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Kim Brooks Tandy
Children's Law Center, Inc.

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Do No Harm: The Enhanced Application of Legal and Professional Standards in Protecting Youth from the Harm of Isolation in Youth Correctional Facilities

*By Kim Brooks Tandy, Esq.**

I. INTRODUCTION

The reliance by state and local agencies on incarceration as a means to rehabilitate youth and protect community safety is increasingly questioned as both counterproductive and costly. A 2011 study released by the Annie E. Casey Foundation found fifty-seven lawsuits in thirty-three states and the District of Columbia challenging unconstitutional conditional or other alleged abuses in juvenile facilities.¹ The study shows that pervasive violence and abuse have been widespread and systemic, including excessive use of isolation and/or restraint.² An extensive review of recidivism studies compiled from this report suggests that probation or alternative sanctions may be as effective as incarceration in reducing the criminal conduct of youth who have been adjudicated delinquent and, further, that the use of incarceration may actually exacerbate criminality.³ In spite of the proven success of many community-based alternatives and evidence-based programs in lieu of incarceration, states continue to incarcerate youth in programs that are often “both poorly designed and ill equipped to provide effective treatment.”⁴ This is particularly true for youth with severe mental health conditions, learning disabilities, significant substance abuse problems, or other acute needs.⁵

It is against this backdrop that this Article seeks to examine the widespread use of unnecessary, and often unregulated, physical and social isolation by juvenile detention and correctional facilities. Even though youth are especially susceptible to the damaging effects of isolation because they are still in the process of development, facility staff often attempt to justify its use. The history of trauma, emotional and cognitive disabilities, and immature responses with which a significant portion of this population of young people enters the system further exacerbate the consequences of isolation.

There have been numerous cases involving the conditions of confinement in juvenile detention and correctional facilities that raise claims challenging the use of isolation, including several cases brought under the Civil Rights of Institutionalized Persons Act (CRIPA) by the United States Department of Justice, Office of Civil Rights. Both the Fourteenth Amendment Due Process Clause as well as, in some circuits, the Eighth Amendment prohibition against cruel and unusual punishment, are used in successful litigation of conditions of confinement claims.

* Kim Tandy is an attorney and Executive Director of the Children’s Law Center, Inc. in Covington, Kentucky. She has litigated conditions of confinement cases in Ohio and Kentucky, including cases involving the use of isolation in juvenile facilities. The author wishes to thank Amy Grover and Kari Underwood for their research and writing assistance with this Article.

¹ RICHARD A. MENDEL, ANNIE E. CASEY FOUND., NO PLACE FOR KIDS: THE CASE FOR REDUCING JUVENILE INCARCERATION 5 (2011).

² *Id.*

³ *Id.* at 11. Mendel’s research was based on an extensive internet search and literature review in addition to interviews and outreach with state corrections agencies. *Id.* at 9. The research conclusions were based upon recidivism analyses in thirty-eight states and the District of Columbia. *Id.* “These recidivism studies vary in many important dimensions, including the populations examined and the measures employed to track recidivism over different lengths of time.” *Id.* However, in general, the study concluded that the overall body of recidivism evidence indicates confinement is an ineffective approach to deter youth from future delinquent behaviors. *Id.*

⁴ *Id.* at 22.

⁵ *Id.*

Courts often base their decisions upon a finding that the facility lacked sufficient policies and procedures regulating how isolation can be used, thus denying the youth sufficient procedural due process protections. Other courts focus attention on the treatment received while the youth is isolated, such as healthcare, reading materials, outdoor exercise, and/or social integration. For youth with a documented history of serious mental illness, or who develop serious mental illness while incarcerated, courts have also recognized the risk of self-harm and the exacerbation of psychological symptoms. But the application of legal and professional standards in challenging the overuse of isolation does not fully address the physical, psychological, and social damage that comes from the unnecessary use of isolation with youth. Such challenges should draw more expansively from the application of evidence-based practices, research on promising approaches, and the United States Supreme Court's affirmation that constitutional protections apply differently to youth.

This Article begins with a definition and description of isolation and its varied uses in juvenile detention and correctional facilities, which are often indicative of underlying problems in a system's behavior management program, staffing, or underlying correctional philosophy. This Article next examines how research on the harmful effects of isolation on adults, combined with emerging best practices and an adolescent development framework, can help structure a harm-based analysis to strictly minimize or eliminate the use of isolation practices in juvenile facilities. The subsequent section focuses on the legal and professional standards currently available to guide juvenile detention and correctional programs in their use of isolation practices, whether to manage, treat or discipline youth. This section argues that the application of these standards can and should utilize a more robust harm-based analysis in addition to procedural due process considerations, and take into account developmental differences between youth and adults. Finally, this Article concludes with recommendations and promising practices that can eliminate or drastically reduce the use of isolation for youth in confinement.

II. TYPES AND USES OF ISOLATION

Isolation is used for a variety of purposes in juvenile facilities. Nevertheless, there is not one uniform definition of isolation that is used in correctional settings, nor is there agreement among jurisdictions as to how and why isolation should be used. For purposes of this Article, isolation is defined as a mechanism for physical and social isolation in a cell for an extended period of time, up to twenty-four hours a day for one or more days, regardless of the purpose for which it is imposed.⁶

Identified purposes of isolation used in juvenile facilities as described by the American Corrections Association include discipline, protection, and management of special populations.⁷ Disciplinary isolation is used as a result of rule infractions for a limited amount of time, and generally follows a hearing regarding that infraction.⁸ The use of isolation for protective custody refers to instances where youth need protection from others until other housing is found.⁹ Isolation used for special management of youth typically involves high-risk youth with assaultive behavior, or youth who present a danger to themselves.¹⁰

⁶ See IAN KYSEL, HUMAN RIGHTS WATCH, AM. CIVIL LIBERTIES UNION, GROWING UP LOCKED DOWN: YOUTH IN SOLITARY CONFINEMENT IN JAILS AND PRISONS ACROSS THE UNITED STATES 1 (2012), available at <https://www.aclu.org/files/assets/us1012webwcover.pdf>.

⁷ AM. CORR. ASS'N, PERFORMANCE-BASED STANDARDS FOR JUVENILE CORRECTIONAL FACILITIES 51-52 (4th ed. 2008).

⁸ *Id.* at 52 (Standards 4-JCF-3C-03, 4-JCF-3C-04).

⁹ *Id.* at 51 (Standard 4-JCF-3C-02).

¹⁰ *Id.* (Standard 2-JCF-3C-01).

