Kalief Browder was 16 when he was arrested in the Bronx. Walking home from a party along Arthur Avenue with a friend, several police cars swarmed toward them, one containing a man who reported being robbed of his backpack. Kalief and his friend said that they hadn’t done anything and showed their empty pockets to prove the point. Then the story changed, and the victim in the police cruiser said that he had been robbed weeks earlier, not that night. He identified Kalief and his friend as the culprits. Both of them were arrested and arraigned on robbery and assault changes. Kalief received bail of $3,000, which his family could not raise. The high bail stemmed from a prior guilty plea in a joyriding case, for which he was given a “youthful offender” status and probation. In every state except for New York and North Carolina, this series of events likely would have resulted in either a referral back to community probation or detention in a juvenile facility. But New York and North Carolina are the two remaining states where 16- and 17-year-olds are routinely remanded to the adult jail system while they await trial. A reform movement known as “Raise the Age” hopes to end this practice but hadn’t even started in earnest when Kalief was arrested.\footnotemark\footnotetext{Within 24 hours of being stopped on the street, Kalief Browder made the frightening journey across the bridge to Rikers Island in a Department of Correction bus. He was headed to the Robert N. Davoren Complex (RNDC), the notorious jail for adolescents, where Christopher Robinson was killed two years earlier in an attack sanctioned by correction...}
officers. The depth of brutality in this jail would prompt investigation by the US Department of Justice, which would find that “adolescent inmates at Rikers are not adequately protected from harm, including serious physical harm from the rampant use of unnecessary and excessive force by DOC staff.” In her description of Kalief’s case in the New Yorker, Jennifer Gom- nerman documents the violent and chaotic setting Kalief was dropped into.

His housing area was controlled by gangs who seemed to operate with the open acquiescence of security staff, and the only way to survive was to keep to himself and then fight when challenged. For newly arriving adolescents, there was an immediate need to establish a pecking order. That meant frequent challenges and brutal fights.

This dynamic was first revealed to me with the death of Christopher Robinson in RNDC in 2008. For him, the consequences of not fitting into this hierarchy of housing area violence were fatal. In his case, correction officers in RNDC openly conspired with a group of inmates to extort, assault, and otherwise abuse adolescents in the jail. This conspiracy was widely known as “The Program” and involved both correction officers actively participating in crimes and others turning a blind eye. Christopher Robinson resisted the efforts by this group to extort money from him, and consequently he was beaten to death in his cell. Two correction officers who participated in the homicide were sentenced to just one- and two-year sentences.

Some will know the story of Kalief Browder, but many more will not. His arrest, detention, and death reflect the deep racial disparities in the criminal justice system. His case caught the attention of many in New York City, was repeatedly featured in the New Yorker, and was referenced by both President Obama and Supreme Court Justice Anthony Kennedy. More recently, Jay-Z produced a documentary on Kalief’s life, and numerous other films and series have featured his story. His tragedy also drew attention to the practice of placing 16- and 17-year-olds in adult jails and in solitary confinement. While the disproportionate rates of arrest and incarceration among young men of color like Kalief Browder are well documented, the brutality of other experiences that harm their health behind bars is less well known. There is no reason to believe that the racial disparities that steer greater shares of black and Latino youth toward incarceration wouldn’t persist once they arrive there. But the paramilitary nature of jails and prisons shuns transparency, and correctional management is
rarely based on rational analysis of data. As we examined our own health service at Rikers, where Kalief Browder was held, we found disturbing evidence that white patients were more likely to receive mental health treatment while in jail, while nonwhite patients were more prone to be punished with solitary confinement.

At the core of these jail-based disparities is a hidden punishment apparatus that propels more than twice as many blacks as whites into solitary confinement. Every jail and prison has a set of rules for people held there, and in the United States, the official consequences for being found guilty of breaking these rules can be anything from a verbal warning, to loss of privileges, to sentences of solitary confinement. It’s also important to note that patients routinely report to us that the infraction process is used as a way to keep inmates quiet about abuse. At infraction “hearings” there is no offer of representation and no external oversight. In virtually every instance, when someone is charged with an infraction, the staff bringing the charge, judging the merits of the charge, and hearing the appeal all work for the same group, DOC or the sheriff. The lack of transparency in this process, combined with the deep racial preconceptions baked into criminal justice and health systems, results in a tremendously harmful widening of disparities after people arrive in jail or prison.

