

Testimony of Samantha Buckingham

Clinical Professor, Loyola Law School

Co-Director, Juvenile Justice Clinic, Center for Juvenile Law and Policy

I am faculty at Loyola Law School in Los Angeles, California.¹ Through my work at Loyola's Center for Juvenile Law and Policy, I am the co-director of a juvenile justice clinic. Within the clinic, I teach substantive classes on trial skills and juvenile law and I supervise law students representing clients in delinquency proceedings in Los Angeles. In addition, I teach Criminal Procedure and a seminar course on issues in criminal justice. Before joining the faculty at Loyola, I was a trial attorney at the Public Defender Service for the District of Columbia ("PDS"). At PDS, I represented three categories of clients: 1) children charged in delinquency court, 2) children charged as adults with serious and violent felonies, including homicide, and 3) adults charged with serious and violent felonies, including homicide. Prior to becoming a lawyer, I taught high school and ran an after-school volunteer program at the Maya Angelou Public Charter School in Washington, D.C. As a teacher, I worked with many youth who had been adjudicated delinquent and had spent time in juvenile correction facilities.

My testimony will describe how the use of solitary confinement impacted two clients I have represented. These two stories illuminate some of the problems with the use of solitary confinement with vulnerable populations, particularly children, children charged as adults, the mentally ill, those who have previously endured abuse and neglect, and those who are at risk for suicide. My testimony will also propose a framework through which to view the efficacy of solitary confinement and suggest some questions that deserve greater research and attention in the committee's quest to understand the issues related to solitary confinement more fully.

INMATE STORIES

I offer what I know about the experiences of two clients who have been placed in solitary confinement. I share these two stories to provide the committee with a lens through which to view in human terms some of the challenges with the use of solitary confinement in U.S. prisons and jails. The first story belongs to Joan,² a mentally ill, previously abused, female juvenile client held in an adult facility and locked down 23 hours a day, seven days a week, on the basis that it was for her own protection. The

¹ My testimony is offered in a personal capacity and is not a representation of either Loyola Law School or the Center for Juvenile Law and Policy.

² Joan is not her real name. To protect attorney client confidences, I have changed her name. I have purposefully decided to refer to her by a name because I believe that to do so promotes her humanity.

second story belongs to Bob,³ a mentally ill, previously abused, adult male client serving time on a drug distribution charge and held in solitary confinement as punishment.

JOAN'S STORY

Mentally Ill, Previously Abused, Female Juvenile Client held in an Adult Facility and Locked Down 23 hours a day, seven days a week, on the basis that it was for her own protection.

Joan's background:

Joan was abused and neglected in her childhood. Joan was born in extreme poverty to an alcoholic, crack-addicted mother. Joan was addicted to crack at birth and experienced withdrawal in the first breaths of her life. Joan was raised by this same parent, a mother who had struggled due to her own mental health issues, abuse she had suffered, and addictions. Joan was exposed to extreme violence and abuse in her early life. She saw and heard her mother being raped. She saw her mother burned. She saw her mother running naked through the streets in her neighborhood. Early childhood records indicated that Joan came to school without adequate clothing and was hungry. Joan was a child who should have been identified as in need of special education services. At ten years old, Joan was left alone to care for several younger siblings, including one sibling who was developmentally disabled. Joan was left alone and responsible for her siblings for over a week before a parent returned.

Joan had behavior problems in school and was adjudicated delinquent, all before she was thirteen years old. Though Joan had experimented with some substances, she adamantly refused to touch crack because of her experience growing up with a crack addicted mother. Psychologists and psychiatrists who evaluated Joan thought her delinquent acts were a cry for help. In particular, doctors believed that Joan's aggressive acting out directed at women was indicative of Joan's anger towards her mother.

Joan was diagnosed with bi-polar disorder and chronic post traumatic stress disorder ("PTSD").

At fifteen, Joan moved in with her much older boyfriend. In that household, were several adult men, all much older than Joan. At sixteen, Joan was charged with killing of one of those men. There were extenuating circumstances in that case, such as Joan's mental health status, previous inappropriate actions towards Joan by the adult man, and drug use by the adult man shortly before the incident which led to his death.

