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1. *EXPERT REPORT OF STUART GRASSIAN, M.D. , 2018 MISC. FILINGS LEXIS 7936*

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EXPERT REPORT OF STUART GRASSIAN, M.D. , 2018 MISC. FILINGS LEXIS 7936

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF IOWA

Case No. 4:17-cv-00417

April 20, 2018

Reporter
2018 MISC. FILINGS LEXIS 7936 *

C.P.X., et al. v. Foxhoven, et al.

Expert Name: ***Stuart*** ***Grassian*** , M.D.

Text

[*1] Psychiatric Report of ***Stuart*** ***Grassian***, M.D.

I. Qualifications.

I am a Board-certified psychiatrist, licensed to practice medicine in the Commonwealth of Massachusetts. My professional experience as a psychiatrist has spanned nearly forty years.

During the course of my professional career, I have had extensive experience in evaluating individuals who have been subjected to stringent conditions of confinement, a very large percentage of whom had pre-existing neuropsychiatric vulnerabilities or overt psychiatric illness. I have evaluated several hundred inmates who were experiencing, or had in the past experienced, confinement in solitary. Included in this are many adolescents who were confined in juvenile detention facilities in conditions that are virtually identical--and in some instances worse--than those experienced in solitary confinement in adult prisons.

I have also described the high incidence of psychiatric disorders among those so housed, and the particular vulnerability of both juveniles and those with pre-existing psychiatric disorders to the destructive effects of such confinement.

In addition to my experience with juvenile detention facilities, I also have **[*2]** extensive clinical experience in evaluating and treating adolescents with behavioral problems associated with delinquency, substance abuse, and psychiatric illness (especially Attention Deficit Hyperactivity Disorder and Bipolar Mood Disorder). My clinical involvement with these juveniles has generally been in psychiatric inpatient settings, inpatient and outpatient addictions treatment programs, and in individual or family outpatient treatment. I have served as Director or Clinical Director on two inpatient units serving adolescents and adults.

It might be thought that juveniles seen in a psychiatric inpatient setting represent a very different population than that seen in a juvenile detention facility. That, however, is quite often not the case. In my professional experience, I have come to recognize that it is often almost a matter of chance as to whether a behaviorally disruptive or delinquent adolescent will be placed in the correctional system, or whether he will be referred for psychiatric hospitalization. In a number of cases I have treated juveniles who seemed to bounce back and forth between psychiatric hospitals and juvenile detention facilities. This is not difficult **[*3]** to understand; these adolescents almost invariably have some combination of severe problems with impulse control--impulsivity, emotional volatility, explosive anger--and for many or most, addictive behavior and/or bipolar mood disorder and/or Posttraumatic Stress Disorder from childhood abuse and violence. Many seemed to be dedicated to fight against any assertion of authority, and many had committed acts of violence. While there is a spectrum of presentations among those in juvenile detention and those in a psychiatric hospital, there is a great deal of overlap.

I have given lectures and seminars regarding these issues. They include, but are not limited to, lectures at Harvard Medical School, Harvard Law School, meetings of the Nova Scotia, Virginia and New York State Bar Associations, the Office of Military Commissions of the U.S. Department of Defense, The Federal Capital Defenders Habeas Unit and the Correctional Association of New York, as well as invited testimony before state legislative hearings in New York, Massachusetts and Maine.

I have been retained as an expert in class-action investigations and lawsuits regarding these issues in Massachusetts (2), New Jersey, New **[*4]** York (3), California (2), Kentucky, Michigan, Ohio (2), Pennsylvania, Texas and Florida, as well as individual cases in other states, including Arizona, California, Connecticut, Florida, Georgia, Kansas, Kentucky, Illinois, Louisiana, Maine, Massachusetts, Mississippi, New Mexico, New York, Oregon, Pennsylvania, Tennessee, Texas, Vermont, Virginia, and the State of Washington.

I have been retained and consulted by a variety of governmental agencies and public advocacy groups, including The Legal Aid Society of New York, Prisoner's Legal Services of New York, the Correctional Association of New York, the New York Justice Center, the Center for Constitutional Rights, the Massachusetts Correctional Legal Services, the Massachusetts Civil Liberties Union, the National Prison Project of the American Civil Liberties Union, the Department of Corrections of the State of Florida, and various religious organizations.

My observations and conclusions generally regarding this population and the psychiatric effects of solitary confinement have been cited in a number of federal court decisions, for example: *Davenport v. DeRobertis, 844 F.2d 1310, 1316 (7th Cir. 1988)*, *Coleman v. Wilson, 912 F. Supp. 1282 (E.D. Cal. 1995)* (aff'd sub nom *Brown v. Plata, 131 S. Ct. 1910 (2011))*, and *Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995)*.