For Kalief Browder, his walk home from a party would propel him into a brutal jail setting, where he was subjected to the physical violence of other inmates and correction officers and the mental trauma of solitary confinement. When the case against him finally evaporated after three years, he left Rikers Island as a battered young man. After making progress by starting college and advocating against solitary confinement, the torment of Kalief Browder’s three years in jail proved too great a burden, and he took his own life.

For Kalief Browder, 16 years old and a first-time resident in RNDC, his sole priority was likely survival. As he related in the New Yorker, “The dayroom was ruled over by a gang leader and his friends, who controlled inmates’ access to the prison phones and dictated who could sit on a bench to watch TV and who had to sit on the floor. ‘A lot of times, I’d say, “I’m not sitting on the floor,”’ Browder said. ‘And then they’ll come with five or six dudes. They’d swing on me. I’d have to fight back.’” For Kalief, the beatings were not only at the hands of other inmates. He reported that correction
officers beat him and other inmates and threatened them with infractions and solitary confinement if they reported their injuries to medical staff. Several years later, it would become clear that using threats to keep injuries hidden was not a problem limited to individual correction officers, but a systemic problem.⁶

Kalief Browder’s tragic experience has helped to galvanize national attention on the racial disparities in our criminal justice system. We had long wondered about racial disparities in our own health service, but even with our electronic medical record, we suspected that the relatively low number of white patients in jail would make an analysis difficult. I reached out to colleagues who helped me understand how important it was to look at this part of our service. Kathy Boudin and Five Mualimm-ak were national experts on criminal justice and had both experienced solitary confinement. They became regular contributors to our human rights meetings and shared their views of the basic unfairness in how prison and jail rules were applied. At a meeting with the American Civil Liberties Union (ACLU), another mentor and national expert on solitary confinement, Dr. Craig Haney, recounted similar observations. He told me that he was quite certain that nonwhite patients were more often victimized by the infraction process. All three of these intelligent colleagues reinforced the degree to which the mental health service is entangled with the punishment apparatus. They shared stories and ideas about how many people end up in the mental health service as a result of spending time in solitary confinement.

So although we knew that it would be hard, we designed an analysis to assess race- and age-related disparities in the entry to the mental health system, as well as the exposure to solitary confinement. We focused on first-time jail admissions, with 45,189 cases occurring between 2011 and 2013.⁷ First-time admissions would let us home in on the way in which the jail system first responds to people, which labels were applied, and how the decisions about treatment and punishment were made. Among our cohort, about 41 percent were Latino, 46 percent black, 9 percent white, and 4 percent other. We looked at who came into the mental health service, who went into solitary confinement, and when these two variables occurred together. We also looked at diagnoses, knowing that some jail diagnoses are
viewed as more legitimate than others. For example, being diagnosed with depression, schizophrenia, anxiety, or bipolar disorder was often viewed by security and health staff alike as more “legitimate,” while people diagnosed with personality disorders, especially antisocial personality disorder, were often viewed as problematic or not really being sick.

What we found when we looked at the mental health service surprised us. Half as many black and Latino patients (as compared to whites) ever entered the mental health service, even when we adjusted for length of stay. Remember that this is despite white inmates being just 9 percent of the population. Most patients enter the mental health service during their first days in jail, either because they report concerns to our health staff or following our review of their records during the intake process. So this disparity might reflect levels of mental health care access in the community, where fewer nonwhite patients engage in mental health care.8

Next, we looked at who went into solitary during their stay. Black and Latino patients were much more likely to enter solitary confinement than whites. When we adjusted for length of stay, the likelihood that black patients ever entered solitary was 2.52 times greater than that for whites. For Latino patients, the risk of solitary was 1.88 times greater than that for whites. While many have documented the disparities in arrests and convictions in the United States, this is the first large-scale analysis to report disproportionate application of solitary confinement to nonwhites. It was clear that we had a huge racial imbalance, both in who was sent to solitary and in who received mental health care. If we were to dig deeper, would we find the mechanisms that lead to these differences?

