Every day, in juvenile detention and correctional facilities across the United States, children are held in solitary confinement and other forms of extreme isolation. They spend hours, days, weeks, or longer alone, isolated both physically and socially. Sometimes there is a window allowing natural light to enter or a view of the world outside cell walls. Sometimes it is possible to communicate by yelling to other youth, with voices distorted, reverberating against concrete and metal. Occasionally, youth in solitary confinement get a book or Bible, or education materials like worksheets. But inside this cramped space, few things distinguish one hour, one day, or one week from the next.

While held in isolation, children are commonly deprived of the services and programming they need for healthy growth and development. Solitary confinement can cause serious psychological, physical, and developmental harm—or, worse, can lead to persistent mental health problems and suicide. These risks are magnified for young people with disabilities or histories of trauma and abuse.

There is no question that confining young people who have been accused of or found responsible for crimes can be extremely challenging. Youth can be defiant, and they sometimes hurt themselves and others. In rare, emergency situations, facilities may need to use limited periods of separation to protect young people from other prisoners or themselves, particularly when a youth is uncontrollably violent. But solitary confinement profoundly harms young people, and brief periods of isolation should be used only when a youth is out of control, presenting an immediate physical threat that cannot otherwise be contained.

Indeed, there is broad consensus that the most effective and developmentally appropriate techniques for managing youth and promoting their healthy growth and development while they are detained require strictly limiting and regulating the use of isolation, and emphasizing positive reinforcement over punishment. This need for effective

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1 See AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, POLICY STATEMENTS: SOLITARY CONFINEMENT OF JUVENILE OFFENDERS (Apr. 2012), available at http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders; LINDSAY M. HAYES, DEP’T OF JUSTICE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY (2009), available at https://www.ncjrs.gov/pdfs1/ojjdp/213691.pdf. The study suggests that, “When placed in a cold and empty room by themselves, suicidal youth have little to focus on – except all of their reasons for being depressed and the various ways that they can attempt to kill themselves.” Id. at 28 (citing LISA M. BOESKY, JUVENILE OFFENDERS WITH MENTAL HEALTH DISORDERS: WHO ARE THEY AND WHAT DO WE DO WITH THEM? 210 (2002)).

2 See, e.g., ATT’Y GEN.’S NAT’L TASK FORCE ON CHILDREN EXPOSED TO VIOLENCE, REP. OF THE ATT’Y GEN.’S NAT’L TASK FORCE ON CHILDREN EXPOSED TO VIOLENCE, DEFENDING CHILDHOOD: PROTECT, HEAL, THRIVE 178 (2012), available at http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf (“[i]solation is a damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement.”); DEP’T OF JUSTICE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, STANDARDS FOR THE ADMINISTRATION OF JUVENILE JUSTICE 4.52 (1980), available at http://catalog.hathitrust.org/Record/000127687 (“[i]solation is a severe penalty to impose upon a juvenile, especially since this sanction is to assist in rehabilitation as well as punish a child … After a period of time, room confinement begins to damage the juvenile, cause resentment toward the staff, and serves little useful purpose.”). The most up-to-date national standards are consistent on this point. See, e.g., JUVENILE DETENTION ALTERNATIVES INITIATIVE (JDAI), A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE
and developmentally appropriate management techniques applies regardless of whether young people are detained in the juvenile or adult criminal justice system.

Every set of national standards governing age- and developmentally-appropriate practices to manage children in rehabilitative or correctional settings strictly regulate and limit all forms of isolation. The Department of Justice Standards for the Administration of Juvenile Justice limit isolation to a maximum period of 24 hours. Another leading set of national standards bans all punitive isolation and limits isolation for other reasons to four hours or less, and yet another recommends that isolation be kept to a few minutes, not hours (and, in all cases, be limited to the shortest duration necessary). Standards governing the isolation of children in medical and mental health facilities and in educational settings are even more restrictive.