I prepared a written declaration for Madrid describing **[*5]** the medical literature and historical experience concerning the psychiatric effects of restricted and isolated conditions of confinement as well as of other conditions of restricted environmental and social stimulation, and subsequently prepared the general (non-institution specific) and non-redacted (non-inmate specific) portions of that declaration into a general statement, which I have entitled Psychiatric Effects of Solitary Confinement, *22 Wash. U. J. L. & Pol'y 325 (2006)*, which is attached hereto as Appendix A and incorporated herein. It describes the extensive body of literature, including clinical and experimental literature, regarding the effects of decreased environmental and social stimulation, and more specifically, observations concerning the effects of segregated confinement on prisoners.

A copy of my curriculum vitae, which summarizes my qualifications and professional experience, including a listing of my testimony over the past four years, is attached as Appendix B to this report.

II. Engagement in the Present Matter.

In the present matter, I was asked to provide expert opinion regarding the care of the adolescents at the Iowa Boys State Training School ("BSTS" **[*6]** or the "School"), with special reference to the School's use of solitary confinement and psychotropic medications. For this purpose, I reviewed a number of documents. In addition, I also reviewed the BSTS records of all four of the named plaintiffs in this case--CPX, GRX, JSX, and KNX (inclusive of current and former named plaintiffs). [1] I also interviewed CPX, JSX, and KNX.

A list of the documents I considered in forming my opinions is attached as Appendix C. I considered also my interviews of the named plaintiffs in forming my opinions. I reserve the right to supplement this report.

My professional fee for this work is $ 500/hour. My fees are not contingent on the outcome of this matter or on the opinions provided therein.

III. Solitary Confinement.

[1] I understand that GRX is no longer a named plaintiff in this case.

Although the BSTS apparently denies that it employs conditions of confinement that amount to solitary confinement, the reality is that it actually employs solitary confinement extensively.

Solitary confinement is generally defined as the housing of an individual alone in a relatively small cell (usually in the range of 80-100 square feet) with minimal opportunity **[*7]** for social, perceptual and occupational stimulation. Generally:

(a) The inmate is allowed out to exercise one, or upwards of two hours a day.

(b) Outdoor exercise is generally alone, usually in a small area enclosed by concrete walls or chain link fencing.

(c) If more than one inmate is allowed out at the same time, inmates can speak with each other through the chain link fencing.

(d) In inclement weather, exercise is indoors, and generally there is some minimal opportunity for large muscle and aerobic exercising.

(e) The walls, floor and ceiling of such cells generally are of cement and concrete.

(f) The cell usually contains a sink and toilet (most often a stainless steel sink and toilet combination) and a platform (either a concrete slab or a metal frame) on which is placed a relatively thin mattress.

(g) There is usually a narrow window looking out onto the outside world.

(h) In particularly harsh conditions of confinement, either there is no window or the window is frosted/painted or otherwise altered so that the inmate cannot see through the window.

(i) The door to the cell is typically a solid steel door on a sliding track and typically contains a **[*8]** horizontal slot in which food may be passed and hands shackled, and a second small window facing onto the tier.

(j) The food slot is typically closed and opened with a latch outside the cell, and in particularly harsh conditions of confinement, the window facing the tier may also have a cover that can be latched from outside the cell.

(k) There is often, but not always, a stainless steel shelf/small desk that is bolted to the wall, and a stool or other place to sit by the shelf/desk.

(l) Other than the thin mattress, pillow and bedding, which are almost always provided, items allowed in the cell vary.

(m) Inmates confined to such cells generally are allowed some legal material and a limited amount of other reading material in their cell. Television and/or radio and/or personal devices (e.g. video games, iPods, etc.) may or may not be allowed, though the number of stations available is generally limited.

(n) Almost always paper, a writing instrument, envelopes and stamps are permitted.

(o) Other personal items (e.g. clothing, photographs and so on) may or may not be allowed.

In short, solitary confinement imposes harsh and sterile conditions which provide exceedingly **[*9]** little stimulation or opportunity for productive engagement. It also imposes perceptual deprivation, [2] forced idleness and social isolation.

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[2] The term "sensory deprivation" has sometimes been used to describe the perceptual deprivation associated with such conditions, but that term is actually a misnomer. What is lacking in solitary is not the absence of all stimulation, but rather the lack of meaningful, anchoring, stimulation. The stimulation of, for example, steel doors banging and inmates yelling does not ameliorate the effects of environmental deprivation, nor does the brief interactions through the cell door with staff making rounds or providing meal trays. Indeed, noxious stimulation has been shown to worsen the effects of perceptual deprivation. For

Not surprisingly, inmates exposed to such conditions experience such confinement as punitive, **[*10]** cruel, and even sadistic. The use of solitary confinement will inevitably increase the inmate's sense of powerlessness, fear, paranoia, and will create intense mutual hostility between staff and inmate. As described in section VII of my report, at BSTS, these effects are exacerbated by the use of "the wrap"--a fourteen-point restraint system that crushes both body and spirit.