We continued, looking for some interplay between the decisions to treat and to punish, specifically regarding when people came into the mental health service. This is critical because early entry into mental health service usually occurs because the patient and/or their jail health providers have identified a clinical issue. We observed that patients who came into the mental health service early in their stay were more likely to be designated as seriously mentally ill, an important indicator that informs jail and discharge planning. We also saw that those who entered the mental health service in the first week were more likely to receive diagnoses of depression and anxiety, while those who came into the services later were more likely to receive diagnoses of mood, antisocial, or adjustment disorder. Patients
who enter the mental health service later in their stay often do so because of solitary confinement. Many patients sentenced to solitary hurt themselves in attempts to escape the inhumane punishment. Could a link between those disparities show us the root of the problem?

To find out, we looked at the subset of patients who entered the jail mental health service and whether or not they experienced solitary. Patients with no solitary during jail entered the mental health service in the first days of jail, with 70 percent entering by day 7, and trailing off steadily as time went on. For patients who both experienced solitary and entered the mental health service, we saw a different pattern. Entry into the mental health service was instead neatly grouped around the day they entered solitary, and only 35 percent of them entered the mental health service in their first week of jail. For these patients, entry to the mental health service and solitary confinement appeared to be linked, suggesting that solitary was the key event that would predict whether someone who wasn’t already in mental health care soon would be. When we assessed the racial breakdown of these groupings, among those who came into the mental health service later than day 7, only 9 percent of the white patients went into solitary, while 39 percent of black and 26 percent of Latino patients did. Taken together, this shows that nonwhite people are more likely to receive punishment than treatment in jail, whereas whites are not only more likely to receive treatment but also more likely to receive treatment in a true clinical (nonpunishment) context. The obvious link between solitary and patients entering mental health services makes the questions around the entry into solitary, and the practice as a whole, all the more urgent.

There are a couple of possible explanations for what we saw in the solitary-linked mental health encounters. One is that nonwhite patients may not be engaged in care before they enter the jails and their symptoms later on reflect undiagnosed mental illness. Some of this surely happens, but another view, which tracks with my own experience in caring for these patients, is that these symptoms of distress and acts of self-harm reflect normal human reactions to the stress of solitary confinement.

Time after time I’ve heard from patients that they ended up in solitary because they had to fight when challenged in their housing area, or for other reasons completely unrelated to maintaining the security of the jails. Once in solitary, they felt the stress and pain of the setting, often leading to a cascade
of behavioral problems and repeated infractions. Medicalizing these normal human reactions along racial lines has a historical precedent. In the 1850s, American physician Samuel Cartwright coined the term “drapetomania,” which he claimed was a psychological disease that caused slaves to flee captivity. In his work “Diseases and Peculiarities of the Negro Race,” he wrote, “If any one or more of them, at any time, are inclined to raise their heads to a level with their master or overseer, humanity and their own good requires that they should be punished until they fall into that submissive state which was intended for them to occupy. They have only to be kept in that state, and treated like children to prevent and cure them from running away.”

It makes my skin crawl to think of a medical doctor inventing a disease to justify both slavery and the abuse that he recommended as treatment. And looking at our solitary population, mostly black and Latino, it seems possible that we’re doing the same thing again.

Kalief Browder’s rocky introduction to Rikers quickly resulted in him receiving infractions and being sent to solitary confinement. He was held in the central punitive segregation unit, known by everyone on Rikers as “the Bing.” Amid the decay of the aging jails on Rikers Island, the Bing was a sturdy, new five-story building dedicated to solitary confinement. One of the first things I would show visitors to Rikers during this period was the Bing and another solitary unit, also new and imposing. They reminded me of the buildings that Joseph Stalin had placed in Eastern European cities to ensure that nobody ever forgot where power sat.