Federal law also takes the harms of youth isolation into account. In 2003, Congress passed the Prison Rape Elimination Act (PREA) in response to high rates of sexual assault across all forms of detention facilities in the United States. The final PREA regulations implementing the law provide a range of protections for young people, including substantive limits on solitary confinement, which the standards characterize as a measure of “last resort.” States that do not comply with PREA face a 5% reduction in federal corrections funding unless the Governor certifies that those funds will be used to enable compliance in the future. In 2014, the Department of

3 Department of Justice Office of Juvenile Justice and Delinquency Prevention, Standards for the Administration of Juvenile Justice, Standard 4.30 (2011), available at http://catalog.hathitrust.org/Record/000127687 (“juveniles should be placed in room confinement only when no less restrictive measure is sufficient to protect the safety of the facility and the persons residing or employed therein … Room confinement of more than twenty-four hours should never be imposed.”)
4 See A Guide to Juvenile Detention Reform: Juvenile Detention Facility Assessment 2014 Update, supra note 2, at 177-78.
5 PBIS Learning Inst., PBIS Goals, Standards, Outcome Measures, Expected Practices and Processes 10 (2007), available at http://sccounty01.co.santa-cruz.ca.us/prb/media%5CGoalsStandardsOutcomes%20Measures.pdf; Performance-Based Standards, Reducing Isolation and Room Confinement, supra note 48, at 2 (“PBIS standards are clear: isolating or confining a youth to his/her room should be used only to protect the youth from harming himself or others and if used, should be brief and supervised. Any time a youth is alone for 15 minutes or more is a reportable PBIS event and is documented”).
6 42 C.F.R. 482.13(c) (2012) (implementing 42 U.S.C. § 1395x § 1861(e)(9)(A)), available at http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=5ba18485f8033f30bf496db1ce87c626&rgn=div8&view=text&node=42:5.0.1.1.1.2.4.3&idno=42 (Prohibiting isolation used for coercion, discipline, convenience or retaliation and allowing involuntary isolation only (1) when less restrictive interventions have been determined to be ineffective, (2) to ensure the immediate physical safety of the patient, staff member, or others, and (3) must be discontinued at the earliest possible time. The regulations also limit involuntary isolation to a total maximum of 24 hours and limit individual instances of involuntary isolation to 2 hours for children and adolescents age 9 to 17); Nat’l Comm. On Corr. Health Care, Standards for Health Services in Juvenile Detention and Confinement Facilities, Standard Y-E-09 (2011); Nat’l Comm. On Corr. Health Care, Standards for Health Services in Juvenile Detention and Confinement Facilities, Standard Y-39 (1995), available at http://www.jdcap.org/SiteCollectionDocuments/Health%20Standards%20for%20Detention.pdf (Requiring that segregation policies state that isolation is to be reserved for incidents in which the youth’s behavior has escalated beyond the staff’s ability to control the youth by counseling or disciplinary measures and presents a risk of injury to the youth or others); Dept’ of Education, Restraint and Seclusion: Resource Document 11-23 (2012), available at http://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf (stating that isolation should not be used as a punishment or convenience and is appropriate only in situations where a child’s behavior poses an imminent danger of serious physical harm to self or others, where other interventions are ineffective, and should be discontinued as soon as the imminent danger of harm has dissipated).
Justice issued a letter to state governors reminding them of the upcoming first deadline, May 15, 2014, for this required certification, and of the Fiscal Year 2014 funds that could be cut off if certification is not received.  

### Promoting Better Practices for Youth Held in Juvenile Detention and Correctional Facilities

As the experience of some states has already shown, juvenile detention and correctional facilities can implement changes to policy and practice that provide for safe management of youth while still meeting their developmental, educational, physical, mental health, and rehabilitative needs. Effective management of a juvenile justice facility can be more effectively accomplished without resort to harmful and extreme forms of isolation. One core change is ensuring staffing levels, such that youth are adequately supervised and not exposed to significant levels of physical and social isolation.

Various national standards for youth facilities provide a clear framework for developmentally appropriate institutional practices which can reduce reliance on isolation. The most comprehensive set of standards is the Juvenile Detention Alternatives Initiative (JDAI), a nationally recognized set of best practices. Another is the Performance-based Standards Initiative (PbS), a program of the Council of Juvenile Correctional Administrators. Both strictly regulate isolation practices and identify a range of institutional practices that can be used to discipline and care for young people in custody without exposing them to harm, undermining rehabilitation, or compromising public safety.