IV. Psychiatric Effects of Solitary Confinement, Generally.

In addition to the powerlessness, fear, and anger that solitary confinement will inevitably cause, there are particular psychiatric consequences to its use. It has indeed long been known that the severe restriction of environmental and social stimulation has a profoundly deleterious effect on mental functioning. This issue has, for example, been a major concern for many groups of patients including, for example, patients in intensive care units, spinal patients immobilized by the need for prolonged traction, and patients with impairment of their sensory apparatus (such as eye-patched or hearing-impaired patients). This issue has also been a very significant concern in military situations, polar and submarine expeditions, and in preparations for **[*11]** space travel.

With respect to segregated confinement, the United States was actually the world leader in introducing prolonged incarceration--and solitary confinement--as a means of dealing with criminal behavior. The "penitentiary system" began in the United States in the early nineteenth century, a product of a spirit of great social optimism over the possibility of rehabilitation of individuals with socially deviant behavior. This system, originally embodied in the "Philadelphia System," involved almost an exclusive reliance upon segregated confinement as a means of incarceration. It also became the predominant mode of incarceration--both for post-conviction and also for pretrial detainees--in several European prison systems emulating the American model at the time.

The results were catastrophic. The incidence of mental disturbances among prisoners so detained, and the severity of such disturbances, was so great that the system fell into disfavor and was ultimately abandoned. During this process, a major body of clinical literature developed which documented the severe psychiatric disturbances created by such stringent conditions of confinement. The paradigmatic disturbance **[*12]** was an agitated, confused state, which, in more severe cases, had the characteristics of a florid delirium, characterized by severe confusion, paranoia, and hallucinatory features, and also by intense agitation.

The psychiatric harm caused by solitary confinement became exceedingly apparent. By 1890, in *In re Medley, 134 U.S. 160, 167-68 (1890)*, the United States Supreme Court expressly recognized the massive psychiatric harm caused by solitary confinement:

This matter of solitary confinement is not . . . a mere unimportant regulation as to the safe-keeping of the prisoner . . .[E]xperience [with the penitentiary system of solitary confinement] demonstrated that there were serious objections to it. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.

The consequences of the Supreme Court's holding were quite dramatic for the petitioner, Mr. Medley, who had been convicted **[*13]** of having murdered his wife. Under the statute in force at the time of the murder, he would have been executed by hanging after about one additional month of incarceration in the county jail. But in the interim between the crime and his trial, the Colorado legislature had passed a new statute that called for the convicted murderer to be, instead, incarcerated in solitary confinement in the new Colorado State Penitentiary during the month or so prior to being hung. Mr. Medley's attorneys argued that punishment under this new law was so substantially more burdensome than punishment under the old law as to constitute a violation of the ex post facto clause of the United States Constitution. The Supreme Court agreed with them, even though it simultaneously

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example, in various interrogation situations, such as that used by the British in interrogating suspected IRA members, and that used by the United States military and CIA in interrogation at Guantanamo, noxious stimulation--especially high decibel noise--was intentionally used to worsen the psychiatric effects of solitary confinement.

recognized that if Mr. Medley was not sentenced under the new law, he could not be sentenced at all, since the old law was rescinded when the new law was passed. Despite this, the Supreme Court held that, added to a sentence of death on the gallows, this additional punishment of one month of solitary confinement was simply too egregious to ignore; the Supreme Court declared Mr. Medley a free man and ordered his release from prison. **[*14]**

Dramatic concerns about the profound psychiatric effects of such conditions of isolated confinement continued into the 20th century, both in the medical literature, and in the news. The alarm raised about the "brainwashing" of political prisoners of the Soviet Union, Communist China, and especially of American prisoners of war during the Korean War gave rise to a major body of medical and scientific literature concerning the effects of sensory deprivation and social isolation, including a substantial body of experimental research. It is troubling that this history is often overlooked by those who freely employ segregated confinement today. This history and literature, as well as my own experience and observations, have demonstrated conclusively that, when deprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment. Even a few days of solitary confinement will predictably shift the electroencephalogram ("EEG") pattern towards an abnormal pattern characteristic of stupor and delirium. [3]

This fact is not surprising. Most individuals have at one time or another experienced, at least briefly, the effects of intense monotony and inadequate environmental stimulation. After even a relatively brief period of time in such a situation, an individual is likely to descend into a mental torpor, or a "fog," in which alertness, attention, and concentration all become impaired. In such a state, after a time, the individual becomes increasingly incapable of processing external stimuli, and often becomes "hyper-responsive" to such stimulation. For example, a sudden noise or the flashing of a light jars the individual and becomes intensely unpleasant. Over time, the very absence of stimulation causes whatever stimulation is available to become noxious and irritating.