The frequency with which isolation is used is not entirely clear. For facilities that utilize Performance-based Standards (PbS), the use of isolation and room confinement is tracked along with other measures of facility performance.¹¹ Facilities may otherwise maintain internal data on how isolation is used and the frequency of its usage, at least as the agency or facility defines the practice. A legislative corrections oversight committee in Ohio, for example, reported on the use of isolation in its juvenile correctional facilities for a period between 2009 and 2011, which ranged from 400,718 hours to 228,923 hours.¹² A federal monitor's report, however, noted that during the same period, the state agency did not include data on hours spent by youth in special management units.¹³ Youth in these units were frequently isolated for up to twenty-four hours a day, sometimes for months on end, because the agency instead defined this as "programmatic seclusion."¹⁴ Because the definition of isolation lacks uniformity, the usage of isolation is difficult to track.

The practice of inappropriately isolating youth can be attributed to many factors that arise within juvenile correctional facilities. For example, in jurisdictions where staff training on techniques to de-escalate disruptive or violent behaviors is lacking, staff are more likely to rely on the use of restraint and solitary confinement.¹⁵ Accordingly, policies and practices must limit the use of isolation to short periods of time and only in extreme situations when the safety of others is at stake. When such limits are not clearly established, staff can gravitate toward easy solutions, even for minor misconduct, and place the youth in isolation beyond the time it takes for the youth to calm down.¹⁶ In other cases, insufficient numbers of direct care staff to adequately supervise youth, especially in overcrowded facilities, place staff under pressure to manage situations quickly.¹⁷ Staff may feel compelled to use isolation as a way of attempting to maintain control.¹⁸

Isolation is also used more frequently in facilities that do not have adequate policies and procedures for dealing with youth with mental illness. This includes facilities with an inadequate number of qualified mental health professionals to properly identify, diagnose, and treat youth with emotional and behavioral challenges.¹⁹ Without access to mental health services, youth with mental illness can deteriorate, causing staff to rely more heavily on the use of solitary confinement as a response to the youth acting out. This vicious cycle can result in an exacerbation of a youth's mental health condition.²⁰

¹¹ PBS LEARNING INST., PERFORMANCE-BASED STANDARDS: SAFETY AND ACCOUNTABILITY FOR JUVENILE CORRECTIONS AND DETENTION FACILITIES 2 (2012), http://pbstandards.org/uploads/documents/PbS_Li_MarketingPacket.pdf [hereinafter PERFORMANCE-BASED STANDARDS]. Performance-based Standards is a program developed by the Council of Juvenile Correctional Administrators (CJCA) to improve conditions of confinement. *Id.* PbS addresses seven areas of facility management: safety, security, order, health/mental health, programming, reintegration, and justice. *Id.* PbS collects both quantitative and qualitative data from administrative forms, youth records, incident reports, exit interviews of youths, and climate surveys of youths and staff. *Id.*

¹² *See, e.g.*, CORR. INST. INSPECTION COMM., DYS SECLUSION HOURS 4 (2012) (noting decreasing use of isolation hours between 2009 and 2011 from 400,718 to 228,923).

¹³ *See* Stipulation for Injunctive Relief: Second Annual Report at 17, *S.H. v. Reed*, 251 F.R.D. 293 (S.D. Ohio 2008) (No. 2:04-CV-1206) ("Currently, DYS considers such youth to be in an administrative/management confinement status rather than seclusion (they do include as seclusion hours the time an SMU youth is excluded from any out-of-room programming), but such a practice has not been incorporated into any approved policies and procedures as required by the Stipulation.").

¹⁴ *Id.*

¹⁵ *See* CTR. FOR CHILDREN'S LAW & POLICY, TESTIMONY OF THE CENTER FOR CHILDREN'S LAW AND POLICY FOR THE SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS, AND HUMAN RIGHTS OF THE SENATE JUDICIARY COMMITTEE 4 (2012) [hereinafter TESTIMONY], available at <http://solitarywatch.com/wp-content/uploads/2012/06/center-for-childrens-law-and-policy.pdf>.

¹⁶ *Id.*

¹⁷ *Id.* at 4-5.

¹⁸ *Id.*

¹⁹ *Id.* at 5.

²⁰ *Id.* at 4; *see, e.g.*, Plaintiff's Motion for Specific Performance to Secure Compliance with Stipulation Terms Regarding Operation of Progress Units and Related Matters at 15, *S.H. v. Reed*, 251 F.R.D. 293 (S.D. Ohio 2008) (No. 2:04-CV-1206). *S.H. v. Reed* (formerly *S.H. v. Stickrath*) is a class action civil rights case brought on behalf of youth committed to ODYS facilities in Ohio. *See id.* at 1.

Facilities with poorly designed behavior management programs and a lack of structured programming also tend to rely on isolation practices to sanction misconduct.²¹ Acknowledging and rewarding compliance and building on the strengths of a youth has been shown to be more effective than employing behavior management techniques focused primarily on punishment and control.²² Similarly, it is easier to manage behaviors when youth are kept busy, and have the majority of awake hours occupied in productive ways.²³ Accordingly, effective programming does not rely on the use of isolation to manage behavior, a practice that can be harmful and counterproductive to young people in custodial care.

A. *The Harmful Effects of Isolation Practices on Adolescents*

Adolescents require a higher standard of care in correctional facilities because the risk of harm from the use of isolation is greater. Isolation can not only exacerbate the symptoms of mental illness and result in further traumatization, but it can also create mental illness in youth who have not previously exhibited symptomology. This is particularly true of youth with depression, suicidal ideation, and those with Adult Deficit Hyperactivity Disorder (ADHD) or mood disorders. Isolating youth may also deny them necessary services such as education, mental health, and recreation.

1. A Higher Standard of Care Is Required for Adolescents than Their Adult Counterparts Because the Harm of Isolation Is Greater

The concept of “developmental immaturity” is used by researchers to describe adolescent development and the emerging neurological, cognitive, behavioral, emotional, and social capacity.²⁴ Specifically, researchers note four key components of developmental immaturity that distinguish adolescents from adults: independent functioning, decision-making, emotion regulation, and general cognitive processing.²⁵ In short, adolescents lack maturity in decision-making, are more likely to act impulsively, and are more likely to be influenced and manipulated by others.²⁶

Recently, the Supreme Court recognized these differences in a series of cases acknowledging that adolescents are “more vulnerable, more susceptible to outside pressures, and more capable of change than their adult counterparts.”²⁷ Not only is the impact of harm from isolation more significant on youth than adults, but also the expectation of treatment and effective

Pleadings filed by Plaintiffs’ counsel alleged that youth were held in special management units for months, and years in some cases, often spending as much as twenty-four hours a day in their rooms. *Id.* at 5. Many if not most of these youth were diagnosed with “mental health issues, histories of trauma, and/or cognitive delays, which have a significant effect on behaviors.” *Id.* at 7.