Additionally, specific state systems provide valuable models for holistic reforms that focus on the needs of youth and provide rehabilitative models. These reform states have been successful in both improving conditions for youth in custody and providing effective management tools that promote rehabilitation and institutional safety. New York, for instance, has moved away from using isolation by implementing the more therapeutic “Sanctuary Model” in many of its facilities. This model provides a holistic structure for trauma-informed and evidence-based care, and discourages punitive responses to youth misbehavior or aggression. Meanwhile, the “Missouri Model” for juvenile justice has focused on rehabilitation by instituting therapeutic facilities like smaller group homes and treatment centers that maintain safety through fostering positive relationships among youth and between youth and staff and providing adequate staff supervision, and thus avoiding isolation and other punitive and extreme correctional responses.

1. **Promoting Youth-Centered Practices and Operations**

Managing and caring for children deprived of their liberty requires adequate staff who can respond appropriately to the needs of youth. Appropriate supervision of youth while keeping them engaged ensures that youth are safe, and reduces the circumstances in which facilities might otherwise resort to punishment or isolation. The following are

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11 See [A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE](http://www.aecf.org/~/media/Pubs/Initiatives/Juvenile%20Detention%20Alternatives%20Initiative/MOModel.pdf), supra note 2, at 177-80.


general policy and operational changes that can be implemented to better serve the unique needs of youth in confinement:

- Facilities should maintain staff-to-youth ratios of at least 1:8\(^{15}\) (ideally 1:6) during waking hours, and 1:12 during sleeping hours (counting only staff who engage in continuous and direct supervision of youth).\(^{16}\)
- Facilities should provide staff with specialized training and ongoing coaching in age-appropriate, positive behavior-management techniques, particularly de-escalation techniques designed for youth.\(^{17}\)
- Facilities should implement positive, rewards-based management practices that do not primarily rely on punitive discipline to manage youth behavior.\(^{18}\)
- Facilities should provide age-appropriate education, programming, recreational activities, and other services that take up a significant proportion of the youth’s waking hours, seven days a week, available to all youth at all times (even when they are separated from the general population).\(^{19}\)
- Facilities should provide access to dental, medical, and mental health services from qualified professionals with specialized training in caring for children and adolescents; these services should be available to all youth at all times (even when they are separated from the general population).\(^{20}\)
- Facilities should ban the use of mechanical and chemical restraints, corporal punishment, pain compliance, stun weapons such as tasers and stun shields, and chemical agents such as pepper spray or mace.\(^{21}\)
- Facilities should use age-appropriate classification and evaluation instruments to identify educational, programming, mental health and other needs and diagnoses.\(^{22}\)

2. **Banning Solitary Confinement and Strictly Regulating Other Isolation Practices**

The use of isolation in juvenile detention and correctional facilities is widespread. Facilities generally justify solitary confinement and other forms of physical and social isolation for one of four reasons:

- **Disciplinary Isolation** (common euphemisms: punitive segregation, disciplinary custody, lock-up, room confinement): Physical and social isolation used to punish children when they break facility rules, such as those prohibiting talking back, possessing contraband, or fighting;
- **Protective Isolation** (common euphemisms: protective custody, administrative confinement): Physical and social isolation used to protect a child from other children;

\(^{15}\) 28 C.F.R. § 115.313(c) (2012) (requiring, in the PREA regulations, adequate staffing of juvenile justice facilities).


\(^{17}\) PIS GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, supra note 5; AM. CORR. ASS’N, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS 4-4312 (4th ed. 2003); THE MISSOURI MODEL, supra note 14, at 27.

\(^{18}\) PIS GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, supra note 5, at 10; MENDEL, supra note 11, at 29.

\(^{19}\) See, e.g., A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 178 (providing that individualized plans for youth in room confinement should include “[f]irn[person provision of educational services]”).


\(^{21}\) See, e.g., A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 174 (providing standards requiring that facilities prohibit the use of chemical agents on children).

