod (F-pod). I interviewed the medical administrator and two social workers at the facility. During the tour I also had the opportunity to ask questions of Defendant Mark Smolinsky the jail administrator. Prior to the tour I interviewed two of the five juveniles that were held at the facility at that time.

13. In forming my opinions below, I relied on my review of documents, observations of the facility, interviews of the medical and mental staff, and discussions with the juveniles. I also relied on my academic and clinical experience, as well as the extensive body of literature regarding the psychiatric effects of solitary confinement, cognitive and behavioral development in adolescents, and juveniles in correctional settings including those referenced throughout this declaration.

14. I am being compensated at the rate of $187.50 per hour or $1,500 per day to prepare this declaration. My compensation is not dependent on my opinions or the outcome of this matter.

15. For purposes of rendering my opinions, I was asked to assume that the youths' Declarations and first-hand reports were accurate

OPINIONS AND BASES OF OPINIONS

I. Conditions of Solitary Confinement at the Broome County Correctional Facility are Excessively Harsh and Punitive

16. Based on my review of the allegations in the Complaint, the declarations of multiple juveniles, the Sheriff's Office's written policies and other documents, it is my opinion the policies and practices guiding the placement of youth in solitary confinement are extraordinarily harsh and are extremely damaging to youth so confined. The Sheriff's Office's adherence to these policies place all juveniles who are, or will be, incarcerated at the Jail at substantial risk of serious harm.

17. It is the policy and practice of the Jail to punish inmates, whether they are adults or juveniles or whether they have a serious mental illness or not, with solitary confinement, which the Jail calls "keep-lock", for any violation of the rules. My review of the records indicates that "keep-lock" is given for such minor violations as going to the bathroom

during count, throwing toilet paper out of their cell, horseplay or having extra cleaning supplies. When youth are either on keep-lock on F-Pod or in the SHU they are placed in a cell measuring about 70-80 square feet – with a solid steel hinged door that has a small window facing onto the tier and a food slot, also used for handcuffing the juvenile before allowing the door to be opened.

18. As further stated in the complaint and declarations, the cells in the SHU and F-pod are almost entirely barren with usually nothing but a mattress on the floor or placed on a concrete or stainless steel platform. There is a stainless steel sink and toilet combination. There are no other furnishings – no desk or table, no chair, no mirror, and there is virtually nothing with which the juvenile can meaningfully occupy himself.

19. During their time on the SHU, juveniles are given a bible, and minimal hygiene supplies and personal items.

20. Juveniles in the SHU are afforded no meaningful access to writing implements or art supplies or paper, no meaningful educational material, no radio or television, minimal amounts of personal possessions, and no opportunity for social interaction. On keep-lock on F-pod juveniles are allowed access to their personal items however it was reported that due to the shortage of books available to them, many juveniles on keep-lock re-read the same book over and over again.

21. Juveniles in keep-lock on F-pod or the SHU are confined in their cells for 23 or more hours a day. They are denied all access to education and programming. They eat alone in their cells.

22. On most days, youth are allowed out of their cells for one hour of recreation. Recreation in both the SHU and F-Pod is in a small area with cement walls and a mesh-like covering

over the large cement walls. These areas are barren with only the F-pod yard having a basketball hoop (with no net) – and juveniles report often there is no basketball for them to use. On keep-lock in F-Pod juveniles at least have access to the general indoor living area however juveniles report they are sometimes denied this one hour outside their cell, or it is cut short so they do not have an opportunity to benefit from it.

23. Routinely, during at least the first week that youth are held in the SHU, they are heavily shackled with their hands cuffed, attached to a waistband and their ankles cuffed. This time can be extended to two weeks or longer in the discretion of the corrections officers. Shackled in this fashion, youth are not able to do any large muscle exercise at all.

24. Both in the SHU and on F-Pod juveniles are housed within sight and sound of adults. Juveniles report regularly being physically, verbally or sexually harassed by adults.

25. Although even one day of solitary has the potential to cause harm to a juvenile, the length of SHU sentences and aggregate time juveniles spend in isolation show a total disregard for the harm. A review of the records show B.C. spent at least 247 days in solitary confinement, A.T. spent over 200 days in solitary, still other juveniles have spent weeks and months.

26. The conditions of solitary confinement at the Broome County Jail are some of the most severe and restrictive I have ever encountered in my over 30 years of professional experiences. These deprivations of human contact and environmental stimuli would be substantial for anyone, but for juveniles they are devastating.