²¹ TESTIMONY, *supra* note 15, at 5.

²² MARK W. LIPSEY ET AL., GEORGETOWN UNIV. CTR. FOR JUVENILE JUSTICE REFORM, IMPROVING THE EFFECTIVENESS OF JUVENILE JUSTICE PROGRAMS: A NEW PERSPECTIVE ON EVIDENCED-BASED PRACTICE 23-24 (2010). The analysis of juvenile justice programs varied between those which were therapeutic with restorative practices, skill building, and counseling as compared to those utilizing control, surveillance, and managing by fear. *Id.* “When the mean effects on reoffense rates were compared for the programs associated with these two broad approaches, the programs with a therapeutic philosophy were notably more effective than those with a control philosophy.” *Id.* at 24.

²³ TESTIMONY, *supra* note 15, at 5.

²⁴ Marsha Levick et al., *The Eighth Amendment Evolves: Defining Cruel and Unusual Punishment Through the Lens of Childhood and Adolescence*, 15 U. PA. J.L. & SOC. CHANGE 285, 293 (2012) (citing Kathleen Kemp et al., Characteristics of Developmental Immaturity: A Cross-Disciplinary Survey of Psychologists 7 (Aug. 2010) (unpublished Ph.D. dissertation, Drexel University) (on file with Hagerty Library, Drexel University)).

²⁵ *Id.*

²⁶ *Id.* at 295-97.

²⁷ *Id.* at 306. The Supreme Court decisions in *Roper v. Simmons*, *Graham v. Florida*, *Miller v. Alabama*, and *J.D.B. v. North Carolina* forced a re-examination of juvenile and criminal justice policies and practices based on the “evolving standards of decency” doctrine under the Eighth Amendment, and utilized developmental psychology concepts to the treatment of children from adults. *Id.*

rehabilitative processes is greater.²⁸ Unlike the adult criminal justice system, the rehabilitative process has been at the cornerstone of the juvenile justice system since its inception.²⁹

Additionally, the United States Department of Justice, Office for Civil Rights recognized that using isolation on juveniles as punishment has a more profound effect on youth than adults.³⁰ The Office of Juvenile Justice and Delinquency Prevention stated that being subjected to isolation “begins to damage the juvenile, cause resentment toward the staff, and serves little useful purpose.”³¹ Courts also have recognized the harmful effects of placing youth in isolation. In *Inmates of Boy's Training School v. Affleck*, the court concluded that:

To confine a boy without exercise, always indoors, almost always in a small cell, with little in the way of education or reading materials, and virtually no visitors from the outside world, *is to rot away the health of his body, mind, and spirit*. To then subject a boy to confinement in a dark and stripped confinement cell with inadequate warmth and no human contact *can only lead to his destruction*.³²

Further examination of the consequences of isolation practices with youth suggests that isolation can increase symptoms in youth with existing mental illnesses, including agitation, aggression, anger, and difficulties with concentration and thinking.³³ For youth without underlying mental illnesses, symptoms may occur as a result of isolation.³⁴ The lack of positive reinforcements and rehabilitative services, which often accompany isolation practices, further exacerbate the negative consequences.

2. Isolation Can Exacerbate a Youth's Underlying Mental Illness

Although only limited research exists regarding the negative effects resulting from isolation on the mental stability of youth, studies on adults in solitary confinement demonstrate that isolation “often result[s] in severe exacerbation of a previously existing mental condition.”³⁵ Such measures have not only been shown to be an ineffective method of treatment,³⁶ they can also increase the likelihood of future delinquency or criminal activity.³⁷ The harmful effects are “especially significant for persons with serious mental illness,”³⁸ as “stress, lack of meaningful social contact, and unstructured days” can trigger or aggravate the symptoms of youth's pre-existing mental disorders.³⁹

²⁸ *Id.*

²⁹ *Id.* at 286.

³⁰ See Letter from R. Alexander Acosta, Assistant Att'y Gen., to Jennifer M. Granholm, Governor of Mich. 4 (Apr. 19, 2004) [hereinafter Letter to Governor of Mich.], available at http://www.justice.gov/crt/about/spl/documents/granholm_findinglet.pdf (“These lengthy isolations can have serious negative consequences for residents. Indeed, lengthy periods of isolation can be psychologically damaging to youth, *who generally experience time differently from adults*. Youth may experience symptoms such as paranoia, anxiety, and depression even after short periods of isolation.”) (emphasis added).

³¹ OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, STANDARDS FOR THE ADMINISTRATION OF JUVENILE JUSTICE 496 (1980).

³² *Inmates of Boys' Training Sch. v. Affleck*, 346 F. Supp. 1354, 1365-66 (D.R.I. 1972) (emphasis added).

³³ Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325, 328-36 (2006).

³⁴ *Id.*

³⁵ *Id.* at 329. Research in this area is limited. Dr. Grassian is among a limited number of psychiatrists in the country that have conducted extensive interviews with adults in isolation.

³⁶ COAL. FOR JUVENILE JUSTICE, HANDLE WITH CARE: SERVING THE MENTAL HEALTH NEEDS OF YOUNG OFFENDERS 70 (2000).

³⁷ *Id.* at 71. The report notes that interventions for youth who are mentally ill which focus on family rebuilding and intensive therapy can reduce the changes of recidivism by eighty percent. *Id.* at iii.

³⁸ Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY & LAW 104, 104 (2010).

³⁹ *Id.* at 105; see also Karen M. Abram et al., *Posttraumatic Stress Disorder and Trauma in Youth in Juvenile Detention*, 61 ARCH. GEN. PSYCHIATRY 403, 408-09 (2004) (describing prevalence estimates of exposure to trauma and rates of posttraumatic stress disorder (PTSD) among juvenile detainees).