\(^{22}\) See id. at 99-102 (providing standards that govern classification in juvenile detention and correctional facilities), 134-43 (governing programming in juvenile detention and correctional facilities).
• **Administrative Isolation** (common euphemisms: room confinement, administrative segregation): Physical and social isolation—sometimes for a short period but other times without any limit on duration—used during initial processing at a new facility, because officials do not know how else to manage a child, or when a child is deemed too disruptive to the safe or orderly operation of an institution, such as when they are deemed to be out of control;

• **Medical Solitary Confinement** (common euphemism: therapeutic seclusion, medical quarantine): Physical and Social isolation to medically treat children, such as for a contagious disease or for having expressed a desire to commit suicide;\(^{23}\)

In rare circumstances, isolation may be warranted as a brief, temporary response to behavior that threatens immediate harm to the youth or others, such as during a fight where the youth cannot be calmed down using de-escalation techniques and other accepted methods of crisis management. Youth should never be subjected to any practice that involves significant levels or extended periods of physical and social isolation. Implementing this imperative requires adopting practices that are appropriate to youth, addressing their unique developmental and educational needs.

*Successful reform requires a shift in systemic thinking about solitary confinement and other isolation practices.*

It is acceptable to separate individual youth from the general population to accomplish a limited range of legitimate objectives. Youth can be *separated* to interrupt current acting-out behavior; to keep them safe; or to medically treat them. But separation policies and practices must further distinguish between practices which *do not* involve significant levels of physical and social isolation and those which *do*.

Youth can be separated to provide individualized services, programming, treatment and greater staff contact—in short, the opposite of isolation—but this separation must involve regular interaction with staff and other helping professionals.

Youth can be subjected to separation practices involving *short* periods of physical and social isolation—measured in minutes or hours—to interrupt current acting-out behavior that poses an immediate risk of serious harm to the youth or others. These practices must be clearly limited in policy and practice and subjected to strict oversight. Separation must end as soon as the need for it has concluded—for example, once the youth has calmed down or after a new mental health plan has been put into place.

*Administrators of juvenile detention and correctional facilities can modify their policies and practices and implement a number of reforms that strongly discourage isolation:*

• Facilities should completely **prohibit solitary confinement**—physical and social isolation for 22-24 hours per day\(^{24}\)—and should never use solitary confinement or other forms of isolation for


punitive/disciplinary reasons or for any reasons other than as a temporary response to current acting-out behavior that poses an immediate risk of physical harm to the youth or others. 25

- Facilities should reform **disciplinary practices** to completely eliminate all forms of isolation. Separation from the general population for disciplinary purposes should be prohibited. 26

- Facilities should reform **short-term isolation practices** to strictly limit emergency isolation (to interrupt current, acting-out behavior) to a maximum of 4 hours, and only for as long as an immediate physical threat exists. 27 Emergency isolation should never be assigned for fixed periods of time; it should be discontinued as soon as the youth no longer poses a threat. 28

- Youth who have been separated from general population for any reason must continue to receive access to education, medical, mental health and other services, visits, telephone calls and other forms of **social interaction**. 29 Separation of youth due to assaultive or dangerous behavior or mental health needs should increase staff interaction as well as access to specialized programming and services, and should maintain a goal of returning the individual to the general population. 30

- Facilities should reform **protection practices** to eliminate social and physical isolation and resolve immediate needs for protection without subjecting youth to conditions of solitary confinement. 31 Temporary separation of youth from the general population due to a current need for protection, until alternative housing can be arranged, should ensure a level of staff interaction and access to programming and services substantially equivalent to youth in general population.

- Facilities should reform **medical quarantine** and seclusion practices to eliminate significant and prolonged social and physical isolation, and should transfer youth with an active risk of suicide to a medical facility or section of the facility that can provide appropriate treatment. 32

- Facilities should ensure that all youth, including youth separated from the general population, are provided a hygienic environment and managed in a way that respects their basic rights, including: living quarters with a mattress, pillow, blankets, and sheets; a full complement of clean clothes and personal hygiene items; access to clean water, bathroom facilities, and an opportunity for a daily shower; parental and attorney visits and means for communication with counsel and loved ones; age-appropriate meals and snacks; educational programming; the right to receive and send mail; access to reading and legal materials; and an opportunity to attend congregant religious services and/or obtain religious counseling of the youth’s choice. 33

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25 See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 177 (banning all “room confinement” of youth except as a “temporary response to behavior that threatens immediate harm to the youth or others”).

26 See id. at 177.

27 See id. at 178.

28 See id.

29 See id. at 177-80.


31 See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 102 (noting that room confinement should never be used to protect a youth from others), 177 (noting that room confinement may only be used as a temporary response to an immediate threat of physical harm); see also AM. CORR. ASS’N, PERFORMANCE BASED STANDARDS JUVENILE CORR. FACILITIES, supra note 28, at Standard 4–JCF–3C–02.