In the Bing, Kalief suffered through intense heat, the chaos of constant yelling, violence, and the mind-numbing boredom of having nothing to do. While it may seem illogical that fights occur on solitary units, where people are held in their cells almost all the time, my experience was that fights and assaults in these areas, including both staff and inmates, were routine. I also came to appreciate that even the highest level of security could be overcome when violence was planned ahead of time. I once found myself in a blood-soaked elevator responding to a near-fatal slashing, and as one part of my brain processed the clinical issues, another wondered how the incident was possible, because both the victim and aggressor had special security status that mandated multiple officers and waist chain restraints at all times. On a solitary unit, the transfer of inmates to showers, recreation,
medical visits, and other appointments meant that more than one person was often moving across the tier. Add in the abuse by security staff, which would often include directed beatings and staged fights with inmates, and these units were extremely chaotic. For Kalief Browder, his first stint in solitary lasted two weeks, followed by several others for longer periods. Eventually, he would be placed in solitary for 10 months and then even longer. Amid the chaos and depersonalization of solitary, there are daily challenges that can be difficult to navigate. Every inmate is supposed to be offered a daily shower and an hour of recreation time, but many people don’t go to rec, either because it isn’t truly offered or because of the stress and vulnerability of standing, placing one’s hands backward out the food slot in the cell door to be rear-cuffed, and then being escorted to a small cage the size of a dog kennel for an hour.\textsuperscript{10} Kalief also reported a type of DOC assault that I had long heard about but almost couldn’t believe until I saw it with my own eyes a couple of years later. He told Jennifer Gonnerman of the \textit{New Yorker} that an officer took offense at something he said and then challenged him to a fight. The officer came to his cell to fight, but not alone; Kalief was jumped by multiple officers and beaten. The cases I came to know about would sometimes look exactly like a schoolyard fight, with officers taking off their pepper spray, badge, and other gear and then having a fight with an inmate. Eventually, the violence and stress took its toll on Kalief Browder. In February 2012, over 600 days into his incarceration, he ripped up his sheets inside his solitary cell, tied them into a rope, and tried to hang himself. Guards saw him attempting to hang himself and took him to the jail health clinic. But ultimately he was put right back in solitary.

The decision to offer a treatment or punishment response to problems in jail has a profound and lasting impact on the millions of people who pass through jails and prisons every year. We strayed into this topic during discussions of traumatic brain injury (TBI) with adolescent patients in 2012.\textsuperscript{11} We had discovered through screenings that half of adolescents in jail had a history of TBI.\textsuperscript{12} Exploring the circumstances that lead to TBI in focus groups, we quickly learned that survival in the jails was a violent enterprise. While anyone would rather not suffer a blow to the head, there were much higher priorities that often made it impossible to avoid for most.
We began each conversation with a short video clip that depicted a violent blow to the head. The facilitator then asked a series of open-ended questions, including “What is your reaction to the violence in the clips you just watched?” and “How does violence in jail compare to violence in the community?” Each focus group started with these broad questions but inevitably turned to questions of power, race, and inequity, especially in the jails. One participant stated, “The tough thing is, when we fight someone, we’re doing it to actually hurt them . . . we want them to make sure they are in pain for what they did to us.” Another participant described how you “feel like you have to be a bigger man by hurting the next man.” Each focus group then split into smaller groups, with the adolescents developing their own grouping of causes and consequences of violence, relating to personal, community, and societal factors.

The results from these groups revealed how race impacts the experiences of people in jail. It was striking to us in the health service that our patients treated the racial differences in their exposure to jail violence as matter-of-fact. This disconnect is part of the hypocrisy of American incarceration: the incarcerated endure inconsistent, violent, and biased treatment, while those who run the jails and prisons and the community at large act as if it’s the inmates who create strife and discord. Common themes from our focus groups included the role of racial and income disparities in violence, the use of violence as capital, and the inevitability of violence. Many participants discussed the need for violence as a basic survival tool in jail. One adolescent reported, “A short-term show of violence can scare off more serious violence later.” Another stated, “Reputations are like currency in jail. Your reputation can determine whether you get an extra tray of food in the box or a nice cut at the barber shop.” Some discussed the impossibility of avoiding this dynamic in jail. Said one, “There is no place to go [without] someone bother[ing] you . . . in jail you see a lot of crazy shit. Correctional officers punching inmates, stabblings, knives in cells; I’ve seen one guy use a scalpel. [They make] weapons out of anything, like toilet pieces.” Some respondents acknowledged that correction officers were trapped in the same dynamic: “If he puts his hands on someone that generates respect in the house.” Others identified the need for alternative approaches: “It’s important to talk to people you respect who are going through the same thing. You can lessen the pain by speaking to each other.”
Kalief fought in order to avoid more fights. And when he couldn’t escape the need to fight, it chipped away at his spirit. If his experiences in jail were characterized by brutality, his treatment by the legal system was marked by indifference and incompetence. Kalief’s case was relatively straightforward: one person claimed that Kalief and his friend had assaulted him and robbed him of a backpack containing electronics and cash. But time after time, the prosecutors, defense, and judge in Kalief’s case would not be ready or available for key hearings and trial dates. Throughout his stays in solitary, Kalief refused to take a plea in his case, insisting on his innocence.