An adequate state of responsiveness to the environment requires both the ability to achieve and maintain an attentional set--to focus attention--and the ability to shift attention. The impairment of alertness and concentration in solitary confinement leads to two related abnormalities:

. The inability to focus, to achieve and maintain attention, is experienced as a dissociative **[*16]** stupor. It is like a mental "fog" in which the individual cannot focus attention. The individual cannot, for example, grasp or recall when he attempts to read or to think.

. The inability to shift attention results in a kind of "tunnel vision" in which the individual's attention becomes stuck almost always on something intensely unpleasant. He cannot stop thinking about that matter and becomes obsessively fixated upon it. These obsessional preoccupations are especially troubling. Individuals in solitary easily become preoccupied with some thought, some perceived slight or irritation, a perceived injustice, tortured by it, unable to stop dwelling on it. In solitary confinement, ordinary stimuli become intensely unpleasant, and small irritations become the focus of paranoid rage. Individuals in such confinement brood upon normally unimportant stimuli, and minor irritations become the focus of increasing agitation and paranoia. Random, chaotic and impulsive violence often results. This violence can be self-directed (cutting, head-banging, suicide attempts), or directed outward (assaults, destruction of property, smearing of feces, and so forth).

Somatic preoccupations are common. **[*17]** For example, an inmate becomes obsessively preoccupied with some minor, almost imperceptible bodily sensation, a sensation that grows over time into a worry, and finally into an all-consuming, life-threatening illness. This can also happen with a bodily function. I once evaluated an inmate who became obsessed with the feeling that he could not empty his bladder fully, and this preoccupation became an all-consuming agony such that he would stand over the toilet literally for hours on end. The inmate would try anything to relieve the feeling, including drinking excessively to "wash it through" or not drink at all to "dry it out." Of course, none of that worked. It was truly an agony for him.

In summary, the psychopathological effect of solitary confinement has several typical features: [4]

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[3] ***Stuart Grassian***, Psychiatric Effects of Solitary Confinement, *22 Wash. **[*15]** U. J. L. & Pol'y 325, 331 (2006)*.

1. Perceptual distortions, illusions and hallucinations in multiple spheres (visual, auditory, olfactory, somatosensory, etc.); [5]

2. Affective disturbances--especially intense anxiety and panic attacks;

3. Difficulties with thinking, concentration and memory, at times resulting in overt confusional states;

4. Obsessive, intrusive thoughts, at times accompanied by compulsive behaviors; and

5. Impulsive, chaotic violence, either self-directed or directed outward.

There are, of course, substantial differences in the effects of solitary confinement upon different individuals. Some descend deeper into a mental fog, and those most severely affected may develop states of florid psychotic delirium, marked by severe hallucinatory confusion, disorientation, and even incoherence.

Individuals who are less severely affected will still experience substantial psychiatric harm: difficulties with thinking and concentration, intense anxiety, agitation, irritability, paranoia, hostility and random violence, obsessional thinking, difficulty tolerating external stimuli, and so forth. Some become obsessively fixated on their conditions of **[*19]** confinement or upon the rage they feel at what they perceive to be intentional cruelties and injustices.

V. The Particular Vulnerability of Juveniles in Solitary Confinement.

Solitary confinement of juveniles causes far greater harm than it does for adults, and the risks to juveniles of solitary confinement are alarming. Research on adolescent development makes clear why juvenile solitary confinement is uniquely harmful.

Isolated confinement challenges any individual's capacity to maintain alertness and attentional set, as well as his capacity to control his emotional reactions and impulses. Juveniles have a particular vulnerability in this regard, especially so because a high proportion of those who end up in juvenile detention have such disorders, and, moreover, have also suffered traumatic childhood experiences that have further impaired their capacity to modulate affect and control impulsive behavior. But more centrally, adolescence itself is indeed marked by intense emotional reactivity and poor impulse control.

New technologies in brain research have allowed us to recognize and observe brain plasticity, recognizing that brain function and neural connectedness are **[*20]** still evolving and developing during adolescence. This is especially true in regard to the functioning of the prefrontal cortex--that part of the brain most centrally involved in inhibiting emotional reactivity, allowing mastery over the emotional reactivity of the subcortical amygdala and nucleus accumbens--the brain's more primitive emotional centers.