27. Even at the Federal Bureau of Prisons' ADX Florence facility, one of the most secure super max facilities in the country, inmates have access to writing materials, art supplies,

educational materials, closed circuit TVs providing access to programming, personal items and both individual and group mental health treatment.

II. THE SHERIFF'S OFFICE'S USE OF SOLITARY CONFINEMENT PUTS JUVENILES AT SUBSTANTIAL RISK OF SERIOUS HARM

28. It is my opinion, within a reasonable degree of certainty in the field of clinical psychology, that all juveniles subjected to the Jail's policy and practice of solitary confinement as described above are at a substantial risk of serious harm to their social, psychological, and emotional development.

A. Juveniles in Detention Are as a Group More Vulnerable to the Risk of Serious Harm From Solitary Confinement

29. Solitary confinement can be dangerous for anyone. Severely limiting an individual's environmental and social stimulation has a profoundly deleterious effect on mental functioning.

30. Research over the last half-century has demonstrated that it can worsen mental illness and produce symptoms even in prisoners who start out psychologically robust. Individuals who are deprived of meaningful external stimuli are soon unable to maintain an adequate state of alertness and attention to the environment. Even a short time in solitary confinement will predictably shift the electroencephalogram (EEG) pattern towards an abnormal pattern characteristic of stupor or delirium.[1]

31. Due to their developmental vulnerability, solitary confinement causes juveniles much greater harm than does such confinement of adults. The risks of solitary confinement to juveniles are alarming.

[1] These harms are discussed in further detail in Psychiatric Effects of Solitary Confinement, 22 Wash. U. Journal of Law & Policy 325 (2006) an article written by Stuart Grassian, M.D. one of the leading experts on the harmful effects of solitary confinement.

32. Because juveniles are still developing socially and psychologically, and emotionally, they are especially susceptible to psychological, and neurological harms when they are deprived of environmental and social stimulation. For a juvenile, simply being placed in isolation – the utter helplessness of it – is enormously stressful. This surge of cortisol – of fear, anxiety, and agitation – will be especially severe in juveniles.

33. Our knowledge of the harms caused to juveniles in solitary confinement is based on extrapolation from the clinical interviews of adults and the expanding knowledge of adolescent development. It is widely accepted that in the adolescent brain, the connections between the frontal lobe and the mid-brain are still developing.[2] The frontal lobe sits just behind the forehead. As it develops, teenagers can reason better, develop more control over impulses and make better judgments. [3] This part of the brain continues to develop until an individual's mid-twenties.

34. Because of their still developing brain, compared to adults, juveniles are less able to control impulses and exercise self-control; less able to consider alternative courses of action and avoid risky behaviors; less oriented towards the future and therefore less attentive to the consequences of their often impulsive actions. Juveniles also are more vulnerable and susceptible to negative influences and outside pressures, and juveniles lack the freedom and autonomy that adults possess to escape such pressure. Juveniles are ruled by emotions. They are less capable of mature judgments and decision making. [4]

---

[2] See, e.g.: Casey, B.J., Jones, R.M., and Hare, T.A., (2008) The Adolescent Brain, Ann. N.Y. Acad. Sci. 1124: 111-126; Ernst, M., Mueller, S.C. (2008) The adolescent brain: Insight from functional neuroimaging research. Dev. Neurobiology 68(6) 729-743.

[3]Noted developmental psychologist Lawrence Steinberg, details adolescents' growing capacity for executive functioning as their brains mature. Age of Opportunity: Lessons from the New Science of Adolescents. Houghton, Miffin, Harcourt, 2014).

[4] *See*, e.g.: Plessow, F. et.al. (2012) The stressed prefrontal cortex and goal-directed behavior;

35. Juveniles experience time differently-a day for a child feels longer than a day to an adult.[5] In addition, juveniles have a greater need for social stimulation.

36. Exposure to chronic, prolonged traumatic or stressful experiences, such as solitary confinement, has the potential to permanently alter an adolescent's brain which may cause longer-term problems in the following domains:

    a. **Attachment:** Trouble with relationships, boundaries, empathy, and social isolation;

    b. **Emotional (Dis)Regulation:** Difficulty identifying or labeling feelings and communicating needs;

    c. **Cognitive Ability:** Problems with focus, learning, processing new information, language development, planning and orientation to time and space;

    d. **Behavioral Control:** Difficulty controlling impulses, oppositional behavior, aggression, disrupted sleep and eating patterns, trauma re-enactment[6]

37. Across all developmental spheres, children are different from adults, making their time spent in isolation even more difficult and the developmental, psychological, and physical damage more comprehensive and lasting. [7] The consequences, including actual changes in brain structure, have been demonstrated to persist into adulthood.[8]

---

acute psychosocial stress impairs the flexible implementation of task goals. Exp Brain Res 216:397-408.