While juvenile psychiatric facilities have used isolation for youth who present a danger to themselves or others, “the research has found seclusion to be harmful to patients and not related to positive patient outcomes.”⁴⁰ More than thirty years of evidence regarding the use of isolation in psychiatric facilities shows that “[t]here is no theoretical foundation for the use of seclusion with children” and that “the practice of seclusion does not add to therapeutic goals.”⁴¹ In short, the use of isolation lacks any foundation as an evidence-based practice. Indeed, increased scrutiny of the use of restraint and seclusion in psychiatric facilities has created a “legal and regulatory environment” in which the practice is discouraged because its use is arbitrary and risky.⁴²

More than two-thirds of youth confined in juvenile facilities suffer from one or more mental illness.⁴³ Common mental illnesses found in youth in juvenile facilities include disruptive disorders, substance abuse disorders, anxiety disorders, and mood disorders.⁴⁴ One study “identified from 19% to 46% of youth in the juvenile justice system as having attention deficit disorders.”⁴⁵ Research suggests that adults who struggle with these mental illnesses are more likely to engage in behaviors that lead facility staff to place them in isolation.⁴⁶

Youth who are disruptive or violent, in spite of their mental health status, may be placed in a facility’s disciplinary unit where the focus is on containing and deterring future disruptive behaviors rather than treatment or psychosocial management of such behaviors.⁴⁷ These units isolate youth, often from both sight and sounds of others, as a sanction for rule breaking.⁴⁸ In contrast to psychiatric units that may use isolation for brief periods of time and contingent on the individual’s ability to safely return to a regular unit, disciplinary seclusion in a correctional context may be longer and pre-determined as a sentence.⁴⁹

3. Isolating Victims of Trauma Can Further Victimize

The prevalence of exposure to trauma among youth in the juvenile justice system is significant and profoundly important to treatment efforts. According to a 2010 survey released by the Office of Juvenile Justice and Delinquency Prevention, seventy percent of youth confined in correctional facilities revealed that they had personally “seen someone severely injured or killed,” and seventy-two percent “had had something very bad or terrible happen to [them].”⁵⁰

⁴⁰ Linda M. Finke, *The Use of Seclusion Is Not Evidence-Based Practice*, 14 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 186, 186 (2001).

⁴¹ *Id.* at 189.

⁴² STEPHAN HAIMOWITZ, ET AL., RESTRAINT AND SECLUSION- A RISK MANAGEMENT GUIDE 1 (2006).

⁴³ JENNIE L. SHUFELT & JOSEPH J. COCOZZA, NAT’L CTR. FOR MENTAL HEALTH & JUVENILE JUSTICE, YOUTH WITH MENTAL HEALTH DISORDERS IN THE JUVENILE JUSTICE SYSTEM: RESULTS FROM THE MULTI-STATE PREVALENCE STUDY 4 (2006), <http://cfc.ncmhjj.com/wp-content/uploads/2013/11/PrevalenceRPB.pdf>.

⁴⁴ *Id.* Of the number of youth in the juvenile justice system, this study suggests that approximately 46.5% have disruptive disorders, such as conduct disorders, 46.2% have substance abuse disorders, 34.4% have anxiety disorders, and 18.3% have mood disorders such as depression. *Id.* at 2. Seventy-nine percent of the youth in this study meet the criteria for more than one diagnoses, and sixty percent meet the criteria for three or more diagnoses. *Id.* at 3.

⁴⁵ ROBERT B. RUTHERFORD JR. ET AL., YOUTH WITH DISABILITIES IN THE CORRECTIONAL SYSTEM: PREVALENCE RATES AND IDENTIFICATION ISSUES 18-19 (2002).

⁴⁶ See HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 147 (2003), available at <http://www.hrw.org/sites/default/files/reports/usa1003.pdf> (“The mentally ill are disproportionately represented among prisoners in segregation. As discussed earlier in this report, persons with mental illness often have difficulty complying with strict prison rules, particularly when there is scant assistance to help them manage their disorders. Their rule-breaking can lead to increasing punishment, particularly if they engage in aggressive or disruptive behavior. Eventually accumulating substantial histories of disciplinary infractions, they land for prolonged periods in disciplinary or administrative segregation.”).

⁴⁷ Christopher A. Cowles & Jason J. Washburn, *Psychological Consultation on Program Design of Intensive Management Units in Juvenile Correctional Facilities*, 36 PROF. PSYCHOL.: RES. & PRAC. 44, 45 (2005).

⁴⁸ *Id.*

⁴⁹ See *id.*

⁵⁰ MENDEL, *supra* note 1, at 22 (calculating data from the Survey of Youth in Residential Placement online database).

Another study found that more than ninety percent of a sample of juvenile delinquents had experienced at least one traumatic event, and more than half of the population had been exposed to trauma six or more times.⁵¹ Additional research illustrates “that a significant proportion of juvenile offenders have a substantiated history of child maltreatment,”⁵² and “that at least [seventy-five percent] of youths in the juvenile justice system have been exposed to victimization.”⁵³ Traumatic victimization is defined as “being threatened or harmed intentionally by a caregiver or other trusted person (e.g., sexual, physical, or emotional abuse), witnessing caregivers or significant others being intentionally harmed (e.g., domestic violence), or neglect, separation from, or abandonment by trusted adults or youths.”⁵⁴ Such traumatic victimization has been linked to psychological disorders such as PTSD, and can cause youth to develop ongoing difficulties with oppositional-defiance and aggression.⁵⁵

Youth with PTSD or other trauma-induced illness may feel like their victimization has “stripped away” their sense of self-respect and control, and, consequently, they may enter a “survival coping” mode where they resort to anger, defiance of rules and authority, and aggression.⁵⁶ They may also become persistently stubborn, resistant to directions, and unwilling to compromise.⁵⁷ Because psychological trauma is emotionally and physically shocking, victimization can have a physiological effect as well.⁵⁸

Trauma also slows down development and can cause disturbances of emotional regulation, relationships, and communication.⁵⁹ Aggressive youth tend to overreact to actions by correctional officers as a perceived threat, typically because it is reminiscent of past victimization.⁶⁰ These youth do not see their responses as excessive, because they “have little experience expressing their thoughts and resolving their feelings verbally rather than through aggression,” and “may feel helpless about regulating their behavior.”⁶¹ Instead of helping youth heal from the victimization that has traumatized them, juvenile facilities are prone to punishing aggressive children by placing them in isolation for their misbehavior.

The placement of youth in isolation who have already experienced trauma may further re-victimize the youth.⁶² Research on victimized children shows that the experience of trauma increases their “vulnerability to stressors- even mild stressors that healthy individuals are able to

⁵¹ Abram et al., *supra* note 39, at 407.

⁵² Heather Y. Swanston et al., *Juvenile Crime, Aggression and Delinquency After Sexual Abuse: A Longitudinal Study*, 43 BRIT. J. CRIMINOLOGY 729, 729 (2003).

⁵³ Julian D. Ford et al., *Pathways from Traumatic Child Victimization to Delinquency: Implications for Juvenile and Permanency Court Proceedings and Decisions*, JUV. & FAM. CT. J., Jan. 2006, at 13, 13.