Joan was arrested and detained. Joan was charged as an adult and held in an adult facility.

The circumstances under which Joan was held:

The facility where Joan was detained had no other juveniles charged as adults. On the basis that it was for Joan's own protection, the correctional facility held Joan in a cell 23 hours a day, seven days a week. Initially, she did not have access to mental health treatment or appropriate education.

³ Bob is not the real name of my client. To protect attorney client confidences, I have changed his name. I have purposefully decided to refer to him by a name because I believe that to do so promotes his humanity.

Through litigation, her conditions of confinement improved, but were never consistent with what would have been afforded her had she been held in a unit with other juveniles.

Joan reported that she felt as though solitary confinement was being used to punish her. She felt that time passed extremely slowly. Joan felt hopeless and scared.

Joan hoarded medication she received and attempted suicide. She also acted out against female corrections officers. The corrections officers who were charged with Joan's care were not specially trained in dealing with juveniles, juveniles charged as adults, or the mentally ill.

Lessons from Joan's story:

- Mentally ill are held in solitary confinement, even when there is no basis to punish them;
- Juveniles are held in solitary confinement as a way to separate them from adults, even when there is no basis to punish them;
- There is no screening process to determine if solitary confinement may have deleterious effects on the individual;
- There is no accommodation for vulnerable individuals, including juveniles and mentally ill;
- The use of solitary confinement with juveniles can impact their access to education;
- The use of solitary confinement with juveniles can communicate to juveniles that they are being punished whether or not punishment is the stated reason for its use;
- Juveniles in solitary confinement may feel like time passes very slowly, more slowly than the passage of time is felt by adults;⁴
- The use of solitary confinement can impact the prisoner's access to mental health services;⁵
- As a matter of policy and in an effort to adhere to sight and sound restrictions that necessitate separation of juveniles and adults in adult facilities,⁶ juveniles may be held in solitary confinement;

⁴ James Austin et al., *Juveniles in Adult Prisons and Jails: A National Assessment* 25 (2000) ("What may be acceptable as punishment for adults may be unacceptable for children. Children have a very different perception of time (five minutes may seem like an eternity), and their capacity to cope with sensory deprivation is limited").

⁵ Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons*, 38 *J Am Acad Psychiatry Law* 104, 104-8 (2010). .

⁶ Juvenile Justice and Delinquency Prevention Act, 42 U.S.C. §5653 (2003) [hereinafter JJDPA] (provides guidelines for incarcerating juveniles in adult jail, including a "sight and sound" restriction that prohibits juveniles from being able to see or hear adult inmates). See *Id.* at §(a)(13). ("no juvenile will be detained or confined in any jail or lockup for adults ... only if such juveniles do not have contact with adult inmates and only if there is in effect in the State policy that requires individuals who work with both such juveniles and adult inmates in collocated facilities have been trained and certified to work with juveniles"). Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Interim Report*, U.N. Doc. A/66/268 (Aug. 5, 2011) [hereinafter *Interim Report*].

- The conditions in solitary confinement can exacerbate mental health symptoms;⁷
- The conditions in solitary confinement can lead to greater incidents of violence;⁸
- The link between solitary confinement and future acts of violence should be further explored;
- Suicide attempts can be a by-product of the conditions in solitary confinement, particularly with vulnerable populations such as juveniles and the mentally ill.⁹

BOB'S STORY

Mentally Ill, Previously Abused Adult Male Client Serving time on a drug distribution charge and held in solitary confinement as punishment.

Bob's Background:

As a child, as young as eight years old, Bob was physically and sexually abused by multiple members of his family. In order to avoid staying with abusers, Bob turned to jumping out of moving car, running away from home, living on the streets, selling drugs to earn money to support himself, and using drugs to escape his reality. Looking back, Bob reflected to me that he was not “living pretty,” but he was “surviving.”

