Testimony to the Inter-American Commission on Human Rights:
Solitary Confinement for Youth in the United States

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The Children's Law Center (CLC) would like to commend the IACHR Commissioners for holding this hearing today on solitary confinement. I submit my testimony today to highlight solitary confinement as it pertains to U.S. youth held in juvenile detention and corrections facilities as well as in adult jails and prisons.

My name is Kim Brooks Tandy and I am Executive Director of CLC. For over 20 years, CLC has focused on issues involving children in custody and advocated for reducing incarceration rates and ensuring humane and constitutional conditions in locked facilities. In 2008, CLC – along with a civil rights law firm – filed a lawsuit challenging conditions of confinement for youth in Ohio's juvenile correctional facilities. (Ohio is the 7th largest state in the United States and has a substantial urban population.) Despite many improvements that have resulted in large scale changes to Ohio's juvenile justice system, today this lawsuit remains ongoing, with many of the outstanding issues focusing on the use of solitary confinement.

In my testimony today, I will focus on the unique effects of solitary confinement on youth, whose age, level of maturity, and social, psychological and moral development, warrant a different approach and how the practice of isolating youth can be detrimental to the youth's development and reintegration into our communities.

Overview: Conditions in Juvenile Correctional Facilities Nationwide and In Ohio

Across the United States, states are moving away from incarcerating youth in correctional facilities and toward serving youth in their home communities in less restrictive environments. These changes have been driven by research-informed and evidence-based programming that can reduce costs and provide better outcomes for youth. In Ohio alone, institutional placements in juvenile correctional facilities have declined from about 1,800 youth in 2008 to about 500 youth today. The state closed four of its eight juvenile corrections facilities, developed a continuum of care designed to serve youth locally, and undertook an impressive initiative to keep youth who are mentally ill out of institutional placement, where they are more likely to have their condition worsen, and less likely to adapt to institutional rules.

Despite impressive efforts to keep youth in their local communities, the reality in Ohio, and throughout the country, is that many youth remain in secure correctional facilities.

Unfortunately, these facilities are ill-equipped to rehabilitate or improve the lives of youth and have been questioned as both counterproductive and costly. Reports of pervasive violence and abuse have been widespread, often resulting in years of litigation. A recent study commissioned by the Annie E. Casey Foundation showed that 57 lawsuits in 33 states plus the District of Columbia had been filed in response to alleged abuse or otherwise unconstitutional conditions in juvenile corrections facilities.[1] Nearly all of these lawsuits included allegations of systemic problems with violence, physical or sexual abuse by facility staff and/or excessive use of isolation or restraint.[2] An extensive review of recidivism studies compiled from this report suggests that incarceration is no more effective than alternative sanctions, such as probation, in reducing the criminal conduct of youth who have been adjudicated delinquent, and that the use of incarceration actually exacerbates criminality.[3] In spite of the proven success of many community-based alternatives and evidence-based programs in lieu of incarceration, states continue to incarcerate youth in programs that are often poorly designed and ill-equipped to provide effective treatment, particularly for youth with severe mental health conditions, learning disabilities, significant substance abuse problems or other acute needs.[4]

Use of Solitary Confinement in Juvenile Correctional Facilities

Within juvenile correctional facilities, Ohio, like a number of states, uses isolation not only for short term disciplinary purposes for up to five days, but also operates two special management units that house youth for longer periods – sometimes years – for more serious behaviors. The majority of youth placed in these units suffer from mental illness, some severe, before their placement in these units, and most are non-White. These environments fail to provide adequate behavioral health treatment, education, recreation, and positive human interactions.

In examining this issue over the past 20 years, my experience indicates that there is a significant void in research on the harmful effects that isolation, even for short term use, causes in the adolescent population. However, much of what we know about the devastating effects of solitary confinement with adults is likely to apply to youth, and the harm may well be even greater for many reasons. For example, in recent years, the United States Supreme Court has utilized adolescent brain development research on the changing nature of youth's development to justify abolishment of the juvenile death penalty and life without parole in certain cases.