⁵⁴ *Id.* at 14.

⁵⁵ Julian D. Ford, *Traumatic Victimization in Childhood and Persistent Problems with Oppositional-Defiance*, 6 J. AGGRESSION, MALTREATMENT & TRAUMA 25, 26 (2002).

⁵⁶ Ford et al., *supra* note 53, at 17.

⁵⁷ CAELAN KUBAN, NAT'L INST. FOR TRAUMA & LOSS IN CHILDREN, OPPOSITIONAL DEFIANT DISORDER AND TRAUMA 2 (2011), available at <http://www.lianalowenstein.com/articlesODDKuban.pdf>.

⁵⁸ *Id.* at 5-6. Kuban notes that “[c]hildren with a history of trauma have greater oppositional defiant behaviors,” likely because “of the negative physiological impact that trauma has on core regulatory systems.” *Id.* at 5. Trauma increases the individual’s vulnerability to stressors, and makes problem solving more difficult. *Id.* at 6. Central nervous system brain structures are affected by trauma, which can impact the ability to communicate, affect how individuals respond to perceived threats, and impact new memory storage and learning, social behavior, and decision making. *Id.* at 6.

⁵⁹ *Id.* at 5-6.

⁶⁰ MICHAEL PUISIS, CLINICAL PRACTICE IN CORRECTIONAL MEDICINE 124 (2d ed. 2006); *see also* Ford, *supra* note 55, at 39 (“[T]hese children’s emotions and thought processes reflect a fearful and hypervigilant concern with the possibility of severe danger. It is as if they view their lives as an almost constant effort to be prepared for, and to survive, the recurrence of traumatic danger.”).

⁶¹ PUISIS, *supra* note 60.

⁶² JULIAN D. FORD ET AL., NAT'L CTR. FOR MENTAL HEALTH & JUVENILE JUSTICE, TRAUMA AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM: CRITICAL ISSUES AND NEW DIRECTIONS 3 (2007), <http://www.cwla.org/programs/juvenilejustice/ncmhjjtraumayouth.pdf>.

handle.”⁶³ Stressors, which are “environmental events or chronic conditions that objectively threaten the physical and/or psychological health or well-being of individuals of a particular age in a particular society,” have also been shown to aggravate symptoms of depression.⁶⁴ Institutions that fail to screen and identify youth with a history of trauma risk further harm to the child when isolation is used as a method of controlling behaviors.

4. Isolation Can Exacerbate the Symptoms of Depression

Depression is also a common problem among youth in juvenile facilities. A 2006 study by the National Center for Mental Health and Juvenile Justice suggests that nearly one in five youth in juvenile justice programs suffered from mood disorders, such as depression.⁶⁵ Those rates were even higher for females, where nearly thirty percent were diagnosed with mood disorders, and fifty-six percent with anxiety disorders.⁶⁶

As with PTSD, adolescent depression may manifest in ways that lead to the imposition of isolation. Adolescents manifest depression through a combination of symptoms, including depressed mood and feelings of hopelessness and helplessness.⁶⁷ Research indicates that irritability is another common characteristic of depression in young adults, and increases with the severity of the depressive state. Adolescent depression can also create anger and hostility, which “increases the likelihood that [depressed youth] will provoke angry responses from other youth (and adults)” and may “increase the risk of altercations with other youth.”⁶⁸ Based on the author’s experience, these behaviors and attitudes may lead facility officials to respond to such behaviors by placing the youth in isolation. Facility officials make this decision without regard to the fact that “[w]hat might look first to be bad behaviour may be a symptom of a major mental disorder that if left untreated can have significant . . . psychological consequences.”⁶⁹

Research on adult inmates who “are prone to depression and have had past depressive episodes will become very depressed while in isolated confinement.”⁷⁰ Isolation has also been shown to increase self-mutilation and suicide attempts in mentally ill prisoners,⁷¹ due to the fact that it “undoubtedly worsens emotional state, hinders problem-solving and can increase the risk for life-threatening behavior.”⁷² Facilities can utilize more effective means of behavior control in lieu of isolation, particularly for youth with mental health disorders such as depression and anxiety. Such measures are discussed later in the Article.⁷³

5. Isolation Can Agitate Youth with Attention Deficit Hyperactive and Bipolar Mood Disorders

While studies show that in the general school population only two to ten percent of youth have ADHD,⁷⁴ anywhere from nineteen to forty-six percent of youth in the juvenile justice system are identified as having ADHD.⁷⁵ Isolation can also be especially damaging for youth who have

⁶³ KUBAN, *supra* note 57, at 6.

⁶⁴ Benjamin L. Hankin, *Adolescent Depression: Description, Causes, and Interventions*, 8 EPILEPSY & BEHAV. 102, 105 (2006).

⁶⁵ SHUFELT & COCOZZA, *supra* note 43, at 2. The study on prevalence collected information from Louisiana, Texas, and Washington from three different settings: community-based programs, juvenile detention centers, and secure residential treatment facilities. *Id.*

⁶⁶ *Id.* at 4.

⁶⁷ Marie Crowe et al., *Characteristics of Adolescent Depression*, 15 INT’L J. MENTAL HEALTH NURSING 10, 13, 15 (2006).

⁶⁸ Thomas Grisso, *Adolescent Offenders with Mental Disorders*, FUTURE CHILDREN, Fall 2008, at 143, 145.

⁶⁹ Crowe et al., *supra* note 67, at 16.

⁷⁰ HUMAN RIGHTS WATCH, *supra* note 46, at 152 (quoting Dr. Terry Kupers on the impact of segregation on adult inmates).

⁷¹ *Id.* at 179.

⁷² Raymond Bonner, *Rethinking Suicide Prevention and Manipulative Behavior in Corrections*, JAIL SUICIDE/MENTAL HEALTH UPDATE, Fall 2001, at 7, 7-8 (2001).

⁷³ See *infra* Part IV.

⁷⁴ ROBERT B. RUTHERFORD, JR. ET AL., *supra* note 45, at 18; see HUMAN RIGHTS WATCH, *supra* note 46, at 179 (quoting Raymond Bonner).

⁷⁵ ROBERT B. RUTHERFORD, JR. ET AL., *supra* note 45, at 18-19.