Brain research, both human and animal studies, has amassed a clear picture of this process, [6] and there is clear evidence that this process of brain development can be derailed by stress. The effects of stress on adolescent brain development have been described in detail, [7] and there is by now a substantial body of research describing the

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[4] See ***Stuart Grassian***, Psychopathological Effects of Solitary Confinement, 140 AM. J. PSYCHIATRY 1450-54 (1981).

[5] Note that in the more typical psychiatric disorders, one sees generally only auditory hallucinations of voices. Visual hallucinations are uncommon, and when **[*18]** they do occur, they are generally of life-sized people who are the authors of the auditory hallucinations. Hallucinations in other sensory modalities are virtually non-existent.

[6] See, e.g., B.J. Casey, Rebecca M. Jones, & Todd A. Hare, The Adolescent Brain, 1124 ANN. N.Y. ACAD. SCI. 111-126 (2008); Monique Ernst & Sven C. Mueller, The Adolescent Brain: Insight from Functional Neuroimaging Research 68 DEV. NEUROBIOLOGY 729-743 (2008).

[7] See, e.g., Nim Tottenham & Adriana Galvan, Stress and the Adolescent Brain: Amygdala-Prefrontal Cortex Circuitry and Ventral Striatum as Developmental Targets, 70 NEUROSCI. & BIOBEHAVIORAL REVS., 217-227 (2016).

severe lasting effects of stress **[*21]** on the human brain, and the particular vulnerability of juveniles to such effects. [8]

There has also been a large body of research using animal models, [9] demonstrating long-term consequences of chronic, unpredictable stress. The research has demonstrated that the brain's reaction to stress, the surge of cortisol (the stress hormone) modulated through the brain's hypothalamic-pituitary-axis, is massively affected in adolescents who have experienced chronic stress.

Research further demonstrates that acute stress impairs the juvenile's ability to maintain goal-directed, as opposed to emotion-driven, behavior. [10] Functional brain studies have provided evidence that, while adults are able to engage prefrontal cortical mechanisms to inhibit behavior that is likely to have adverse consequences, adolescents are unable to do so. [11] These consequences--including actual morphological changes in brain structure--have been demonstrated to persist into adulthood. [12]

The very act of placing a juvenile in isolation--the utter helplessness of it--is enormously stressful. This surge of cortisol--of fear, anxiety, and agitation--will be especially severe in juveniles.

The brain research has yielded very clear and consistent results. As noted in an amicus brief to the United States Supreme Court **[*23]** "each key characteristic of solitary confinement--lack of physical activity, meaningful interaction with other people and the natural world, visual stimulation and touch--is by itself sufficient to change the brain and to change it dramatically." [13] As brain researchers have noted, especially in juveniles, factors like stress and depression can literally shrivel areas of the brain, including the hippocampus--the region of the brain involved in memory, spatial orientation and the control of emotions--a burden that may well become permanent.

In a review article, [14] Dr. Laurence Steinberg notes that studies of adolescents in Juvenile Detention institutions likewise provide evidence that placing disturbed youth in solitary confinement is both counterproductive and dangerous, and that such conditions are highly likely to create psychological disturbance, stunt emotional and cognitive growth, and impair the development of psychosocial maturity.

Placing a juvenile in solitary will have severe, and possibly lethal, consequences. In a 2012 **[*24]** law review article, [15] Attorney Sandra Simkins provides a review of pertinent literature in this area. Moreover, studies

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[8] For a detailed discussion and bibliography, see, e.g., J. Douglas Bremner, Traumatic Stress: Effects on the Brain, 8 DIALOGUES CLINICAL NEUROSCI. 445-461 (2006).

[9] The harm caused animals by experimentation involving social isolation has in fact led to restrictions of such experimentation by academic review boards. For example, Columbia University has passed rules severely restricting the housing of experimental animals alone in cages.

[10] See, e.g., Franziska Plessow et al., The Stressed Prefrontal Cortex and Goal-directed Behaviour: Acute Psychosocial Stress Impairs the Flexible **[*22]** Implementation of Task Goals, 216 EXPERIMENTAL BRAIN RES. 397-408 (2012).

[11] Jessica P. Uy & Adriana Galvan, Acute Stress Increases Risky Behavior and Dampens Prefrontal Activation Among Adolescent Boys, 146 J. NEUROIMAGE 679 (2016) (available at http//dx.doi.org/10.1016/j.neuroimge.2016.08.067).

[12] See, e.g., Fiona Hollis et al., The Consequences of Adolescent Chronic Exposure to Unpredictable Stress on Brain and Behavior, 249 J. NEUROSCI. 232 (2012) (available at *http://dx.doi.org/10.1016/j.neuroscience.2012.09.018*); Tottenham & Galvan, supra note 7, at 217-227.