In addition to research, over the past 8 years, I have interviewed countless Ohio youth; portions of these interviews are included below to provide firsthand accounts of the effects of solitary confinement on youth. These youth have all been held in isolation cells, often devoid of anything other than a toilet and sink, mat, blanket, paper and pencil and a book. Some of these cells lack windows to provide any outside light. By design, they are often stark, cold and lack any positive aesthetic qualities for stimulation. One expert noted that youth on these units are

[1] Mendel, Richard A, No Place for Kids: The Case for Reducing Juvenile Incarceration, The Annie E. Casey Foundation (Baltimore, Maryland) 2011, p. 5.
[2] Id.
[3] Id. at 11. Mendel's research was based on an extensive internet search and literature review in addition to interviews and outreach with state corrections agencies. The research conclusions were based upon recidivism analyses in 38 states and the District of Columbia.
[4] Id at 22.

treated more harshly than individuals in adult prisons by being denied "reading material, writing or drawing material,…[and] close *(sic)* circuit television for educational programming."[5]

Harmful Effects of Solitary Confinement on Youth

Research on the effects of solitary confinement on youth is lacking. However, research on adults in isolation and on other aspects the juvenile justice system can help shed light on this issue.

A. Isolation can Exacerbate a Youth's Underlying Mental Health Issues

Research on juvenile justice in the United States indicates that many youth who come to the attention of the juvenile justice system have a history of trauma and mental health issues. The Office of Juvenile Justice and Delinquency Prevention's 2010 Survey of youth in the "deep-end" of the system suggests that 70% of youth confined revealed they had "seen someone injured or killed," and 72% had "something very bad or terrible" happen to them.[6] Additional research has shown that a significant proportion of juvenile offenders have a substantiated history of child or adolescent maltreatment,[7] and that at least three out of four youth in the juvenile justice system have been the victim of traumatic victimization.[8] Such traumatic victimization has been linked to psychological disorders such as Posttraumatic Stress Disorder and can cause the youth to develop ongoing difficulties with oppositional-defiance and aggression.[9] Exposure to trauma also slows down development and can cause disturbances of emotional regulation, relationships, and communication. These youth are prone to engage in the type of defiant behavior and rule breaking that result in their placement in punitive isolation.[10]

In addition, research shows that youth who seem aggressive are prone to overreact to actions by correctional officers as a perceived threat, typically because it is reminiscent of past victimization.[11] These youth do not see their responses as excessive, because they "have little experience expressing their thoughts and resolving their feelings verbally rather than through aggression," and "may feel helpless about regulating their behavior."[12] Instead of helping youth

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[5] Grassian, Stuart, M.D., *Declaration: Psychiatric Report in S.H. v. Reed*, October 2012, p. 15.

[6] Survey for Residential Placement online database, available at http://www.dataxplorer.com/Project/ProjUser/AdhocTableType.aspx?reset_true&ScreenID+40

[7] Swanston, Heather Y, Parkinson, Patrick N., O'Toole, Brian I., Plunkett, Angela M., Shrimpton, Sandra & R. Kim Oates, Juvenile Crime, Aggression and Delinquency After Sexual Abuse: A Longitudinal Study, 43 Brit. J. Crimnol 729 (2003).

[8] Julian D. Ford, John Chapman, Judge Michael Mack & Geraldine Pearson, *Pathways from Traumatic Child Victimization to Delinquency: Implications for Juvenile and Permanency Court Proceedings and Decisions*, Juvenile and Family Court Journal 13, Winter 2006. [hereinafter "Pathways"].

[9] Julian Ford, *Traumatic Victimization in Childhood and Persistent Problems with Oppositional-Defiance*, Journal of Aggression, Maltreatment & Trauma, 6:1, 25-58, p. 26 [hereinafter "Persistent Problems"]

[10] *See* Christopher A Cowles & Jason J. Washburn, *Psychological Consultation on Program Design of Intensive Management Units in Juvenile Correctional Facilities*, Professional Psychology: Research and Practice, Vol 36, No. 1, 44-50, p. 45 (2005). ("Consequently, incarcerated juveniles who are disruptive or violent, regardless of their mental health status, may be relegated to a facility's disciplinary unit.")