[5] Age effects in perception of time. Psychol Rep. 2005 Dec;97(3):921-35.Wittmann M, Lehnhoff S.

[6] How Trauma Affects Child Brain Development – N.C. Division of Social Services. Vol. 17, No.2, 2012; See, e.g.: Tottenham, N., Galvan, A. (2016) Stress and the adolescent brain. Amygdala prefrontal cortex circuitry and ventral striatum as developmental targets. Neuroscience and Bio-behavioral Reviews 70:217-227.

[7] See, e.g. Bremner,J. (2006) Traumatic Stress: effects on the brain. Dialogues in Clinical Neuroscience; Vol. 8, No. 4, 445-461

[8] Tottenham, N, Galvan, A. (2016). Stress and the adolescent brain; Amygdala-prefrontal cortex circuitry and ventral striatum as developmental targets. Neuroscience and Behavioral Reviews, 70, 217-227.

38. The American Academy of Child and Adolescent Psychiatry,[9] the American Medical Association,[10] the World Health Organization and the United Nations[11] have all concluded that, due to their developmental vulnerability, adolescents are in particular danger of adverse reactions to prolonged stays in isolation.

39. The National Commission on Correctional Health Care,[12] which accredits the Jail, has taken the position that juveniles should be excluded from solitary confinement.

B. Juveniles with Intellectual and Mental Health Disabilities are Particularly Vulnerable to the Effects of Solitary Confinement

40. Juveniles in jails are also vulnerable to a substantial risk of serious harm from solitary confinement because they are more likely than the general population to have diagnosed mental illnesses, learning disabilities, and a high incidence of trauma. Research shows that over 60% of the youth in correctional settings have an underlying major mental illness. These include posttraumatic stress disorder, Attention Deficit Hyperactivity Disorder, and various forms of Bi-Polar mood disorders. Youth in solitary confinement have an even higher incidence of mental disorders than those in general population. [13]

---

[9] *See* American Academy of Child and Adolescent Psychiatry Juvenile Justice Reform Committee report titled *Solitary Confinement of Juvenile Offenders* (April 2012), http://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx.

[10] *See* AMA Adopts New Policies to Improve Health of Nation at Interim Meeting (Nov. 11, 2014), http://www.pressreleasepoint.com/ama-adopts-new-policies-improve-health-nation-interim-meeting

[11] *See* General Comment No. 10 titled Children's Rights in Juvenile Justice (2007), http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.10.pdf.

[12] *See* National Commission on Correctional Health Care report titled Solitary Confinement (Isolation)(April 2016) http://www.ncchc.org/solitary-confinement.

[13] James, D.J. and Glaze, L.E., Mental Health Problems of Jail and Prison Inmates, Bureau of Justice Statistics, Special Report, 2/06).

41. Documentation and first-person reports indicate that the incidence of mental illness at the Jail is consistent with the national estimates. Of the seven youth being considered in this declaration, five had one or more mental health diagnoses, with three youth diagnosed with Bipolar Disorder and almost all diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or learning difficulties.

42. The incidence of trauma among incarcerated youth is also significant, with some studies reporting the number to be as high as 50 – 90%.[14] Again, documentation and first-person reports from the Jail indicate that the incidence of trauma among youth incarcerated there are consistent with those studies. One youth spoke of being sexually molested when he was six years old. Another reported being beaten by his father.

43. There is a clear medical consensus that for those juveniles with mental illness, the risk of harm is especially great. People with mental illnesses already have cognitive defects in their brain structure or biochemistry. They already have weakened defense mechanisms, are at a higher risk for mental health abnormality and are more susceptible to significant trauma from lack of environmental and social stimuli. Therefore, the trauma that can occur in juveniles with pre-existing mental illnesses will be more significant than the already significant and long lasting effects on juveniles without a mental health condition.

44. Medical professionals, including organizations like the American Medical Association, agree that juveniles with mental illnesses should not be placed in solitary confinement for longer than one hour without a comprehensive evaluation from a physician. Solitary confinement should never be used to punish people will mental illnesses.