33 See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 177-80 (requiring access to educational materials, hygienic quarters, and other necessities while in room confinement and setting standards for generally adequate conditions in juvenile detention and correctional facilities).
3. Reforming Short-Term Isolation Practices

Standards and best practices for managing and caring for youth recognize that in a very limited set of circumstances, separating individual youth from the general population may help interrupt current acting-out behavior and allow a young person to regain self-control while protecting others. This separation should only be used in cases of emergency, where the youth presents a serious risk of immediate physical harm to him- or herself or others. It should never constitute or approximate solitary confinement. In cases where short-term separation is justified, it should be strictly limited and used only as a last resort. Such isolation should also be distinguished from voluntary time-outs, in which youth voluntarily remove themselves from programming to regain control over themselves and then return.

In the absence of legislative reform, facility administrators can review policies and practices to permit appropriate and limited uses of isolation.

The following are guidelines for the use of short-term isolation on youth:

- Facilities should limit emergency isolation only to those limited circumstances where youth pose an imminent threat to themselves or to others; labeling such physical and social isolation “emergency isolation” helps reinforce that limited isolation is only appropriate in a small range of circumstances. 34
- Facilities should ensure that, before emergency isolation is used, all de-escalation techniques are exhausted. 35
- Facilities should use emergency isolation for periods measured in minutes, with an absolute maximum of 4 hours. 36
- Facilities should prohibit any use of isolation as a disciplinary or punitive measure, or for administrative convenience, staffing shortages, or retaliation. 37
- Facilities should ensure that emergency isolation persists only as long as necessary to abate the current imminent threat to the youth or others. 38
- Facilities should ensure that any youth subjected to emergency isolation is constantly monitored, one-on-one, by qualified staff. 39
- Facilities should ensure that youth who cannot regain self-control after 4 hours of emergency isolation—or whom a medical professional concludes cannot be managed by non-medical staff—are transferred to a medical or mental health unit or facility for care and supervision by mental health professionals, or that some other appropriate treatment plan is immediately developed and implemented. 40

35 See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 177 (requiring that de-escalation techniques be used before resorting to placing a child in room confinement).
36 See id. at 177–78; REDUCING ISOLATION AND ROOM CONFINEMENT, supra note 28, at 2.
37 See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 177.
38 See id. at 177–78; PBIS GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, supra note 5, at 10 (2007).
39 See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 177.
40 See id. at 178; POLICY STATEMENTS: SOLITARY CONFINEMENT OF JUVENILE OFFENDERS, supra note 1.
• Facility administrators should make regular “spot checks” to ensure that emergency isolation is being used appropriately and/or the approval of a facility administrator should be required to authorize the use of emergency isolation beyond 60 minutes.

• Facilities should ensure that every instance of emergency isolation is documented, reviewed by facility administrators, and regularly publicly reported.

• Facilities should ensure that any youth separated from general population for medical reasons is admitted to the facility infirmary by a qualified medical professional; the facility infirmary should have 24-hour staffing by qualified medical professionals and should have physicians on call 24 hours per day.

• Youth who have expressed suicidal ideation should be engaged in social interaction and not placed in room confinement. They should be permitted to engage in programming and social activities while supervised one-on-one by qualified staff who check on the youth at least every ten minutes.

• For a youth who has engaged in suicidal acts or other acts of self-harm, facilities should develop an individualized suicide crisis intervention plan approved by a licensed mental health clinician who has evaluated the youth. Facilities should place any youth who is actively suicidal on constant observation by a qualified staff member, or should transfer the youth to a mental health facility.

4. Reforming Disciplinary Practices

Standards and best practices for managing and caring for youth suggest that the most effective techniques rely on positive reinforcement in lieu of discipline. A range of disciplinary measures can be safely employed in conjunction with practices that promote good behavior and healthy development. Youth should never be placed in solitary confinement or isolation for purposes of punishment or discipline. Appropriate disciplinary management practices should never involve social or physical isolation, or rise to the level of solitary confinement.