Bob had several juvenile adjudications involving drugs. At eighteen, Bob was convicted of drug distribution and sentenced to federal prison. At the time of his incarceration, Bob had no record of violence.

Bob was diagnosed with depression, schizophrenia (which is characterized by paranoia as well as auditory and / or visual hallucinations), schizoaffective disorder (which is both mania and a mood disorder), and post-traumatic stress disorder (“PTSD”).

While incarcerated for drug distribution, Bob's mental health worsened. Bob experienced his first hallucination at eighteen while serving his sentence. The voices Bob heard communicated messages that were degrading and debasing of Bob, often telling Bob that he should be dead.

While incarcerated, Bob was exposed to violence, was the victim of violence, and acted out violently in the prison environment. Bob witnessed many acts of violence, including seeing other inmates beaten to death right in front of him. Bob was stabbed in the head and back by another inmate. Bob was raped (sodomized) in prison. Bob reported being extremely concerned for his own personal safety, one of the

⁷ *Interim Report, supra* note 6, at 15-17.

⁸ *See id.* (parenthetical after signal like “See”)

⁹ *See id.*; Metzner, *supra* note 5, at 2; *See Austin, supra* note 4, at 7-8 (“Research has shown that juveniles in adult facilities are at much greater risk of harm than youth housed in adult facilities. The suicide rate for juveniles held in jails is five times the rate in the general youth population and eight times the rate for adolescents in juvenile detention facilities”) (citation omitted). *See also* Joshua T. Rose, *Innocence Lost: The Detrimental Effect of Automatic Waiver Statutes On Juvenile Justice*, 41 BRANDEIS L. J. 977, 993 (2003) (“juveniles adjudicated in the adult system . . . are more likely to suffer the terrible consequences of being incarcerated in adult facilities”).

hallmarks of individuals who suffer from PTSD. Bob reported that it was out of concern for his own safety that Bob himself acted out violently in prison. Bob was punished with solitary confinement. Bob's first of several suicide attempts occurred in solitary confinement. Bob ingested cleaning fluid he had requested under the guise of cleaning his cell along with medication he had been hoarding. Bob passed out and hit his head on the toilet, sustaining an injury. He was hospitalized.

During the course of his incarceration, Bob spent several stints in solitary confinement. Bob attempted suicide several times. While in prison, though Bob received medication, Bob did not receive treatment for his PTSD, history of sexual abuse, history of physical abuse, mental illness, and the neglect he suffered as a child.

After spending greater than a decade incarcerated on drug distribution, Bob was released from prison and turned once again to street drugs to cope with a very scary reality. Bob recounted that he felt unprepared to live in the outside world. Within a few years, Bob was arrested for, and ultimately convicted of, a homicide.

Lessons from Bob's story:

- Mentally ill are held in solitary confinement as a form of punishment;¹⁰
- There is no screening process to determine if solitary confinement may have deleterious effects on the individual;
- There is no accommodation for vulnerable individuals, including mentally ill;
- The use of solitary confinement can impact the prisoner's access to mental health services;¹¹
- The conditions in solitary confinement can exacerbate mental health symptoms;¹²
- The conditions in solitary confinement can lead to greater incidents of violence;¹³
- The link between solitary confinement and future acts of violence should be further explored;
- Suicide attempts can be a by-product of the conditions in solitary confinement, particularly with vulnerable populations such as the mentally ill.¹⁴

RECOMMENDATIONS

Framework:

In assessing the effectiveness of solitary confinement, the committee might consider the following:

- I. What are the goals of the use of solitary confinement?
 - a. Are these goals broad? For instance, to reduce violence in society generally.
 - b. Are these goals specific? For instance, to reduce violence on one particular cell block?
- II. How well are the goals achieved?

¹⁰ See Interim Report, *supra* note 6, at 12-13.

¹¹ See Metzner, *supra* note 5, at 2.

¹² See Interim Report, *supra* note 6, at 18 and 26-27.

¹³ See *id.*

¹⁴ See *id.*; see Metzner, *supra* note 5, at 2.

