Center for Children's Law and Policy

Testimony of the Center for Children's Law and Policy for the Subcommittee on the Constitution, Civil Rights, and Human Rights of the Senate Judiciary Committee

June 15, 2012

Chairman Durbin and Members of the Subcommittee:

This testimony is submitted on behalf of the Center for Children's Law and Policy, a national public interest law and policy organization located in Washington, DC. The Center works to reform juvenile justice and other systems that affect troubled and at-risk children and to protect the rights of children in those systems. Our staff members have decades of experience working to remedy dangerous conditions of confinement – including the misuse of solitary confinement (also described in this testimony as "isolation" and "room confinement") – in facilities that house youth. We have done so through training, technical assistance, administrative and legislative advocacy, litigation, research, writing, public education, and media advocacy.

The Center is widely recognized for our expertise on issues related to conditions of confinement of youth. We drafted the extensive Juvenile Detention Facility Standards used by the Annie E. Casey Foundation in its Juvenile Detention Alternatives Initiative (JDAI), which operates in more than 150 sites across the country. We have provided advice to the U.S. Department of Justice and many state and local agencies on how to improve conditions of juvenile confinement. We have also written about unsafe juvenile conditions in professional and lay publications, including the article, "Juvenile Justice: Lessons for a New Era," 16 Georgetown Journal on Poverty Law & Policy 483, 506-521 (Symposium Issue 2009).

We appreciate the opportunity to contribute to the Subcommittee's review of solitary confinement in U.S. prisons, jails, and detention centers. We submit testimony to address three important questions related to the solitary confinement of children in the juvenile and adult criminal justice systems:

(1) Why is solitary confinement particularly harmful to children?

(2) Why do some juvenile facility administrators and staff rely heavily on solitary confinement, while others use it rarely or do not use it at all?

(3) What are the most effective ways of reducing and eliminating the inappropriate and excessive use of solitary confinement of children?

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Our answers reflect our experience with the solitary confinement of youth in dozens of facilities throughout the country, as well as our efforts to support laws, policies, and practices to reduce its use.

I. Why is solitary confinement particularly harmful to children?

Administrators and staff charged with supervising youth in the juvenile justice system have a fundamental responsibility to ensure the safety and security of the youth in their care. The inappropriate and excessive use of solitary confinement not only undermines that goal, but can result in psychological harm and emotional trauma to youth. In some cases, it has led to serious injury and death.

When we refer to the "inappropriate" use of isolation, we are referring to its use in situations when a youth does not present a serious risk of imminent harm to the youth or others. "Excessive" isolation refers to its use beyond the amount of time necessary for the youth to regain self-control and no longer pose a threat to self or others. These definitions recognize that it may be necessary to briefly isolate youth in certain situations. For example, if a youth is in a fit of rage because of bad news from home, or has gotten into a violent physical confrontation with another youth, it may be necessary to put that youth into his room until he can gain self-control, for his own protection as well as the safety of others in the facility.

Some facilities also use room confinement as a sanction for violating rules, which is different from isolation for out-of-control behavior. In situations involving room confinement, the JDAI Juvenile Detention Facility Standards afford youth a range of due process protections before being placed in room confinement, limit its use to a maximum of three days, and ensure that confined youth have access to services including education, health care, and exercise.

It is our experience, though, that staff often use isolation and room confinement in a much broader range of circumstances. One needs to look no further than recent investigations by the Special Litigation Section of the U.S. Department of Justice's Civil Rights Division to find numerous examples of the inappropriate and excessive use of solitary confinement:

- At the Oakley and Columbia Training Schools in Mississippi, staff punished girls for acting out or being suicidal by stripping them naked and placing them in a cell called the "dark room," a locked, windowless isolation cell cleared of everything but a drain in the floor that served as a toilet.[1]

- At the Indiana Juvenile Correctional Facility, staff isolated youth for consecutive periods of up to 53 days – long stays that the Justice Department characterized as "short-sighted

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[1] Findings Letter from Ralph F. Boyd, Jr., Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Ronnie Musgrove, Governor, State of Mississippi (June 19, 2003), *available at* http://www.justice.gov/crt/about/spl/documents/oak_colu_miss_findinglet.pdf.

way[s] to control behavior" that "serve[d] no rehabilitative purpose."[2]