[14] Ford, J., et.al, Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions, National Center for Mental Health and Juvenile Justice, 2007.

45. Striking to me is the Jail's own policies state juveniles may be placed in solitary confinement for "exhibiting unusual behavior." In my opinion, this is simply another way of saying they will place individuals with mental illnesses in solitary confinement when they exhibit behaviors consistent with their disabilities.

46. Youth exposed to traumatic or stressful events exhibit a wide range of symptoms. They present with not just internalizing problems, such as depression or anxiety, but also externalizing problems like aggression, conduct problems, and oppositional or defiant behavior. These are the very behaviors that result in institutional infractions that lead to placements in solitary confinement. This in turn causes more trauma, and can lead to more negative behavior, resulting in infractions, prolonging a youth's time spent in solitary. Both A.T. and B.C. spent months in solitary confinement due to this cycle of trauma and behavior infractions. A.T. reported that he felt that once he was placed in solitary "it was impossible to ever get out."

47. Based on my review of the available records it is my opinion that many if not most, of the juveniles' infractions are attributable to: 1) their maturation process and, 2) their (under treated) mental health disorders and trauma experiences. Unsurprisingly, youth with ADHD, for example, can be *expected* to behave impulsively and to exhibit hyperactivity.

48. For example, A.T. a juvenile with ADHD and Bi-Polar disorder, was placed in solitary for getting into an argument with a corrections officer over wanting to eat outside his cell. This impulsive behavior is consistent with the behaviors of someone with ADHD. He was given 15 days for that behavior. While in solitary for that infraction A.T. was again punished, this time for writing on his sweatshirt. It should come as no surprise that a juvenile with ADHD like A.T. would look for ways to deal with his hyperactivity when

denied meaningful social and environmental stimuli in solitary confinement. Further review of the records shows juveniles have been disciplined for "horse play" behaviors which any developing adolescent would exhibit.

C. The Sheriff's Office is no Assessing or Addressing the Serious Harm or Substantial Risk of Serious Harm Correlated to the Use of Solitary Confinement

49. The Jail contracts for medical and mental health services from Correctional Medical Care, Inc. There are two Masters level social workers providing mental health care for the over 400 inmates at the jail. These social workers work 40 hours a week Monday-Friday and are on call over the weekends. A psychiatrist works at the facility for only 12 hours per week and is on call as needed. There is also one drug and alcohol counselor on staff.

50. During a group meeting with all medical and mental health providers during our site visit, we asked the social workers what they thought the level of mental health acuity was among the inmate population. One social worker stated that he did not think many inmates in the jail had mental health disorders. This was a surprising response given the voluminous data on the incidence of mental illness among incarcerated individuals noted above. The discrepancy between the social workers' perception of mental illness among the population and the reality is striking.

51. The social workers went on to inform me that they have no input on the placement of a juvenile in solitary confinement, even when that juvenile is already on their caseload, and therefore recognized as having a mental health or intellectual disability. In over 30 years of experience, I have never seen a facility where there are not formal or informal processes for mental health providers to have input into the disciplinary hearing process, so as to be able to inform the relevant actors of the particular vulnerabilities of youth, including youth with mental health or intellectual disabilities. This is most typically done

so that alternative sanctions to placement in solitary can be entertained. The only "input" the social workers seem to have is recommending the juvenile be moved to suicide watch. Once the suicide watch is over the juvenile is immediately placed back in solitary confinement.

52. One social worker went on to opine that he thought placing a juvenile in solitary following an infraction was actually helpful to them as it gave them time to think about what they had done and to "chill out." This ignorant observation runs against the mountain of evidence to the contrary. This comment, when combined with the social workers' earlier stated belief that few of the jail inmates suffered from genuine mental health disorders, raises serious concerns about their level of clinical sophistication, and thus adequacy of services provided to juveniles.

53. Mental health staff does not make rounds in the SHU or to juveniles in keep-lock on F-pod. The medical administrator of the facility explained to me that medical (nursing) staff do "rounds," which consist solely of briefly looking at everyone in their cells. The medical records reveal these "rounds" are performed erratically. This is consistent with reports from juveniles in which they state they only see medical staff when they are on the pod passing out medications. These "rounds" are wholly inadequate for assessing mental health concerns or risks.