[11] Clinical Practice in Correctional Medicine, Michael Puisis, ed. Mosby: Philadelphia, 2006, p. 124. *See also* Persistent Problems at 39, ("[T]hese children's emotions and thought processes reflect a fearful and hypervigilant concern with the possibility of severe danger. It is as if they view their lives as an almost constant effort to be prepared for, and to survive, the reoccurrence of traumatic danger.")

[12] *Id.*

heal from the victimization that has traumatized them, aggressive juveniles are punished by being placed in isolation for their misbehavior.

Adolescent depression may also cause symptoms that lead to the imposition of isolation. Although several of the symptoms of depression are similar for adults and adolescents, including depressed mood, hopelessness, and helplessness, depression may manifest differently in teenagers.[13] In fact, research indicates that irritability is the most common characteristic of depression in young adults.[14] The level of irritability a depressed youth exhibits increases as the adolescent becomes more depressed.[15] Adolescent depression can also create anger and hostility, which "increases the likelihood that [depressed youth] with provoke angry responses from other youth (and adults)" and "increase[s] the risk of altercations with other youth."[16] These behaviors and attitudes often lead facility officials to respond to such behaviors by placing the youth in isolation rather than treating the underlying causes of the behavior through behavioral health programming.

Isolation can also be especially agitating for youth with Attention Deficit Hyperactive Disorder.[17] While studies have shown that in the general school population only 2% to 10% of youth have ADHD,[18] anywhere from 19% to 46% of youth in the juvenile justice system are thought to have ADHD.[19] The percentage of youth in isolation with ADHD maybe be higher, since juveniles with this disorder are more likely to engage in the types of disruptive and impulsive behavior that are often sanctioned with seclusion time.[20] Patients who suffer with ADHD are unable to tolerate the "restricted environmental stimulation" that is found in an isolation unit.[21] This intolerance may cause an increased susceptibility to psychopathological reactions while in isolation.[22] Due to the prevalence of ADHD in the juvenile justice population, one may question whether a significant number of youth who are subjected to isolation may also face a higher risk of developing a psychiatric disturbance.

The majority of youth I have interviewed in long term isolation have a variety of mental health disorders ranging from ADHD to bipolar disorder to borderline mental retardation. Many of these youth also self-report diagnoses of either ADHD and/or Bipolar Disorder. Often they have expressed concerns over the lack medical therapy, or have questioned the types of medication they are given as ineffective or having adverse effects. I have had youth indicate to me that they have been taken off medication altogether, or that the medication that was working for them to treat symptoms of ADHD or Bipolar Disorder were not available at the institution where they were housed. Youth have reported that they receive psychological services "through their door" by a mental health professional, such that even contact by those most highly trained individuals

[13] Marie Crowe, Nic Ward, Bronwyn Dunnachie & Morian Roberts, *Characteristics of adolescent* depression, 15 International Journal of Mental Health Nursing, 10-18 (2006), at 15. [hereinafter "Adolescent Depression"]
[14] *Id*. at 10.
[15] *Id*. at 16.
[16] Thomas Grisso, *Adolescent Offenders with Mental Disorders*, The Future of Children, Vol. 18, No. 2, Fall 2008, p 145
[17] Grassian, *supra* note 119, at 11.
[18] Robert B. Rutherford Jr., Michael Bullis, Cindy Wheeler Anderson, and Heather M. Griller-Clark, *Youth with Disabilities in the Correctional System: Prevalence Rates and Identification Issues*, July 2002 at 18.
[19] *Id*. at 19.
[20] *See id*. at 17-18, listing possible symptoms of ADHD.
[21] *Grassian* at 11.
[22] *Id*. at 12.