- At the W.J. Maxey Training School in Michigan, staff regularly placed youth with severe mental illnesses in the facility's isolation unit because of inadequate staffing and resources to meet youth's needs – a practice that the Justice Department characterized as equivalent to "punish[ing youth] for their disability."[3]

Our experiences in dozens of facilities around the country confirm that these incidents are far from unique. For example, our Executive Director, Mark Soler, successfully litigated against the South Dakota State Training School, which routinely relied on a combination of pepper spray, groups of black-helmeted staff, and extended periods of isolation to manage even minor youth misbehavior. That training school has since been closed. However, we continue to visit facilities that use solitary confinement in inappropriate and excessive ways.

The misuse of solitary confinement in facilities that house youth is particularly troublesome for three primary reasons. First, isolation poses serious safety risks for children, including increased opportunities to engage in self-harm and suicide. A February 2009 report from the Department of Justice's Office of Juvenile Justice and Delinquency Prevention described a "strong relationship between juvenile suicide and room confinement." The study, which reviewed 110 suicides of children in juvenile facilities, found that approximately half of victims were on room confinement status at the time of their death.[4] The Justice Department recently reiterated these safety concerns in its comments accompanying the Prison Rape Elimination Act standards, stating that "long periods of isolation have negative and, at times, dangerous consequences for confined youth."[5]

Second, isolation has particularly negative consequences for youth with mental health needs – youth who are disproportionately represented in the juvenile justice system. In one study, 70% of youth entering juvenile detention met the criteria for a mental health disorder, with 27% of detained youth having a disorder severe enough to require immediate treatment.[6] The use of isolation only exacerbates those conditions. For this reason, many mental health associations advocate against its use. For example, the American Academy of Child and Adolescent Psychiatry opposes the use of solitary confinement in correctional facilities for youth, noting that children are "at a particular risk of . . . adverse reactions" including depression, anxiety,

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[2] Findings Letter from Thomas E. Perez, Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Mitch Daniels, Governor, State of Indiana (Jan. 29, 2010), *available at* http://www.justice.gov/crt/about/spl/documents/Indianapolis_findlet_01-29-10.pdf.

[3] Findings Letter from R. Alexander Acosta, Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Jennifer M. Granholm, Governor, State of Michigan (Apr. 19, 2004), *available at* http://www.justice.gov/crt/about/spl/documents/granholm_findinglet.pdf.

[4] Lindsay M. Hayes, Juvenile Suicide in Confinement: A National Survey, Office of Juvenile Justice and Delinquency Prevention (February 2009).

[5] U.S. Department of Justice, *National Standards to Prevent, Detect, and Respond to Prison Rape* 96 (May 16, 2012), *available at* http://www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf.

[6] Jennie L. Shufelt & Joseph J. Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study* (Nat'l Ctr. for Mental Health & Juvenile Justice, Delmar, N.Y.), June 2006, at 2.

psychosis, and suicide.[7] Similarly, the American Psychiatric Association has stated that "[c]hildren should not be subjected to isolation, which is a form of punishment that is likely to produce lasting psychiatric symptoms."[8]

Finally, the use of isolation undercuts the primary goal of facility administrators and staff who employ it: preserving the safety and security of an institution. A study from the *Archives of Psychiatric Nursing* noted that a majority of researchers who had studied the effect of isolation and restraint on youth concluded that the practices were "detrimental and anxiety producing to children, and can actually have the paradoxical effect of being a negative reinforcer that increases misbehavior."[9] Relying on isolation as a behavior management tool ignores the existence of less restrictive and more effective alternatives to keeping youth and staff safe.

II. Why do some juvenile facility administrators and staff rely heavily on solitary confinement, while others use it rarely or do not use it at all?

Our experiences with secure facilities confirm that the inappropriate and excessive use of solitary confinement of children is widespread. Our experiences also confirm that the misuse of solitary confinement usually stems from a discrete number of problems:

- **Inadequate staff training on effective de-escalation techniques.** In almost every jurisdiction, staff members receive some type of training on techniques for physically managing disruptive or confrontational behavior. However, those training curricula vary widely and are often weighted heavily toward the use physical restraints and holds, not verbal de-escalation and crisis management. Without adequate training, staff lack the skills to respond to situations without resorting to restrictive interventions such as solitary confinement.