54. In my review of the medical records I saw no evidence the jail staff provided meaningful treatment services to juveniles in disciplinary isolation, or even to juveniles under suicide watch. There is no evidence juveniles in solitary confinement are given therapeutic services or meaningful counseling services.

55. Based on my conversations with juveniles and review of medical records it appears that no juveniles in solitary confinement receive any meaningful therapeutic services. There was no evidence of group therapy or one-on-one counseling. There was no evidence of meaningful counseling. There are no individualized treatment plans to get the youth to a place where he or she is safe to return to general population. Based on the records, no immediate psychiatric interventions taking place when a juvenile expresses suicidal ideations. There is no clinical assessment into the cause of the ideations. There are no indications of any step-down or aftercare to get a juvenile to a place where they are safe to return to the juvenile pod. In my opinion, all of these are necessary components of treating and evaluating youth who express suicidal ideations.
56. The course of treatment seems to be waiting until a juvenile says they do not want to hurt themselves and then telling them they can self-refer to see mental health staff in the future. The juvenile is then returned to his placement in solitary confinement. The juveniles I interviewed (D.K. and L.M.) both stated they were brought from suicide watch directly to solitary confinement and the records of B.C. reflect he was on at least two occasions.
57. The Sheriff's Office's system of inadequate care, in which youth are placed in isolation, causing trauma and suicidal ideation, then stripped naked and placed in another kind of isolation on suicide watch, puts youth at a higher risk of experiencing harm, including morbidity and mortality.
58. A review of the medical records of A.T. and B.C. show the Sheriff's Office was aware of and ignored the deleterious effect solitary confinement was having on them. A.T.'s records reflect he suffered from insomnia. When he did fall asleep he was having

nightmares and severe anxiety and depression. B.C.'s records show not only depression and severe anxiety, but self-harming behavior and speaking to himself at night. Any competent clinician would have recognized these symptoms as correlated to their placement in solitary confinement. There is no indication anywhere in the records that their placement in the SHU was ever even considered, except to note when A.T. and B.C. mentioned the SHU as part of their problem.

59. In my opinion the inadequate mental health staffing levels is a major contributing factor to the poor quality of mental health care provided to juveniles held in the Jail. While national standards do not speak to essential staffing levels for mental health providers, there are some guiding principles in terms of what services and supports should be made available to prisoners. As a general matter, they are entitled to adequate medical and mental health care, to protection from harm including staff abuse, and to a facility in which the vulnerable can be protected: a safe, sanitary and humane environment. In order to provide this environment, certain measures should be implemented:

    a. All detainees should be screened upon admission by trained personnel for mental health and substance abuse problems. When the screening detects possible mental health or substance use conditions, detainees should be referred for further evaluation, assessment and treatment by mental health professionals.

    b. Treatment should be provided in an atmosphere of empathy and respect for the dignity of the person. It should be strength-based and recovery-oriented. A reasonable array of mental health interventions should be available.

60. By any measure, the number of mental health providers deployed to the Jail by Correctional Medical Care, Inc. is insufficient to meet these basic mental health needs of

any of the over 400 inmates incarcerated at the facility, let alone the juveniles who as described above are more vulnerable than the general population.

D. The Proposed State Commission on Corrections Regulations Will Not Adequately Address the Harms Faced by Juveniles at the Jail

61. As a part of this analysis I was asked to opine on proposed regulations from New York State's Commission on Corrections, which may go into effect sometime in the future. It is worth noting that these new requirements have not yet gone into effect and it is unclear what the timeline is for their implementation. These new regulations do not change the opinions I have offered above.

62. Under the new regulations juveniles would be entitled to one additional hour of recreation. Although certainly better than receiving one hour, confining a juvenile for 22 hours a day still places them at risk for the substantial harms outlined above. Juveniles in the SHU they would be given an extra hour in the desolate recreation yard, with no meaningful access to environmental or social stimuli.

63. Under the new regulations juveniles can still be placed in mechanical restraints during their recreation time. Based on my experience juveniles in this situation would likely turn down recreation rather than spend two hours in an empty yard shackled by the wrist, waist and ankles.