[13] *Brief of Medical and Other Scientific and Health-Related Professionals as Amici Curiae in Support of Respondents and Affirmance, Ziglar v. Abbasi, 137 S. Ct. 1843 (2017)* (Nos. 15-1358, 15-1359, and 15-1363), 2016 WL 7450491, at *25.

[14] Laurence Steinberg, Adolescent Development and Juvenile Justice, 5 ANN. REV. CLINICAL PSYCHOL. 459-485 (2009).

[15] Sandra Simkins, et al., The Harmful Use of Isolation in Juvenile Facilities: The Need for Post-Disposition Representation, *38 WASH. U. J. L. & POL'Y 241-287 (2012)*.

conducted by the U.S. Department of Justice have concluded that over 50% of all suicides in juvenile detention facilities occur among juveniles confined in isolation, and 62% of those who suicided had been in isolation at some point during their detention. Moreover, a high percentage of the youngsters who suicided in isolation had histories of trauma and abuse (66% of those who committed suicide had such histories, and most were suffering with mental illness during their final days in isolation) and/or substance abuse disorders (approximately 73% of the juvenile suicide victims.) [16]

VI. The Particular Vulnerability of Youth with Mental Health Problems.

The great majority of juveniles in detention have histories of traumatic childhoods, with studies **[*25]** demonstrating that over 90% of youths in juvenile detention have been exposed to traumatic events prior to detention. [17] Moreover, multiple studies have demonstrated that there is a very high incidence of substance abuse disorders, cognitive impairment and/or serious mental illness--Posttraumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and various forms of Bipolar Mood Disorders. [18]

All four of the named plaintiffs whose records I reviewed in this case demonstrate this reality. Not only is the incidence of mental disorders and of traumatic childhood experiences significantly greater among juveniles **[*26]** in detention than those of juveniles in the community, but those in solitary confinement have an even higher incidence of such burdens and mental disorders than seen among those confined in the general population of a detention facility.

In a recent and quite comprehensive review of the literature regarding the particular vulnerabilities of juveniles in detention, and the need to provide a different paradigm for management of juveniles who commit antisocial acts, [19] the authors describe the unique challenges of working with juveniles in confinement. Specifically, they address the ways in which the combination of their traumatic pasts and their still developing brain functions requires a very different understanding and approach to their occasionally disruptive behavior. For example, what might be labeled as willful aggressive defiance may actually be a defensive, fearful reaction to perceived threat:

Youth in juvenile justice settings ... often have histories of complex trauma:

... including polyvictimization, life-threatening accidents or disasters, and interpersonal losses. Complex trauma adversely affects early childhood biopsychosocial development and attachment bonding, **[*27]** placing the youth at risk for a range of serious problems (e.g., depression, anxiety, oppositional defiance, risk taking, substance abuse) that may lead to reactive aggression. Complex trauma is associated with an extremely problematic combination of persistently diminished adaptive arousal reactions, episodic maladaptive hyperarousal, impaired information processing and impulse control, self-critical and aggression-endorsing cognitive schemas, and peer relationships that model and reinforce disinhibited reactions, maladaptive ways of thinking, and aggressive, antisocial and delinquent behaviors.

The authors go on to discuss the parameters of treatment that disturbed and disruptive juveniles need in order to help quiet their emotional and behavioral dyscontrol, and to overcome maladaptive ways of thinking. These include adequate assessment, milieu management and group and individual psychological treatment--effectively, a

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[16] LINDSAY M. HAYES, U.S. DEP'T OF JUSTICE, OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY 5 (2009).

[17] Carly B. Dierkhising, et al., Trauma histories among justice-involved youth: findings from the National Child Traumatic Stress Network, 4: 20274 EUR. J. PSYCHOTRAUMATOLOGY 6 (2013) (available at *http://dx.doi.org/10.3402/ejpt.v4i0.20274*).

[18] These two diagnoses in fact have much in common; indeed, approximately 95% of individuals with BMD meet criteria for the diagnosis of ADHD. See, e.g., Janet Wozniak et al., Mania-like Symptoms Suggestive of Childhood-onset Bipolar Disorder in Clinically Referred Children, 34 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 867-876 (1995).

[19] Julian D. Ford et al., Complex Trauma and Aggression in Secure Juvenile Justice Settings, 39 CRIM. JUST. & BEHAV. 694-725 (2012).

psychiatric, rather than a punitive approach to disruptive and aggressive behavior of juveniles in detention. This is almost precisely the opposite paradigm from what is observed at BSTS.