Inside the jails, there is plenty of advice on how to handle one’s case, and young detainees are often emboldened to stick it out through trial in the hopes that the case against them will fall apart or that they will get a favorable deal. At the same time, prosecutors rely on the horrors of Rikers to coerce defendants into accepting a plea deal.

Families are profoundly influenced by the coercive power of Rikers as well. The visitation process is humiliating and anxiety producing and involves many hours of transport and waiting while hoping for a short visit. For families that cannot make bail for their loved ones, the prospect of a plea deal can be welcome news. It would mean a release from the danger and indignity of Rikers. Almost lost in this struggle between survival and dominance is the idea that any defendant in Rikers who pleads guilty may be innocent of the charges against them.

But despite (or maybe in defiance of) the horrors he suffered, Kalief Browder did not leap at the chance for a plea deal. On the 74th day of his detention, he was indicted and pleaded not guilty. In early 2012, about two years and eight months into his detention, Kalief turned down another plea offer of three and a half years, despite facing a potential of 15 years if found guilty at trial. In March 2013, Kalief went to court and met the eighth judge involved in his case. As part of an effort to reduce the backlogs of court cases in the Bronx, this judge offered Kalief a deal: admit guilt to two misdemeanor charges with a 16-month sentence, essentially time served thus far. This deal would have allowed him to go home that day. Kalief refused, insisting that he was innocent, and was returned to Rikers, where he stayed until another court appearance in May 2013. This time, the judge had shocking news. The complainant against Kalief could no longer be located, and thus the case was being dismissed. Kalief spent one more night in RNDC as
paperwork was completed, and then he was released the next day. He had entered Rikers as a 16-year-old; he returned home to his mother a few days after his 20th birthday.

Back at home, Kalief found himself acting withdrawn and avoiding many of the social settings and experiences that he had enjoyed before Rikers. As he told Jennifer Gonnerman, “I’m trying to break out of my shell, but I guess there is no shell. I guess this is just how I am—I’m just quiet and distant,” he says. “I don’t like being this way, but it’s just natural to me now.” Kalief worked to get his life back on track. He had missed his junior and senior years of high school, and although there was supposed to be some education available during his time in solitary, it really amounted to officers randomly dropping off and picking up worksheets, with rare visits from teachers. In the months after being released from Rikers, Kalief initiated a lawsuit against NYC for his incarceration and treatment. But his struggle with depression that had begun in jail persisted, and Kalief attempted suicide six months after his release, trying to hang himself in November 2013, just as he had a year and a half earlier in solitary confinement.

After an inpatient psychiatric hospitalization, Kalief returned home. He made progress on his goals, earning his GED and starting classes at Bronx Community College. His case seemed to build momentum; celebrities and politicians cited it as an example of the deep problems with the criminal justice system. Months after his release, Jennifer Gonnerman obtained video from Rikers of Kalief being assaulted by correction officers. He insisted on sharing that video on the New Yorker website, just as he had insisted on his own innocence. He wrote an essay in his Bronx Community College courses about the harms of solitary confinement. Kalief was free. People were on his side, and to say that Kalief was a young man of uncommon strength of will would be an understatement. But despite all of his determination, Kalief could not overcome the enduring pain Rikers had inflicted. On June 6, 2014, he ripped his bed sheets into strips, as he had done in Rikers, and hanged himself from his window frame at home. His mother, who had called him “peanut” from childhood, heard the thump of his body weight hitting the window frame and rushed outside to find him hanging.13

Kalief Browder’s story caught the attention of people across the globe because of the tragedy and injustice he suffered, but his was only one of the roughly 12 million incarcerations that occur each year in the United
States. These incarcerations leave their mark on everyone who heads home or moves from jail to prison, and the health consequences may be hard to define. For Kalief Browder, his struggles with depression and depersonalization may have also been exacerbated by physical trauma.