- **Policies that do not limit the use of isolation to short periods and situations that immediately threaten the safety of youth or others.** In our experience, staff tend to gravitate toward the most restrictive intervention available to them when confronted with disruptive behavior. When facility administrators do not place clear limits on the use of solitary confinement, staff will often view it as the "go-to" intervention, even for minor misconduct. Once a child is in isolation, staff do not take care to release the child as soon as the child calms down.

- **Insufficient numbers of direct care staff to adequately supervise youth.** In facilities that are overcrowded, or that suffer from staffing shortages (which amounts to the same thing), staff are under enormous pressure to keep the peace at all costs. In such

[7] American Academy of Child and Adolescent Psychiatry, Juvenile Justice Reform Committee, *Solitary Confinement of Juvenile Offenders* (Apr. 2012), available at http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders.

[8] Press Release, American Psychiatric Association, Incarcerated Juveniles Belong in Juvenile Facilities (Feb. 27, 2009), *available at* http://www.psych.org/MainMenu/Newsroom/NewsReleases/2009NewsReleases/IncarceratedJuveniles.aspx.

[9] Wanda K. Mohr et al., *A Restraint on Restraints: The Need to Reconsider the Use of Restrictive Interventions*, 12 ARCHIVES OF PSYCHIATRIC NURSING 95, 103 (1998) (citations omitted).

situations, staff members feel compelled to react immediately with force to minor misbehavior, out of fear that a small disturbance will become more widespread. Moreover, staff often feel that they must isolate youth with the highest needs, such as youth at risk of victimization by other youth and children with mental health disorders, because staff cannot provide them with adequate supervision.

- **Too few qualified mental health professionals to meet youths' needs.** Although youth with mental health needs are overrepresented in secure facilities, many officials and agency administrators do not or cannot employ sufficient numbers of qualified mental health professionals. Without regular access to mental health professionals, children with emotional disorders often deteriorate markedly. This prompts staff to rely on solitary confinement as a response to acting out behavior, which can further exacerbate youths' mental health conditions.

- **A failure to incorporate mental health staff in interventions for youth who present challenging behavior.** Secure juvenile justice facilities should not house children with serious mental health disorders. Those children should be served in mental health facilities that can meet their needs. However, mental health professionals can help craft behavior management programs for youth with less serious mental health needs that may nevertheless make a stay in a secure facility particularly challenging. In our experience, staff and mental health professionals often fail to collaborate in this way.

- **Poorly designed behavioral management programs.** Research shows that acknowledging and rewarding compliance is a more powerful tool to change behavior than the use of sanctions alone. Nevertheless, many facility administrators employ behavior management systems focused solely on punishments. Others rely on systems that do not apply sanctions and rewards in a consistent manner, which undercuts the goal of ensuring compliance with facility rules.

- **Few activities to keep youth busy.** Fights in secure facilities often emerge when youth are bored, and many facilities lack programming beyond television and gym time. Without a range of engaging activities, youth may resort to horseplay and other behavior that can lead them to conflicts and ultimately to solitary confinement.

III. What are the most effective ways of reducing and eliminating the inappropriate and excessive use of solitary confinement of children in secure facilities?

Although many facility administrators and staff rely excessively on isolation of children, certain strategies can dramatically reduce or eliminate its use.

First, staff should receive regular, comprehensive training on effective de-escalation techniques. High quality staff training curricula, such as Safe Crisis Management, focus heavily on topics such as verbal de-escalation of confrontations, crisis intervention, and adolescent development. Trainings such as these are essential to build staff members' skills to manage incidents without resorting to solitary confinement or other restrictive interventions.

Second, officials should place clear limits on the use of solitary confinement of children. Federal regulations governing the use of isolation already exist for psychiatric treatment facilities and "non-medical community-based facilities for children and youth" that receive federal funding.[10] The rules, promulgated by the Department of Health and Human Services under the Children's Health Act of 2000, reflect the consensus of professionals and experts from the medical and mental health care communities. Unfortunately, they do not extend to juvenile detention and correctional facilities, despite the fact that substantial numbers of mentally ill youth are housed in those facilities.