ADHD or other mood disorders because of their inability to tolerate environments with such restricted levels of stimulus.⁷⁶ Research on ADHD and Anti-Social Personality Disorders indicates that both disorders are characterized by an inability to tolerate restrictions in environmental stimulation.⁷⁷ Both disorders share traits of impulsivity and behavior that seeks stimulation, as well as biological abnormalities in central nervous system functioning.⁷⁸

Dr. Stuart Grassian,⁷⁹ a national expert on the use of solitary confinement, notes the lack of systematic investigation into the characteristics that might raise warning flags as to the susceptibility of an individual in isolation to severe psychological reactions.⁸⁰ Some medical research, however, suggests that in psychiatric settings, patients “whose internal emotional life is chaotic and impulse-ridden and individuals with central nervous system dysfunction may be especially prone to psychopathological reactions to restricted environmental stimulation in a variety of settings.”⁸¹ As Dr. Grassian concludes, these are the individuals that are most likely to break the rules and to be subjected to increasingly severe punishments such as isolation and solitary confinement.⁸²

An expert report filed by Dr. Grassian in *S.H. v. Stickrath*⁸³ included an extensive examination of six youth files evaluating the effects of long-term isolation on youth in a special management unit.⁸⁴ One such youth was admitted at age fifteen and had ADHD.⁸⁵ Although he was originally described as “calm, polite, and not demonstrating any risk to himself or others,” he was immediately placed in a long-term segregation unit.⁸⁶ By the time Dr. Grassian evaluated his file, the youth had been in the Special Management Unit (SMU) for over a year.⁸⁷ Dr. Grassian described the impact that isolation had on this child:

Inevitably, after a few months his mental state and behavior deteriorated ... his emotional reactivity, his ability to tolerate frustration, plummeted. On December 11, 2011 he was going to kill himself because he could not immediately get a drink of water. He was desperate to get his cuff port opened.⁸⁸

This extreme emotional response is an example of how those individuals who suffer from ADHD and bipolar disorder are unable to tolerate the restricted environmental stimulation found in an isolation unit.⁸⁹ This intolerance may subsequently cause an increased susceptibility to psychopathological reactions while in isolation.⁹⁰

6. Isolation Can Create Mental Illness in Youth

⁷⁶ Grassian, *supra* note 33, at 350.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ Dr. Grassian is a Board Certified psychiatrist with “extensive experience in evaluating the mental health care afforded to adults and adolescents in” prisons and juvenile facilities, and in particular, “evaluating the psychiatric effects of isolated confinement.” Declaration: Psychiatric Report in *S.H. v. Reed* at 1, *S.H. v. Stickrath*, 251 F.R.D. 293 (S.D. Ohio 2008), (No. 2:04-CV-1206) [hereinafter Grassian Declaration].

⁸⁰ *Id.*

⁸¹ *Id.* at 350-51.

⁸² *Id.* at 351.

⁸³ *S.H. v. Stickrath*, 251 F.R.D. 293 (S.D. Ohio 2008). Note that *S.H. v. Stickrath* is now *S.H. v. Reed*.

⁸⁴ See Grassian Declaration, *supra* note 79, at 24-32.

⁸⁵ *Id.* at 24.

⁸⁶ *Id.*

⁸⁷ *Id.* at 16.

⁸⁸ *Id.* at 24-25.

⁸⁹ See Grassian, *supra* note 33, at 331-33 (discussing the extreme psychological effects of isolation and sensory deprivation on individuals with preexisting vulnerabilities as compared to those with more stable personalities).

⁹⁰ *Id.*

Studies regarding the onset of psychological disease as a result of isolation practices have primarily focused around adult inmates.⁹¹ This research indicates that isolation can cause severe psychiatric harm, even when the individual had no history of mental illness prior to his or her isolation.⁹² Dr. Grassian's work documents the serious psychiatric pathology found in many of the inmates housed in harsh conditions of solitary.⁹³ These included an inability to tolerate ordinary stimuli, auditory hallucinations of voices saying frightening things or bizarre noises, panic attacks, severe difficulty with thinking, concentration and memory, intrusive obsessional thoughts, primitive aggressive ruminations, and paranoid, persecutory fears.⁹⁴

The research from this study described symptoms, which were not only dramatic, but also not found in any other psychiatric illness.⁹⁵ Dr. Grassian even suggested that the unique nature of the symptoms appeared to form a "discreet syndrome."⁹⁶ Symptoms included "acute dissociative, confusional psychoses," and "extensive perceptual disturbances experienced by the isolated person."⁹⁷ Additionally, loss of perceptual constancy, rarely found anywhere else, is generally associated with neurological illness such as seizure disorders or brain tumors, rather than a primary psychiatric illness.⁹⁸

A number of studies have demonstrated that individuals vary significantly in "their capacity to tolerate a given condition of sensory restriction."⁹⁹ Individuals of average intelligence who have mature and healthy personality functioning can better tolerate the effects of isolation without regression and perceptual disturbances.¹⁰⁰ Even individuals with these stabilizing attributes can "inevitably suffer severe psychological pain as a result of [isolation]," especially where the isolation is prolonged or the punishment is perceived by the individual as arbitrary and unjust.¹⁰¹ The prognosis for those without such stabilizing factors is far worse. "On the other hand, individuals with primitive or psychopathic functioning or borderline cognitive capacities, impulse-ridden individuals, and individuals whose internal emotional life is chaotic or fearful are especially at risk for severe psychopathologic reactions to such isolation."¹⁰² In either case, however, the individual's ability for successful re-integration back into the community may be hampered by the prospect of permanent psychiatric disability caused by isolation.¹⁰³

Dr. Grassian's review of six youth in a special management unit in an Ohio juvenile correctional facility reveals several startling examples of how such deterioration may manifest, although in each case youth were previously diagnosed with some form of mental illness.¹⁰⁴ After reviewing the charts of the youth that were held in isolation for months, and in some cases years, Dr. Grassian's conclusion definitively notes the deterioration patterns found in each case:

⁹¹ *Id.* at 333; *see, e.g.*, Craig Haney, "Infamous Punishment": *The Psychological Consequences of Isolation*, 8 NAT'L PRISON PROJECT J. 3, 4 (1993); Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 484-85 (1997).

⁹² *See, e.g.*, Grassian, *supra* note 33, at 333.

⁹³ *Id.*

⁹⁴ *Id.* at 335-36.

⁹⁵ *Id.* at 337.

⁹⁶ *Id.* Dr. Grassian defines a discreet syndrome as "a constellation of symptoms occurring together and with a characteristic course over time, thus suggestive of a discrete illness." *Id.*

⁹⁷ *Id.* at 335, 337.

⁹⁸ *Id.* at 337.

⁹⁹ *Id.* at 347.

¹⁰⁰ *Id.* at 348.

¹⁰¹ *Id.* at 354.