was impersonal and brief. In one instance, an expert noted that a group to address trauma was "held with the youths in their cells, having to shout through their cuff port in order to participate." It is not a coincidence that programs which rely upon seclusion for behavioral controls in juvenile facilities also often lack adequate mental health and medical services which could address problem behaviors more effectively. **One youth stated "I've been on the mental health caseload, but I'd be lucky to see psych. I saw the psychologist last week, but she just talked about herself and African power. She says it's a shame I have a black family…"** Another youth stated **"For the last 2 ½ years, most of my time was in seclusion. I hated being in my room. It made me mad. It made my anger issues way worse."**

B. Youth Without Mental Health Diagnoses Prior to Isolation May Experience Psychological Harm [23]

Research on the use of isolation on adults suggests that seclusion can cause severe psychiatric harm even when the individual had no history of mental illness.[24] In the most severe cases, adult inmates subject to isolation have displayed "agitation, self-destructive behavior, and overt psychotic disorganization."[25] More than half of the prisoners studied reported an inability to tolerate ordinary stimuli; almost a third heard voices saying frightening things or bizarre noises, and more than half of the inmates interviewed experienced severe panic attacks while in isolation.[26] Many also described having difficulties with thinking, concentration and memory, and almost half of the prisoners complained of "intrusive obsessional thoughts, primitive aggressive ruminations and paranoid, persecutory fears."[27]

Isolation is presumably even more damaging to juveniles because "the adolescent brain is more highly moldable by experience than the adult brain."[28] Adolescence is a unique period of time for human brain development, during which the circuits that coordinate human behavior are remodeled, shaping who youth will become as adults and how their brains function.[29] The majority of this "remodeling" is "influenced by an individual's interactions with the outside world."[30] In other words, an adolescent's brain is essentially "sculpted by his or her interactions with the outside world."[31] Because adolescence is a critical time in a youth's brain development, using isolation on juveniles may have a profound psychological impact on their entire lives. In fact, because the brain's malleability decreases with age, making it increasingly more difficult to heal, the adverse psychological effects of seclusion on juveniles are potentially irreversible.[32] Indeed, one expert has expressed concern that holding a youth in solitary confinement may

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[23] *See generally* S. Grassian, Psychopathological Effects of Solitary Confinement, 140 American Journal of Psychiatry 1450 (1983) [hereinafter "Grassian"]; C. Haney, Infamous Punishment: The Psychological Effects of Isolation, 8 National Prison Project Journal 3 (1993); *and* C. Haney and M. Lynch, Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement, New York Review of Law & Social Change, 23, 477 (1997) [hereinafter "Haney"].
[24] Grassian, *supra* note 119.
[25] *Id*.
[26] *Id*.
[27] *Id*.
[28] Aaron M. White, *The Changing Adolescent Brain*, Education Canada, Canadian Education Association at 5. [hereinafter "Adolescent Brain"]
[29] *Id.* at 6.
[30] *Id*.
[31] *Id*.
[32] *Id*.

"permanently damage the youth's capacity to modulate affect and to inhibit impulsivity, likely permanently impairing his capacity to manage his life as an adult."[33]

Interviews I have conducted with youth in long term seclusion suggest that they lack a sense of hope that they can change or improve their condition. Youth also realize the negative effects of long-term isolation. One young person, when asked to tell me something good about himself, replied, **"lady, I've been locked up so long, there is nothing good about me anymore."** He was 15. Other youth stated **"I be stressing in my room. I get tired of it and gonna spaz out," "after I have spent a whole day in my room, I feel depressed. But now I'm used to it…," and …[a]fter being in my room so much, I realize I talk to myself now..."** The youth also notice changes among themselves; one young man said **"I can tell that being in lockdown has affected other youth. One kid is not the same as when I knew him on a different unit. He is more aggressive and is going crazy…"** Some youth have expressed to me the fear of being around people and knowing how to interact with them after being secluded for long periods of time. I have witnessed other youth who shut out what little contact they have with the world outside of their room by placing paper on their window because they no longer want to know what happens outside of their room or are fearful. I am not a psychologist or psychiatrist, but having worked with youth in the delinquency system for more than 30 years, there have been few interviews that have affected me so profoundly as those done with youth in long term isolation.