64. Juveniles under the new regulations may be entitled to another discretionary four hours of out of cell time a day, unless the Jail determines the inmate is a "threat to the safety, security, or good running order of the facility or the safety, security, or health of the inmate, staff or other inmates." It is apparent from the records that whenever a juvenile commits an infraction the Jail deems them a threat to the safety and security of the facility. For example, B.C. was considered a "danger to the safety or welfare of other

persons in the facility, or to its orderly or secure operations" when he ripped two of the Jail's towels. A.T. was considered a danger because he refused to stand up for count when he was in his cell and another time because he was talking out of his cell. C.J. was also considered a threat to the safety of the facility when he failed to stand for count because he was going to the bathroom. Therefore, it is my opinion juveniles would rarely, if ever, be able to take advantage of this discretionary four hours. It is likely that the Sheriff's Office will deem any and all inmates held in the SHU "threats" under the regulations.

65. However, even if juveniles were afforded the maximum time allowed out under the proposed regulations they would still be confined to their cells for 18 hours a day. Although certainly better than 22 or 23 hours a day, confinement for 18 hours still places juveniles at a substantial risk of harm, especially when those 6 hours out of their cell is not accompanied by meaningful social and environmental stimuli. The regulations contain no requirement juveniles be afforded such stimuli.

66. Finally, the regulations do not in any way account for the special needs of juveniles with mental health or intellectual disabilities. As discussed in detail above this population is particularly vulnerable to the harms of solitary confinement and an assessment with the input of mental health staff must be completed anytime such an individual is at risk of losing access to the Jail's benefits, services, and programs because of their disability.

67. As discussed below juveniles should be held in isolation only when less restrictive measures were first tried and failed, and then only until they are no longer an immediate threat to the safety of the facility, themselves or others. In the rare circumstances isolation is necessary the Jail should immediately be evaluated by mental health workers

and provided meaningful mental health services including counseling until they are stable enough to return to general population. These regulations, if implemented, would not adequately address the substantial risk of serious harm faced by juveniles held at the Jail.

E. Other Punitive Tactics Employed by the Broome County Correctional Facility Further Compound the Toxic Effects of Placement in the Facility

68. In my opinion there are conditions at the Jail which compound the harm and risk of harm to juveniles in solitary confinement including: abuse by corrections officers and adults, improper use of chemical and mechanical restraints, and unhygienic living conditions. Each of these conditions can worsen anxiety, stress, depressive symptoms, and suicidal ideation of juveniles and potentially present them with other forms of psychiatric harm like post-traumatic stress disorder.

69. The level of physical abuse by the Corrections Officers as described by the Complaint and all Declarations seems pervasive and is totally unacceptable. The level of fear and anxiety this engenders sets up what can only be described as a hostile environment. Arguably, these practices work to produce the very responses from youth that they are then punished for.

70. All the juveniles spoke of the harsh and abusive practices the Correctional Officers (COs) with many identifying in exquisite detail the beatings they endured at the hands of the COs'. One youth spoke of the CO taking his clothing and flushing it in the toilet. Another youth spoke of an incident in which he was restrained in a restraint chair and then pepper sprayed while he was restrained. Still another youth spoke of the COs carrying batons they used to beat the kids; they reported that the COs refer to the baton as their "nigga beaters."

71. They also spoke of being harassed by the adults while in the SHU. They report that the adults threaten them that frequently results in fights, which the COs do nothing to interrupt. Many youths talked about forgoing their recreation time so as to avoid these confrontations.

72. As discussed above, juveniles can be further punished while in the SHU by being placed in shackles for their only hour of recreation. In my opinion this practice is punitive and is not rationally related to the safety or security of the facility. Restraints on a juvenile should only be used in situations where all less restrictive options have been explored and then only for short periods of time and with consultation with mental health workers. Here, continuing use of these restraints for weeks at a time only adds to the trauma the youth is already experiencing while in solitary confinement.

73. The use of pepper spray on a juvenile who was in a restraint chair is perhaps most problematic. Pepper spray or oleoresin capsicum, is a form of chemical restraint, generally containing irritants extracted from the resin of hot peppers. It causes intense pain, coughing and eye and skin irritation for those upon whom it is administered. When it is inhaled, pepper spray inflames the respiratory tract and temporarily restricts breathing to shallow breaths. It should rarely be used at all against a juvenile and never when that juvenile is already subject to other restraints such as hand cuffs or the restraint chair.

74. Both of the juveniles with whom we spoke reported that bugs and larva regularly come out of their sink drains and showers. Such horrendous unhygienic conditions only serve to compound the already traumatic experience these juveniles endure.

75. Juveniles' complaints about these traumatic conditions fall on deaf ears. All the youth with whom we spoke and those that filed declarations reported that there was no real grievance process. Youth have to ask corrections officers for grievance forms, and on the rare occasion they actually receive a grievance form, youth report there is no action by the grievance officer. Either the grievance is not responded to or the youth are told that their grievances have no merit.