Currently, the most detailed "best practice" standards on isolation in the juvenile justice field are in the Casey Foundation's JDAI standards for juvenile detention facilities.[11] Our staff helped develop the standards in 2006 with colleagues from the Youth Center and with input from experts and practitioners from many jurisdictions. They contain over 300 best practices for juvenile detention facilities. The standards limit the use of isolation as a way of controlling disruptive behavior to situations where a youth is threatening imminent harm to self or others or serious destruction of property, and only so long as is necessary for the threat to pass. If youth receive room confinement as a sanction for violating rules in the facility, the standards limit the sanction to a maximum of three days. They also afford those youth due process protections before they are confined, including notice of the alleged offense, an opportunity to challenge the charge and present their own version of what happened, a written decision with a statement of reasons, and the opportunity to appeal. The JDAI standards for room confinement also ensure that youth continue to receive access to education, programming, medical and mental health care, and other services while in their rooms. Limits such as these are consistent with the clear consensus of national correctional standards, juvenile justice experts, social scientists, and practitioners from leading jurisdictions.

Over 150 jurisdictions participate in JDAI, and many have used or are using the standards to reduce inappropriate and excessive isolation in their facilities. The JDAI standards have also influenced other jurisdictions in their efforts to improve conditions of confinement. For example, Louisiana recently established its first mandatory statewide standards for juvenile detention facilities. In doing so, officials relied heavily on the JDAI standards for guidance, incorporating similar limits on the use of solitary confinement.

Third, officials should devote more resources to increasing the number of direct care staff and qualified mental health professionals. As described above, the use of solitary confinement often stems from situations that could have been prevented through increased supervision and opportunities for treatment.

Finally, officials should ensure that there is independent monitoring of facilities that house youth. Independent monitoring systems are entities that are fully autonomous and that have sufficient authority and resources to investigate and remedy harmful conditions. We have recommended various models of independent monitoring in our work to improve conditions of

[10] 24 C.F.R. §§ 483.352-483.376.

[11] Juvenile Detention Alternatives Initiative, Detention Facility Self-Assessment (2006), *available at* http://www.aecf.org/upload/PublicationFiles/jdai0507.pdf.

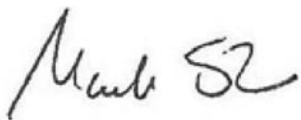
confinement, including independent ombudsmen, state juvenile justice monitoring units, cabinet-level Offices of the Child Advocate, public defenders based inside juvenile facilities, involvement of Protection and Advocacy offices in juvenile justice, and teams of juvenile justice, medical, mental health, and education professionals and representatives of the community.[12] They serve a critical function by identifying safety and security concerns before they become systemic issues, generating critical information for facility managers and agency officials that can guide improvements to service delivery, and providing insights into needed policy and practice changes. For example, as part of JDAI, we conduct comprehensive trainings of local teams of judges, probation officers, prosecutors, public defenders, parents, physicians, nurses, educators, and mental health professionals to inspect their local juvenile detention facilities. The local teams use the JDAI standards described above to assess every area of operations that affects the welfare of confined children. Jurisdictions throughout the country have used this process to help improve a range of conditions of confinement, including reducing the use of solitary confinement.

Conclusion

Unfortunately, the inappropriate and excessive solitary confinement of children is not a new phenomenon. In 1970, a federal judge in New York held that confining a 14-year-old girl in a 6' x 9' room for 24 hours a day for two weeks violated the Eighth Amendment's prohibition on cruel and unusual punishment.[13] More than 40 years later, we are still a long way from eradicating this dangerous and ineffective practice.

We urge the Subcommittee to develop ways to support the interventions described above, which can dramatically reduce the solitary confinement of children. We are ready to assist with your efforts in any way that we can.

Sincerely,



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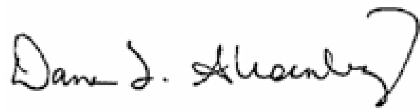
[12] For an overview of models of independent monitoring systems, see Center for Children's Law and Policy, Fact Sheet: Independent Monitoring Systems for Juvenile Facilities (Apr. 9, 2010), *available at* http://www.cclp.org/documents/Conditions/IM.pdf.

[13] *Lollis v. New York State Department of Social Services*, 322 F. Supp. 473 (S.D.N.Y. 1970).



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