¹⁰² *Id.* at 348.

¹⁰³ *Id.* at 354.

¹⁰⁴ *See* Grassian Declaration, *supra* note 79, at 32.

Describing what has been occurring in the Ohio DYS [Department of Youth Services] as unacceptable or unconstitutional does not fully capture the experience of reading the youths' files. It is tragic. I was provided six charts, and every one of them demonstrated the destructive impact of their confinement at ODYS. Youths arrive with severe psychiatric and cognitive burdens, but they arrive with some hope, some willingness to engage. Placing this exquisitely vulnerable group of youngsters in harsh conditions of solitary confinement basically dooms them. They become more violent, more out of control, more rigidly locked into their "evil side" How disabling will be the developmental distortions they have experienced? DYS custody has not resulted in treated and rehabilitation; it may well have permanently crippled them.¹⁰⁵

One young man, admitted at age fourteen, was on and off the mental health caseload, in spite of diagnoses of ADHD and Bipolar Disorder.¹⁰⁶ He was placed in a special management unit where he remained for more than a two-year period, at times receiving no mental health treatment.¹⁰⁷ Dr. Grassian notes his deterioration in this way:

In October 2011, while in seclusion, [E.F.] revealed to [a] psychologist . . . that he was frightened of his own violent obsessional thoughts. He was afraid that he was going to kill two staff members. He felt out of control, believed he was about to do something "catastrophic" and that he was fighting against strong urges. He wanted [the psychologist] to understand that he needed to be separated from the unit to prevent himself from doing what was on his mind. He said that a part of him understood that he was regressing back to the out of control rage he felt while confined at Ohio River JCF; he was fighting, but the bad part of him was growing and eroding away at the good part.

. . .

E.F. continued expressing his fear. He told [a different psychologist] . . . that he was afraid he would never be able to make it in a more open setting. Yet he feared that he would "lose it" if he stayed in solitary any longer. He told the doctor that he was afraid that he was genetically damaged and doomed to follow the path of his parents. He made the point that he had been in solitary for a long time without any indication of sustained success in shedding himself of this anger, and indeed it appeared to be getting worse as he spent a longer period of time on the Cedar Unit.¹⁰⁸

Isolation is not simply unpleasant and counterproductive; as Dr. Grassian suggests, it may impair adolescent development to a crippling degree. In fact, because the brain's malleability decreases with age, making it increasingly more difficult to heal,¹⁰⁹ the adverse psychological effects of isolation on juveniles are potentially irreversible.¹¹⁰

¹⁰⁵ *Id.* at 32-33.

¹⁰⁶ *Id.* at 30.

¹⁰⁷ *Id.* at 30-32.

¹⁰⁸ *Id.* at 31-32.

¹⁰⁹ *Id.* at 12.

¹¹⁰ *Id.*

7. Isolating Juveniles May Correlate with a Higher Risk of Self-Harm or Suicide

Self-harm among incarcerated individuals in correctional settings is common and dangerous.¹¹¹ A recent study of the New York Jail system examined 2,182 incidents of self-harm among inmates over a three-year period to better understand the complex risk factors associated with self-harm and improve intervention methods.¹¹² For purposes of the study, self-harm was defined as “an act performed by individuals on themselves with the potential to result in physical injury, and potentially fatal self-harm as an act with a high probability of causing significant disability or death, regardless of whether death actually occurred.”¹¹³

Controlling for length of stay, serious mental illness, age and race/ethnicity, the study found that the most significant predictor for self-harm was isolation in solitary confinement.¹¹⁴ Individuals with serious mental illness and those who were under the age of eighteen also rated higher for the incidence of self-harm, but greater risk for self-harm and fatal self-harm correlated with isolation independent of these two characteristics.¹¹⁵ Most notably, the results indicate that the majority of self-harm incidents were committed by a small proportion of individuals: those held in isolation who were under the age of eighteen and seriously mentally ill.¹¹⁶ The results of this study call for changes in policies and procedures, which would eliminate the use of isolation as punishment in jails, particularly for those who are seriously mentally ill or for youth.¹¹⁷

Isolating juveniles may also correlate with an increased the risk of suicide.¹¹⁸ Between 1995 and 1999, the Office of Juvenile Justice and Delinquency Prevention conducted the first national survey of suicides in public and private juvenile facilities.¹¹⁹ The study found that fifty percent of youth who committed suicide were in isolation at the time of their suicide; sixty-two percent had previously been in isolation.¹²⁰

Additionally, youth with pre-existing mental illnesses are not the only ones at risk of suicide.¹²¹ The sheer boredom caused by isolation can “be a dangerous condition in a juvenile institution, because mental and physical inactivity increases frustration and depression in youth.”¹²² Because “an adolescent’s mood can swing quickly from a ‘normal’ emotional state to suicidal,” even as a reaction to an event that is seemingly minor, “[a]ny change in a youth’s psychosocial or emotional state may trigger suicidal thoughts or actions.”¹²³ Thus, the high correlation between suicide and the use of isolation suggests that this practice is innately risky for institutions that house adolescents.

8. Isolating Youth May Deny Them Necessary and/or Required Services

Youth in isolation are frequently denied the level of education or other services to which they are entitled.¹²⁴ In addition, the mental health care provided for isolated juveniles is

¹¹¹ Fatos Kaba, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. HEALTH 442, 442 (2014).

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.* at 445. The authors of the study note that “[i]nmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm after we controlled for the length of jail stay, SMI, age, and race/ethnicity. This association also held true for potentially fatal self-harm with a slightly lower OR, 6.3.” *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 447.

¹¹⁸ LINDSAY M. HAYES, NAT’L CTR. ON INSTS. & ALTS., *JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY* ix-x (2004), <https://www.ncjrs.gov/pdffiles1/ojdp/grants/206354.pdf>.

¹¹⁹ *Id.* at ix.

¹²⁰ *Id.* at x.