In my own professional experience, involving interviews and evaluations **[*28]** of scores of juveniles confined in detention, I have found that juveniles in detention have great difficulty in managing their behavior, especially under stressful conditions. Their disruptive behavior is not governed by a rational calculation of its likely consequences, but rather by impulsive reaction to explosive emotions. When placed in detention facilities, many are likely to commit disciplinary infractions, and are especially likely to be placed into solitary confinement. Yet such individuals are precisely the group least capable of tolerating the stresses and the perceptual, occupational, and social deprivations of solitary confinement. Juveniles generally, and those who commit infractions while in juvenile detention, are exquisitely vulnerable to psychiatric and behavioral decompensation when housed in solitary confinement. They are especially likely to become even more behaviorally out of control, leading to more and more time in solitary. For such individuals, increasing the stress and deprivation with which they live is not likely to improve behavior; it is instead extremely likely to make it worse.

The psychiatric paradigm is based upon a much deeper understanding of **[*29]** emotion, emotional volatility and impulsivity, and how those factors push behavior into a disruptive and self-destructive place. This is the basic reason that so many juveniles whose emotional state and behavior deteriorate so greatly in detention that they are psychiatrically hospitalized do so well in the hospital--only then to be returned to an environment that once again produces deterioration and chaos.

VII. The Conditions of Confinement at the Iowa Boys' State Training School and Their Effects.

As is true generally of juvenile detention facilities, the legal mission of BSTS is not one of punishment, but rather one of education and rehabilitation--to foster growth, address the mental health and educational needs, and to promote the development of prosocial attitudes and behaviors among the juveniles consigned to its care.

The named plaintiffs' records I reviewed, the named plaintiffs I interviewed, the policies and procedures, and the staffing pattern of BSTS reveal that BSTS fails to address that mission. Indeed, it promotes the opposite: there has been limited psychological counseling and no licensed mental health therapist at BSTS. There is no expectation that anyone **[*30]** will sit down with a juvenile who has engaged in any disruptive or disrespectful act in order to empathize with the juvenile's feelings and then help the juvenile understand the dysfunctional and self-destructive nature of his response to those feelings. And there is no evidence in the records or from the named plaintiffs whom I interviewed that any such effort is actually made. For example, in my interview with JSX, and from a review of his records, JSX made it quite clear how enraged he was at the lack of psychotherapy at BSTS--at what he perceived as the gross injustice of the place.

Based on the records I reviewed, BSTS has provided virtually no individual psychotherapy. It has also provided only limited family engagement. The families of youth at BSTS have rarely been consulted before medications were prescribed. There has been no meaningful discussion and consent involved. Juveniles signed a form stating that they have been informed and are aware of the potential risks and benefits of the medications they are prescribed, and that they consent, but it is a meaningless form. The form generally does not specify which medications are being referred to, and a new form is not always **[*31]** signed when new medications are prescribed. Moreover, the notion that the juvenile consents to receiving the medication is entirely inconsistent with the reality that juvenile is punished if he refuses to take a medication that was prescribed, as I understand from my interviews with the named plaintiffs.

Dr. Augspurger was the prescribing psychiatrist at BSTS during virtually the entire time period spanning the records that I reviewed. There is no indication in those records that Dr. Augspurger met his responsibility to determine that there was informed consent and voluntariness in the medications he was prescribing to his patients at BSTS.

However, from the records I reviewed and the interviews of the named plaintiffs that I conducted, I have the impression that Dr. Augspurger is a caring individual, but as the most senior--indeed the only--mental health

professional at the school, Dr. Augspurger had an obligation to look beyond the narrow scope of medication prescribing. He had an obligation to look at the whole mental health situation of the youths in his care. The lack of psychological services and the limited family involvement are issues that he should have been confronting. **[*32]** And, more importantly, it was within his professional responsibility to confront the ultimately punitive and destructive structure of the school.

Virtually the only response at BSTS to behavioral difficulties is a harsh and punitive one; there is almost a hair trigger response to any negative behavior by placing the juvenile in some form of solitary confinement. This may be the BSU ("Behavioral Stabilization Unit"), which confines the juvenile in conditions that are actually harsher and more severe than those typically seen in solitary confinement in adult prisons. Based on the records I reviewed and my interviews with the named plaintiffs, it is my understanding that the BSU cells are utterly barren--no paper, no writing instrument, no books, no television, no radio, no personal items, no telephone privilege. There is literally nothing softer than concrete in the cells during the day (the thin mattress, pillow and blankets are removed during the day, and only given to the child for sleeping at night). And there is literally nothing for the child to do other than sit on a concrete slab or concrete stool or toilet, or occasionally stand and pace back and forth in a tiny cell (only **[*33]** 54 square feet, which includes the space occupied by the concrete slab bed platform and the sink/toilet combination). Juveniles so confined are generally deprived of their schooling: not permitted out to class, nor are educational materials provided in the cell.