76. The lack of a meaningful grievance system is troubling and not in conformance with industry standards. The American Correctional Association (ACA) notes that there must be a viable grievance process available to all inmates and that includes at least one level of appeal. [15]

III. THE SHERIFF'S OFFICES USE OF SOLTIARY CONFINEMENT IS COUNTERPRODUCTIVE TO SAFETY

77. Based on my experience, placing youth in solitary confinement as a result of infractions places them at a risk of serious harm but does nothing to contribute to the safety and security of the environment given their greater likelihood of acting out again. The use of solitary confinement does nothing to rehabilitate misbehaving youths or deter bad behavior or encourage better behavior. Removing a person from meaningful contact with others does not help juveniles understand why what they did was wrong, or help them apply those principles to their future behavior. The conditions of isolation do not encourage the juveniles to reflect on their behavior and change it in the future.

78. For over 70 years, behavioral psychological research has demonstrated that rewarding desired behavior is much more effective than punishing undesirable behavior. With this

[15] American Correctional Association (ACA) Standards for Adult Correctional Institutions (4th edition) at 4-4284.

alternative paradigm, youth learn what to do, not just what not to do. As such, rewarded behaviors have much greater likelihood of being repeated as opposed to behaviors which are not reinforced, which have a tendency to extinguish. [16]

79. Placing youths in disciplinary isolation increases assaultive behavior in the facility.[17] Youths held in disciplinary isolation for extended time periods have been observed to be very assaultive with other inmates when they are returned to regular living units.[18] One study of Texas juvenile corrections facilities found that referring juveniles to disciplinary isolation in response to misconduct correlated with an increase in misconduct.[19]

80. Based on my experiences and the emerging professional consensus in this area, it is my opinion that the Sheriff's Office use of solitary confinement is an ineffective disciplinary technique for restoring discipline and security at the facility and is actually counterproductive to facility discipline and safety.

81. Research has shown that effective behavior management programs in juvenile justice systems are based on providing incentives for youths' production of desired behavior. Typically, the youth participate in identifying what rewards would be meaningful (e.g. food, movies, extra phone call, later bed time, etc.) While the rewards jump-start the change process, as youths' behavior changes, so too does the reaction of others engaging with the youth. Over time, an improved interaction with others becomes its own reward.

---

[16] Steinberg, L. (2009) Adolescent Development and Juvenile Justice. Ann. Rev. Clin. Psychol. 5: 459-485.

[17] Michele Deitch et al., From Time Out to Hard Time: Young Children in the Adult Criminal Justice System (Univ. of Tex. At Austin 2009).

[18] *Id.*

[19] Michele Deitch, Desktop Guide to Quality Practice for Working with Youth in Confinement, National Institute of Corrections, Establishing a Therapeutic Culture that Supports Behavior Management: Setting Behavioral Expectations for Youth and Staff, (2016), http://www.desktopguide.info/?q=node/21.

Through this process, youth come to incorporate the behavioral changes into their repertoire. Encouraging the development of more acceptable behaviors while detained, has the greatest likelihood of generalization in the community. It is well understood that positive reinforcement and encouragement can produce more durable behavior management than harsh penalties.[20]

82. A graduated system of sanctions for misbehavior requires correctional officers to manage juveniles by using an appropriate level of sanction that is responsive to the severity of misconduct. The sanction used must be tailored to the misconduct so that the sanction provides an opportunity for the youth to reflect on their behavior. The goal of discipline should not be punitive, and instead must be geared towards changing the youth's behavior in the future. The sanction must be applied immediately after the misconduct to be effective, because juveniles respond best to immediacy. The more time that passes between the misbehavior and the sanction, the less the juvenile will be able to connect the two and learn from the experience.

83. Under a graduated system of sanctions, minor violations of facility rules by juveniles are managed through lower-level sanctions like verbal counseling, participation in mediation, apology letters, temporary loss of privileges (such as commissary, telephone, or TV privileges) and ratcheting back of the rewards earned for good behavior. Counseling is not just ordering the youths to stop the misbehavior; it should include a conversation with the youths as to why certain behavior is not desirable or productive and whether there are other options for behavior.

[20] Leah E. Johnson et al.,Youth Outcomes Following Implementation of Universal SW-PBIS Strategies in a Texas Secure Juvenile Facility, 36.3 Education & Treatment of Children 135-145 (2013).