C. Youth Held In Isolation May Not Receive Adequate Education, Recreation or Necessary Services

Youth in isolation are frequently denied education or other services to which they are entitled. Restricting the ability of youth to participate in education, recreation, group or social skills, programs, or other interactions with youth can have a negative impact on their overall progress in the facility. Requiring youth to miss school or other activities can also increase depression and suicidal ideation and attempts.[34] For example, one young man stated **"I don't go to the school. I go only on unit. I get frustrated when they do not explain why we do not get to go to school…"**

As with mental illness, the prevalence of learning disabilities and other education disabilities is similarly disproportionate among confined youth.[35] Educational achievement and school success is also lower among youth who are incarcerated, with studies suggesting that these youth perform, on the average, four (4) years below grade level, have a history of being suspended from school, and have frequently been held back at least one grade.[36] A significant percentage of youth in detention and corrections facilities have disabilities that substantially affect their education, and either have been or should have been identified for special education. For those youth already identified, up-to-date Individualized Education Plans under the Individuals with

[33] Grassian, Stuart, M.D., *Declaration: Psychiatric Report in S.H. v. Reed,* October 2012, p. 12.

[34] Clinical Practice in Correctional Medicine, Michael Puisis, ed. Mosby: Philadelphia, 2006, p. 139.

[35] Quinn, Mary Magee, Rutherford, Robert B., and Leone, Peter E., Osher, David, and Poirier, Jeffrey M., "Youth with Disabilities in Juvenile Corrections," Exceptional Children, Vol. 71, No. 3 (2005).

[36] Krezmein, Michael P., Mulcahy, Candace A., & Leone, Peter E, "Detained and Committed Youth: Examining Differences in Achievement, Mental health Needs and Special Education Status, Education and Treatment of Children, Vol. 31, No 4, (2008)

Disabilities in Education Act (IDEA) should be in place. A child with a disability does not lose the entitlement for special education and related services, even if excluded from school by being housed in isolation. Nothing in the IDEA excludes from coverage, or diminishes the rights of, children with education-related disabilities who are detained or incarcerated in delinquency facilities.

Yet the reality exists that many youth in isolation do not receive adequate educational programming. Many of my own clients, including a high percentage of those who have learning disabilities or other educational disabilities, have been denied educational services while in seclusion or given paperwork under their door that they were expected to complete on their own without the assistance of teachers. One youth said **"What they called "school"…was actually being handed a packet of papers to work through on my own. I thought school was too easy for me – it was like preschool. I liked the "A+" computer program, but from late spring until mid-summer 2012, we were not allowed to use keyboards anymore because other youth were hitting each other on the head…"**

Recreation and other services are also more limited or non-existent. Youth clients have expressed to me that "out of room" large muscle activity consists of pushups in their room or being moved to another cell with a push up bar. Physical activity is critical to all individuals who are incarcerated, but it is particularly important for adolescents who are still growing and maturing physically as well as emotionally.

In addition to scheduled programming, youth face limited access to food, family contact and other issues. For example, one youth stated **"I am often cold in my cell at night because we get just two blankets and two sheets. They don't got sweaters. They say we're not allowed to have them, so I am still cold…The regular food leaves me hungry."** Another youth noted **"They ain't got no type of guidelines for this unit. They put whoever they want up here. They don't use the score anymore… I get to make phone calls one time every two weeks. I have tried to call to my mother, but I haven't talked to her in three weeks. If she calls me, I will get a message slid under my door saying that she called…I want to read, but there is nothing I want to read here."**

Recommendations

In closing, I would like to again thank the IACHR for your work on solitary confinement and for holding this hearing. As my testimony indicates, subjecting youth to solitary confinement can be extremely harmful and cause long-term damage that not only harms youth, but the communities to which they return.

I urge the Commission to utilize the full extent of its authority to examine the issue of solitary confinement in the United States, particularly as it applies to vulnerable populations including youth and individuals with disabilities. I hope you will continue to observe and report on this practice in the United States, and help to effect international standards recommending that OAS members severely restrict or eliminate altogether the solitary confinement of children and persons with disabilities. Thank you on behalf of the young people I represent for your attention and your willingness to examine this important issue.