One of the outgrowths of our work on TBI was to think about how violence in jail might create long-term public health crises for communities with high incarceration rates. Almost all of the 12 million annual arrests result in a return home, and the impact of physical and emotional trauma lasts well beyond the time one is locked up. To assess how hidden head trauma in jail is, we looked at the amount of jail-based head trauma (and the subset that meets criteria for TBI) that results in patient transfer to the hospital. Hospital transfer is important for individual patients, but it’s also important for us as a society to know about, because only through contact with a community health provider can the Centers for Disease Control and Prevention and other public health agencies track head trauma. As we’ve seen, jails don’t report injuries. In the past few years, football players and their fans and families have heard quite a bit about the link between TBI and chronic traumatic encephalopathy (CTE), a syndrome of behavioral changes linked to prior head trauma. Although understanding of the mechanism of CTE is still evolving, we believe that repeated head trauma causes changes in the brain years later that can drive extreme behaviors. These behaviors range from aggression and violence to social withdrawal and suicide. The characteristic scarring of brain tissue that is associated with CTE has been present in the brains of several National Football League players who have committed suicide, including Junior Seau, Andre Waters, and Dave Duerson. All of our national discussion about CTE has related to contact sports, particularly football. Some attention has been given recently to the prevalence of TBI and CTE in military personnel, but there has been no discussion of the rates of TBI in jail or the potential consequences down the road for those who, like Kalief Browder, return home after experiencing violence. Our review of TBI in Rikers over 42 months found about 10,000 instances of head trauma and 1,500 cases of TBI. These rates are about 50 times higher than what is reported in the community for all causes, with 14 and 55 percent of these cases, respectively, resulting in hospital transfer. When we converted these rates to estimates of the entire American jail/prison population, we projected that each year in the United States there are about
600,000 head injuries in correctional settings and 90,000 cases of TBI. Applying our hospitalization rates nationally, about 500,000 patients with head injuries and 40,000 patients with TBI are not transferred to the hospital. Consequently, all of those patients are off the radar of our national health surveillance for downstream effects like CTE. The short-term physical and emotional toll of these incidents is daunting, but the long-term implications for CTE prevalence in communities disproportionately impacted by mass incarceration are horrifying.

The experiences of Kalief Browder were not an unfortunate turn of events. They were a man-made disaster. Many would view his release and lawsuit against NYC as a correction of a wrong. When he spoke of his experiences to the New Yorker, he summed it up like this: “People tell me because I have this case against the city I’m all right. But I’m not all right. I’m messed up. I know that I might see some money from this case, but that’s not going to help me mentally. I’m mentally scarred right now. That’s how I feel. Because there are certain things that changed about me and they might not go back.” His story, as well as our data, tells us that the health consequences of incarceration are distributed along racial lines. This is not a shock to anyone who knows the criminal justice system. They know how interwoven the health and security systems are inside jails in deciding who merits treatment and who should be punished. One of the central hypocrisies of mass incarceration is to fail at basic management and then punish the incarcerated for these failures. The widespread use of violence as a basic tool of control by security staff forces the incarcerated to trade in the same currency. The lack of connection between the rules and reality leads naturally to the security authority selectively enforcing their rules. Like other settings where transparency and accountability are in short supply, selective enforcement breaks along racial lines.15