- a. How well are the goals achieved as measured by the fiscal expense?
- b. How well are those goals achieved as measured in human success, such as having prisoners behave in a manner in which society expects outside the walls of prison? Outcomes here may be viewed in the long-term, both by those subjected to solitary confinement and by all prisoners who are aware of its use and effects.
- c. Are there other more effective measures?

When stopping to ask what the goal is in implementing solitary confinement, the committee may find, for instance, that the goal of protecting vulnerable individuals, such as juveniles, may not be as legitimate a goal as the removal of violent offenders from the general prison population.

As for solitary confinement's efficacy specifically as a punishment, the committee should consider whether any of the five over-arching justifications for punishment are furthered by its use. They are:

- 1) rehabilitation,
- 2) deterrence (both *general deterrence* to the wider prisoner community and *specific deterrence* to that particular prisoner who is being held in solitary confinement),
- 3) incapacitation,
- 4) retribution (which, at first blush, seems to have less force in the prison context than in society), and
- 5) restitution (which seems wholly inapplicable given the inability of prisoners in solitary confinement to repay any debts).

It seems the strongest argument for the use of solitary confinement can be made for incapacitation; the separation of those who are the most dangerous and volatile from the remainder of the prison population in the short-term may reduce the violence those removed and isolated prisoners may have committed against others in the prison. It may be impossible to predict the future violent acts that may have happened if the prisoner remained in general population. However, if solitary confinement only exacerbates, rather than resolves, the instances of violence that may have led to a prisoner's solitary confinement in the first place, then the overall goal to reduce violence may not be effectively achieved by the use of solitary confinement. I would urge the committee to balance long-term rehabilitation goals with short-term incapacitation goals. If a solution is effective in the short-term, but exacerbates the problem when taking a long view, then its efficacy overall, measured in both fiscal and human cost, is severely undermined.

Suggested Areas To Gather Research:

- What steps are taken to address a problem prior to the implementation of solitary confinement? Is there a graduated approach? How is solitary confinement determined as an intervention tool in each instance of its use?
- Who decides to implement solitary confinement? Is it a corrections officer? Does this person have any specialized training? Is that training sufficient?

- Is a prisoner's mental health a factor in determining whether solitary confinement will be appropriate and effective at achieving the desired end?
- If solitary confinement is used in prisons, should those corrections officers responsible for its implementation have specialized training in mental health, dealing with the mentally ill, and dealing with the types of problems presenting in those prisoners who are exposed to solitary confinement in that facility?
- How can a prisoner's experience in solitary confinement be monitored effectively, in particular for mentally ill?¹⁵
- What is the link between solitary confinement and future acts of violence?
- Is solitary confinement justifiable for use on prisoners who are serving sentences which will allow them to return to our community?

CONCLUSION

I urge the committee not to lose sight of the individuals who are directly impacted by the use of solitary confinement. As I hope the two stories I relayed demonstrate, the individuals who find themselves in solitary confinement have a past and a future. Their pasts may make them more vulnerable and susceptible to the damaging psychological impacts of solitary confinement. Their futures, and the lives of all those with whom they interact, may be negatively impacted by the use of solitary confinement to the extent that it exacerbates violence, propensity for self-harm, and general mental health conditions. I urge the committee to keep the long-term impact of the use of solitary confinement in their calculus.

The committee should examine further the use of solitary confinement with vulnerable populations, particularly children, children charged as adults, the mentally ill, those who have previously endured abuse and neglect, and those who are at risk for suicide. The committee should limit the use of solitary confinement with these populations.

The committee should also endeavor to learn more about the development of any screening processes to determine who may be subjected to solitary confinement, the individuals who decide which prisoners to subject to solitary confinement, how those decision-makers are trained for this task, and how prisoners subjected to solitary confinement are monitored, especially their mental health.

¹⁵ Often video monitors are used and mental health professionals conduct rounds without actually interacting with the prisoners in solitary confinement. See Metzner, *supra* note 5, at 2 (internal citations omitted).