84. More serious violations are managed through temporary isolation or "separation" from the general population to give the juvenile time to "cool down" and the facility a tool to protect life and safety. Separation does not necessarily have to involve locking a youth into a room. For instance, a youth can be separated from the general population and told to walk around in a separate area such as a library or another recreation area. Importantly, this separation should not entail the denial of basic education, recreation, and other services. The youths should be in virtually constant interaction with staff, and mental health professionals must be utilized to assess the psychological status of the young person. Isolation should not be utilized for administrative convenience. All medical isolation must be approved and supervised by health care professionals. In rare cases of serious and repeat violations, some juveniles may require mental health interventions in longer-time isolation away from general population, but such isolation should entail access to regular programming, extensive human contact, and intensive mental health services.

85. In addition to these components of a behavior management system endorsed by a consensus of professionals, experts in the field agree on the importance of preventing misbehavior in juveniles through effective staff training, appropriate staffing levels, environmental factors, the use of small groups within the units, appropriate classification, gang management, highly structured daily schedules with programming, and youth empowerment.[21] Even experts in adult corrections who do not have to take into account the special characteristics of juveniles in crafting disciplinary measures agree that factors like a proper behavior management system, appropriate staffing levels, appropriate

[21] Paul Demuro, Towards Abolishing the Use of Disciplinary Isolation in Juvenile Institutions: Some Initial Ideas (Revised) (2014); *see also* Deitch (2016) *supra*.

classification, and programming that keeps inmates productively occupied are critical to maintaining safety and security in a jail setting (National Institute of Corrections, 2009).

86. After implementing the principles described above, the Ohio the Department of Youth Services saw a 22% decrease in the rate of violent acts in its facilities over a one-year period (comparing January-November 2014 to January-November 2015). Ohio leadership introduced number of initiatives that led to this outcome. They "softened" facilities by having youth paint murals in the hallways. They also allowed youth to pick colors and re-paint their rooms. And perhaps most importantly, they introduced more programming so youth were busy all of their awake time. Juvenile facilities in California, Illinois and Mississippi have found similar results when implementing behavior modification plans.

IV. CONCLUSIONS AND RECOMMENDATIONS

87. Juveniles should only be locked in their cell only for disciplinary purposes where they pose an immediate threat to the safety or security of the facility and only after less restrictive measures were employed and found not adequate to address the threat.

88. Juveniles should only be locked in their cell until they regain self-control and then be let out to resume programming with the general population. This is the standard guiding the disciplinary practices in juvenile facilities as outlined in the Juvenile Detention Alternative standards.

89. If a Juvenile with a mental health or intellectual disability becomes involved in a disciplinary process, and will potentially lose access to the benefits, services and programs offered at the Jail as a result of the behavior, mental health staff shall be contacted immediately to perform an individualized assessment of that juvenile and the underlying behavior. The assessment should include at minimum:

a. A review of the juveniles' underlying mental health diagnosis and treatment provided to him or her both in the community and at the Jail;

b. Whether reasonable modifications to existing Jail policies can address and eliminate any future risk;

c. Whether the juvenile currently poses a risk to himself or others in the facility; and

d. The proper placement within the facility taking into account their unique individual needs.

90. Upon their placement in isolation all juveniles should be evaluated by mental health staff. Staff should employ counseling and de-escalation techniques with the juvenile on each interaction. Reviews by mental health staff should be performed every hour until a juvenile is sufficiently calm to return to general housing. If a juvenile continues be an immediate risk to the safety or security of the facility after 4 hours a psychiatrist/psychologist should be consulted. No juvenile should locked in their cell for more than 4 hours.

91. Mechanical restraints should under no circumstances be used on juveniles during their recreation time.

92. The Jail should re-evaluate their contract with Correctional Medical Care and provide additional mental health providers, including providers working on weekends.

93. Leadership at the jail and all corrections officers who regularly interact with juveniles should be provided with additional training regarding adolescent development and de-escalation techniques. Further, all corrections officers should undergo additional training on use of force and de-escalation techniques.

94. The grievance system should be amended so that inmates have direct access to grievance forms without having to request such from staff.

95. The Jail should have a licensed exterminator inspect and treat each cell for insects.

Dated: February 5, 2018
Washington, D.C.

/S/Andrea Weisman Ph.D_____
Andrea Weisman, Ph.D