Disciplinary policies and procedures should always favor sanctions that do not require separating youth from the general population. Disciplinary policies and practices should always distinguish between major and minor rule violations, and sanctions should be designed to be immediate and proportionate, and take developmental differences and individual characteristics of youth into account. All disciplinary management techniques should guarantee youth due process.

The following are basic principles that should be incorporated into any discipline system involving youth:

• Facilities should never use isolation as a punishment or disciplinary sanction for youth.

• Facilities should take a youth’s age and mental health status into account when deciding any sanction for a rule violation.
• when a youth being disciplined comes to pose an imminent threat to self or others, or exhibits suicidal behavior or commits acts of self-harm, or when a medical professional concludes that the youth cannot be safely managed by non-medical staff, that youth must be transferred to a medical or mental health unit or facility for care and supervision by mental health professionals.49
• If a facility has not yet abolished the use of solitary confinement/isolation for punishment or disciplinary purposes, it should ensure that any disciplinary sanctions are preceded by due process.50 Due process must include effective notice of the alleged misconduct and a hearing at which the youth has the opportunity to challenge the allegations.
• Facilities should also provide youth with due process protections before punishing youth with significant loss of privileges or with transfer to a more restrictive unit/housing assignment.51
• Facilities should ensure that all disciplinary actions are documented and reviewed by facility administrators, and that data are regularly publicly reported.52

5. Creating Therapeutic Environments Where Necessary

Young people with mental disabilities, including serious pre-existing or emerging mental health problems, are often among those who have the most difficulty conforming their behavior to facility rules. Many administrators (often in the absence of adequate diagnostic capacity) react to these management challenges by isolation, including disciplinary “room confinement” or prolonged medical isolation, to house young people with mental disabilities.

Standards and best practices disfavor the use of prolonged solitary confinement or segregation to manage and care for youth with mental disabilities. On the basis of appropriate clinical evaluation and diagnosis, young people with the most serious mental health problems may be diverted to specialized medical facilities. Young people with less acute mental health problems can in some circumstances be effectively managed in smaller, therapeutic communities that provide more individualized attention, services and programming.

In no case should practices for managing young people with serious mental health problems involve significant levels of social and physical isolation, or reduced access to programming, activities, or privileges. As with youth separated for administrative reasons, such groups of young people with mental health problems should generally be managed with more staff and services. The goal of any separation should always be to reintegrate young people into the general population of their facility.

Facilities can implement reforms to care for youth with mental disabilities in the following manner:

• Facilities should have adequate clinical staff, trained in age-differentiated care and diagnosis, so that young people have ready access to mental health treatment and services.
• Facilities should ensure that young people with acute mental health problems that cannot be resolved through treatment, increased programming, or staff contact at the facility—or whom at any time a medical

49 See POLICY STATEMENTS: SOLITARY CONFINEMENT OF JUVENILE OFFENDERS, supra note 1.
50 See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 181.
51 See id.
52 See PnS GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, supra note 5, at 10.
professional concludes cannot be managed by non-medical staff—be transferred to a medical or mental health unit or facility for care and supervision by mental health professionals.\textsuperscript{53}

- A goal of mental health care and services should be to manage youth in the general population whenever possible.
- Young people with mental health problems who are identified as likely to benefit from a higher level of staff interaction and individualized attention, services and programming should not be subjected to significant levels of social and physical isolation.
- Facilities should recognize when young people have histories of trauma and ensure that they do engage in practices that further traumatizes youth in their custody.
- Facilities should ensure that youth identified as requiring a higher level of staff interaction and individualized attention, services and programming receive levels of programming, services, and staff interaction equal to or greater than youth in the general population.
- Facilities should ensure that any separation implemented for treatment purposes is documented, reviewed by facility administrators, and regularly publicly reported.\textsuperscript{54}

6. Reforming Protective Isolation Practices

Youth who have a current need for protection from others may not be placed in solitary confinement, but must be protected through adequate supervision and classification to a safe housing unit or pod. Separation of a youth from the general population should never involve physical and social isolation.