The BSU cells are in a separate building--Corbett-Miller Hall ("CMH")--a building where every resident is single-celled. A juvenile may be moved from his residence cottage to the BSU and then returned to his usual residence, or CMH may become his new residence. A boy confined in BSU will typically not even be allowed phone calls with family, and no visits. If he is transferred to CMH, he will initially be placed in isolation status, in conditions that are only marginally better than those in BSU status. While in isolation status, he is in his cell 23 hours a day; he cannot even attend school. According to the boys whom I interviewed, the different "statuses" at CMH can become confusing and even meaningless. For example, a youth who is in isolation in CMH may speak disrespectfully to a staff member. He is then told he is being transferred to BSU status. And literally nothing changes. He remains in the same cell; he had virtually **[*34]** nothing there, and he still has virtually nothing. Youths can remain in conditions of solitary confinement for many hours at a time, even days, weeks, or months.

There are two cells at CMH offering even harsher conditions of confinement. The first cell is called "Seclusion." It has no window; it has a metal ceiling, and it is filthy--the named plaintiffs I interviewed described a filthy floor and toilet and walls covered with dried blood or feces. The second cell is "The Restraint Room." There is a mat on a metal frame with fourteen restraints that pin down the youth's arms, legs, and chest, called "the wrap." The named plaintiffs whom I interviewed described the restraints as very tight and painful, and the band across the chest as so tight that they could hardly breathe. The restraints are so rigid and confining that they prevent any adequate flow of air; the boys spoke of how hot it was and how much they sweated while in restraints.

The named plaintiffs whom I interviewed described how they coped by trying to give up and not care what "status" they were in. There is a Level System at CMH, and one has to slowly rise to a higher level in order to receive any additional privileges. **[*35]** But there are so many levels; it takes so much time to rise from one level to another, and one slip-up can send a juvenile plummeting back to the very bottom level. It is an invitation for hopelessness and helplessness. And it is an invitation for paranoia and rage. The youths whom I interviewed have an attitude of utter cynicism towards BSTS. It is not that they think every staff member is cruel and uncaring, but they believe something more fundamental--that the place itself is not designed to help them, but rather to control, humiliate, and damage them. And their adjustment to the BSTS reflects this. Each of them has multiple BSU admissions, multiple episodes of restraint, and multiple episodes of self-harming and/or suicidal behavior.

For example, CPX is a very emotionally volatile and impulsive youngster. On multiple occasions he apparently impulsively spoke about suicide or engaged in some form of self-injurious behavior. The documents I reviewed fail

to reveal any attempt to talk with him or to help him calm down. Instead, he was placed on "suicide watch" while in the BSU, sometimes for as long as six days. [20]

Unfortunately, the documents I reviewed, and the youths whom I had the opportunity to interview, demonstrate the reality that BSTS's use of segregation, and its focus only on behavior, rather than inquiring about underlying feelings and thoughts, is not therapeutic. As noted above, BSTS focuses on manifest behavior to the exclusion of considering the factors that lay behind this behavior; there is no inquiry as to why behavior may be negative and destructive some of the time, but positive and constructive at other times. And there is no consideration at all to the possibility that placing these boys in enforced idleness was making their behavior worse, not better. My Appendix D attached hereto provides a more detailed example of the conditions of confinement on KNX, again, based on my documents I reviewed and interview with KNX.

VIII. Conclusory Statement

BSTS has made some token efforts to provide mental health counseling, and to marginally ameliorate its harsh level system and use of solitary confinement. But these token efforts do not address the fundamental problem of the culture of BSTS--a culture of power, control, and punishment, rather than one of **[*37]** caring, of listening and helping youths develop and express the best parts of themselves. In reviewing the many BSU admissions of the named plaintiffs, it is striking how many of these were not the result of any major, important, or dangerous behavior, but instead were the result of an act of simple defiance, a passive unwillingness to comply with a demand. It is not surprising. The staff at BSTS focuses on power and control; the youth refuses to be controlled and humiliated. It is a destructive dance--a self-fulfilling prophecy of control/power/punishment on the one hand, and rage/defiance on the other, that is then used to justify even more control and punishment,

Solitary confinement is the ultimate manifestation of control and punishment. It is utterly destructive. It fosters chaos in the facility, but much more importantly, it does great harm--and likely permanent harm--to the juveniles who have to endure it over and over again. Solitary confinement destroys; it does not rehabilitate. And juveniles are so vulnerable--their further development so likely to be permanently skewed--by their experience of such a destructive environment.

Signed this 2nd day of August, 2018.

[*38] /s/ [Signature]

Stuart Grassian, M.D.

Appendix

[SEE APPENDIX A IN ORIGINAL]

[SEE APPENDIX B IN ORIGINAL]

End of Document

[20] See, e.g., PLTFGRX008674 at PLTFGRX008674-PLTFGRX008679; PLTGRX0008682 **[*36]** at PLTGRX0008704.