The revelation that we provide care in the same racially divided way that the security service enforces their rules is both distressing and predictable. We know that significant disparities exist in the mental health services provided outside jail, so patients arrive with these accumulated differences.16 Others before us have also identified racial disparities in mental health diagnoses in correctional settings, whether by self-report or by clinical
Doctors, nurses, social workers—we can all be susceptible to the same preconceptions about race and punishment as the corrections officers. And whether the health staff start out with these preconceptions or not, bias is baked into the processes around solitary. Because most jails and prisons require health staff to “clear” people for solitary confinement, the inequities in the punishment apparatus are presented to health staff every time someone is punished with solitary confinement. The consequences exist on both sides of the patient/provider relationship. We can see the damage that this clearance process does, as patients quickly come to see us as part of the punishment system. Health and security systems are at the heart of widening racial disparities in jail. The infraction process operates as an unaccountable system of rules enforcement that doles out solitary confinement along racial lines. Detainees have no right to representation in this process, and they often incur both new financial penalties and punishment as a result of infractions. Depending on the jail system, these infractions may stay on the books forever, so that each entry to jail brings a return to solitary confinement, even for a long-distant rules violation. There is no transparency in the infraction process, and no expectation of fair treatment. I question its stated purpose: to deliver swift consequences for rules violations and thereby promote security. Solitary doesn’t discourage violence. Dr. Robert Morris of the University of Texas analyzed data from 70 prisons and found that among inmates who received solitary confinement for violent infractions, solitary had no impact on the likelihood of subsequent violent infractions. The experiences of Kalief Browder and others also reveal the link between solitary confinement and violence by security staff.

As with the other health risks of incarceration, those driven by race can be addressed. First of all, health staff in jails and prisons should be trained on the racial disparities inherent in their system and the potential for their work to further widen the racial divide between treatment and punishment. NYC received federal funding to start this type of training with our health staff, and they have responded. However, educating staff doesn’t help patients unless it’s accompanied by other structural changes. In order for health staff to truly address these concerns, we must uncouple them from the racist punishment system. Removing health staff from the job of “clearing” people for solitary confinement is important. We need real oversight and accountability in infraction processes. DOCs and sheriffs should
be compelled to report data on infractions, and the people subject to these processes should be entitled to representation overseen by external authorities. But even with better training and accountability inside jails and prisons, health consequences will fall along racial lines until the upstream fundamentals of mass incarceration are addressed. Undoing mass incarceration will require active efforts to maintain a commitment to racial fairness throughout the progress that is made. Some settings, like NYC, have made substantial gains in reducing overall rates of incarceration but have been unable to make real changes to the disproportionately black and Latino demographics of the incarcerated.

The necessary work involves far more than sentencing reform, however. The interminable delays that Kalief Browder experienced reflect deep problems in the district attorney’s office, as well as the lack of resources in the public defense and court systems. These shortcomings disproportionately impact the poor and people of color across the United States. In Louisiana, the ACLU has reported that people who need a public defender are being incarcerated without ever seeing a lawyer. Despite the numerous constitutional and other legal principles that seemingly guarantee the right to counsel in the United States, practices in Louisiana reflect the collision between the nation’s highest rates of incarceration and complete dismantling of public defense and other elementary safeguards against the criminal justice system. The losers in Louisiana, as with most of the other mismatched struggles between the need to incarcerate and the promise of justice and fairness, are mostly people of color like Kalief Browder.

It’s important to remember that Kalief Browder did not succumb to his fate out of weakness. He was not a willing or indifferent victim. He railed and resisted the system that beat him down, and when he had the opportunity to escape its clutches with an admission of guilt, he refused. He fought every attempt to coerce a guilty plea from him, even as his spirit and body suffered the consequences. Once free of Rikers, he turned his attention to furthering his own education, and he spread the word of the brutality and unfairness of incarceration to millions through speaking and television appearances.

Similar were the struggles of other young men profiled in this book who died at Rikers: Christopher Robinson, Jason Echevarria, Angel Ramirez, Bradley Ballard, and Carlos Mercado. All of these patients suffered because
the jail system met their problems with punishment rather than treatment. All of these patients died unnecessarily, as a clear consequence of incarceration, and not one of them was white. These deaths generated many press stories and ample outrage, but efforts on their behalf should push us to do more than look for bad apples or individual errors. We should reconsider the risks and benefits of incarceration in the United States and maintain a focus on promoting racial fairness in each of the reform efforts we undertake.