Facilities can implement reforms to care for youth who have a current need for additional protection in the following manner:

- Facilities should ensure that youth separated due to a current need for protection are not subjected to social and physical isolation.\textsuperscript{55}
- Facilities should ensure that youth separated due to a current need for protection receive levels of programming, including education and recreation, services, medical and psychological care and check-ins, and staff interaction equal to youth in the general population.\textsuperscript{56}
- Facilities should ensure that alternative housing is identified for youth with a current need for protection within 4 hours.\textsuperscript{57}
- Facilities should ensure that any separation implemented for protective purposes does not constitute social isolation or solitary confinement, and that it is documented, reviewed by facility administrators, and regularly publicly reported.\textsuperscript{58}

\textsuperscript{53} See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 116 (describing actions that a facility should take to provide appropriate mental-health care); POLICY STATEMENTS: SOLITARY CONFINEMENT OF JUVENILE OFFENDERS, supra note 1.

\textsuperscript{54} See PBIS GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, supra note 5, at 10.

\textsuperscript{55} See, e.g., 28 C.F.R. § 115.342(b) (2012) (requiring daily mental health visits, programming, and other social and supervisory safeguards against isolation for youth who are separated).

\textsuperscript{56} See, e.g., 28 C.F.R. § 115.342(b), (2012).

\textsuperscript{57} See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 117-18 (limiting any instance of room confinement to a maximum of 4 hours).

\textsuperscript{58} See PBIS GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, supra note 5, at 10.
7. Reforming Medical Isolation Practices

Youth who require physical separation as a result of a serious communicable diseases or medical conditions should be managed and supervised by medical professionals in a medical facility or section of the facility. Other youth can be safely managed without separation.

Facilities can implement reforms to care for youth who are under medical supervision in the following manner:

- Youth should receive a medical assessment upon entering the facility which screens for tuberculosis and other communicable diseases.\(^{59}\)
- Youth must be engaged in social interaction—not isolated—while being assessed (such as while a tuberculosis skin test is being employed) and must have an opportunity to participate in activities and programming.
- Youth with medical conditions can be separated from the general population in a medical unit but must be engaged in social interaction—not isolated—while being treated and must have an opportunity to participate in activities and programming.
- Youth identified as having been exposed to serious communicable diseases, such as infectious tuberculosis, can be separated from the general population (such as in a negative airflow room) in a medical unit but should be managed in medical facilities that provide specialized care.\(^{60}\) Youth so separated must be engaged in social interaction—not isolated—while being treated and must have an opportunity to participate in activities and programming.
- When youth are placed in medical isolation they must be checked frequently for changes in physical and mental status and accommodated in a room with, at a minimum: a separate toilet; hand-washing facility; soap dispenser; and single service towels.\(^{61}\)

8. Reforming Isolation Practices

Youth who require separation as a result of an active risk of suicide should be managed and supervised by mental health professionals in a medical facility or section of the facility. Other youth can be safely managed without separation.

Facilities can implement reforms to care for youth who are identified to be at a risk of self-harm in the following manner:

- Youth at risk of self-harm must be engaged in appropriate activities and programs.\(^{62}\)
- Youth at risk of suicide must be engaged in social interaction—not isolated—and must have an opportunity to participate in activities and programming.\(^{63}\)

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\(^{61}\) Standards for Health Services in Juvenile Detention and Confinement Facilities, supra note 6, at standard Y-B-01 (3)(a)-(d).


\(^{63}\) Id. at 120.
Youth who develop an active risk of suicide should be managed by mental health staff (who should be notified immediately regardless) and/or through the procedures for emergency isolation outlined above.

Youth who are deemed to be actively suicidal must be placed on constant observation, and potentially suicidal youth must be monitored on an irregular schedule with no more than 10 minutes between checks.\textsuperscript{64}

Facilities should ensure that youth who pose an active risk of suicide be evaluated by a qualified mental health professional, that an individualized treatment plan be developed, and, if necessary, that the youth is hospitalized and placed under the care of mental health providers.\textsuperscript{65}

If emergency isolation has not yet been abolished as a suicide risk intervention, any instance of isolation as a suicide risk intervention should be documented, reviewed by facility administrators, and regularly publicly reported.\textsuperscript{66}

\textsuperscript{64} Id. at 119-20.

\textsuperscript{65} See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 119; POLICY STATEMENTS: SOLITARY CONFINEMENT OF JUVENILE OFFENDERS, supra note 1.

\textsuperscript{66} See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 177, 179-80 (requiring supervisor approvals and documentation for all instances of “room confinement”); PB\$ GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, supra note 5, at 10.