¹²¹ PUISIS, *supra* note 60, at 139.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ See, e.g., Letter from Thomas E. Perez, Assistant Att’y Gen., to Mitch Daniels, Governor of Ind. 34-42 (Jan. 29, 2010) [hereinafter Letter to Governor of Ind.], available at http://www.justice.gov/crt/about/spl/documents/Indianapolis_findlet_01-29-10.pdf

considerably inadequate, especially given the prevalence of severe mental illness among this population.¹²⁵

i. Denial of educational services

As with mental illness, the prevalence of learning disabilities and other behavioral problems is similarly disproportionate among confined youth.¹²⁶ Educational achievement and rates of success in school are also lower among youth who are incarcerated, with studies suggesting that these youth perform, on average, four years below grade level in reading and math.¹²⁷ Additionally, a significant percentage of youth in detention and commitment facilities have disabilities that substantially affect their education, and either have or should have been identified for special education services.¹²⁸ Forcing youth in isolation to miss school or other activities can also increase depression and suicidal ideation and attempts.¹²⁹

Youth already identified as eligible for services under the Individuals with Disabilities Education Act (IDEA), or in some cases those not yet identified, have special protections against exclusion from school for violations of disciplinary rules.¹³⁰ Nothing in the IDEA excludes from coverage, or diminishes the rights of, children with education-related disabilities who are detained or incarcerated in delinquency facilities.¹³¹ Taking any young person out of school in a detention or long-term incarceration setting is inconsistent with a youth's care and rehabilitation, as well as a state statutory right to education.

ii. Inadequate mental health care

The juvenile justice system is not designed to adequately address the needs of adolescents with mental disorders.¹³² The apparent goal of the juvenile justice system has seemed to move away from rehabilitation and towards community protection.¹³³ The use of isolation and other behavior-control methods is simply not conducive to the care of mentally ill teenagers.¹³⁴ As a result, "[t]he juvenile justice system is fraught with inconsistencies in screening and diagnosis along with a limited capacity for mental health services."¹³⁵

(explaining that the DOJ Special Litigation section found that the Indiana Juvenile Correctional Facility did not provide youth with adequate special education services, as required by the IDEA, including "(1) child find; (2) general education interventions; (3) Individual Education Plans ("IEPs"); (4) access to the general education curriculum; (5) student behavior; (6) staffing; and (7) transition services"); Letter from Wan J. Kim, Assistant Att'y Gen., to Ted Strickland, Governor of Ohio 14-16 (May 9, 2007) [hereinafter Letter to Governor of Ohio], available at http://www.justice.gov/crt/about/spl/documents/scioto_findlet_5-9-07.pdf; Letter from Thomas E. Perez, Assistant Att'y Gen., to Robert Moore, Chair, Leflore Cnty. Bd. of Supervisors 9-14 (Mar. 31, 2011), available at http://www.justice.gov/crt/about/spl/documents/LeFloreJDC_findlet_03-31-11.pdf.

¹²⁵ INT'L SOC'Y OF PSYCHIATRIC-MENTAL HEALTH NURSES, MEETING THE MENTAL HEALTH NEEDS OF YOUTH IN JUVENILE JUSTICE 2 (2008), <http://www.ispn-psych.org/docs/JuvenileJustice.pdf>.

¹²⁶ Mary Magee Quinn et al., *Youth with Disabilities in Juvenile Corrections: A National Survey*, 71 EXCEPTIONAL CHILD 339, 339-40 (2005). "The prevalence of such disorders among the juvenile justice population, has led some professionals to characterize juvenile justice as a 'default system' for youth who can't read or write well, who have mental health problems, and who drop out or are forced out of school." *Id.*

¹²⁷ Michael P. Krezmien et al., *Detained and Committed Youth: Examining Differences in Achievement, Mental Health Needs, and Special Education Status*, 31 EDUC. & TREATMENT CHILDREN 445, 453 (2008).

¹²⁸ *Id.* at 458-59; see also Katherine Twomey, Note, *The Right to Education in Juvenile Detention Under State Constitutions*, 94 VA. L. REV. 765, 771 (2008) (noting that the percentage of incarcerated youth with disabilities that may qualify for special education is as high as seventy percent); Kevin W. Alltucker, et al., *Different Pathways to Juvenile Delinquency: Characteristics of Early and Late Starters in a Sample of Previously Incarcerated Youth*, 15 J. CHILD & FAM. STUDIES 475, 481 (2006) (noting that between thirty and fifty percent "of juvenile offenders have a documented disability, compared with about 13% of the general population").

¹²⁹ PUISIS, *supra* note 60, at 139.

¹³⁰ 20 U.S.C.A. § 1415(a)-(b), (k) (West 2014).

¹³¹ *Id.*

¹³² INT'L SOC'Y OF PSYCHIATRIC-MENTAL HEALTH NURSES, *supra* note 125 ("[T]he primary mission of the juvenile justice system has been the provision of public safety and therefore the system is ill-equipped to be the nation's primary provider of child and adolescent mental health care.").

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

Dr. Grassian similarly noted this disturbing trend at the Ohio facility. The facility employed a behavioral-control method of dealing with children who acted out; “[b]ehavioral manifestations of psychiatric illness and of the erosive effects of solitary confinement are viewed as ‘conscious choices’ and ‘thinking errors’, cognitive distortions that must be corrected.”¹³⁶ Dr. Grassian found that in general, the mental health treatment youth received while in isolation did not look to treat the underlying causes of their bad behavior, but focused solely on the surface and attempted to control that behavior.¹³⁷ He concluded:

ODYS has the responsibility to protect and rehabilitate youth, to help them develop into functioning adults. Instead, it embraces the worldview of harsh punishment, of pounding, never-ending deprivation. It breeds cruelty and dehumanization, as bad or even worse than found in many adult prisons. Over time, the disciplinary sanctions so freely prescribed grow to a point that they are mountainous, and there is nothing left in the youth besides hopelessness and rage. The [SMU] program destroys what it is supposed to nurture.¹³⁸

In evaluating this SMU program, Dr. Grassian concluded that the inadequate, and often virtually nonexistent mental health care these youth received, combined with their long-term placement in isolation, had an extremely anti-rehabilitative effect and led to their eventual psychological and behavioral deterioration.¹³⁹

III. LEGAL AND PROFESSIONAL STANDARDS FOR THE USE OF ISOLATION FOR YOUTH

The Supreme Court has reaffirmed in four recent cases that juveniles require special protections from the juvenile and criminal justice systems. In light of cognitive and developmental differences among youth as compared to adults, the Court first outlawed the death penalty for individuals under the age of eighteen,¹⁴⁰ followed by a prohibition against mandatory life without parole for juveniles at the time of their offenses.¹⁴¹ The Court recognized the vulnerability of children, noting their suggestibility, impulsivity, eagerness to please adults, and immature decision-making.¹⁴² Building on its decisions in the Eighth Amendment context, the Supreme Court in *J.D.B. v. North Carolina* issued an opinion based upon the principle that youth are particularly likely to make involuntary and false confessions, and that children “characteristically lack the capacity to exercise mature judgment and possess only an incomplete ability to understand the world around them.”¹⁴³ These cases together suggest a movement toward jurisprudence that requires a development approach to matters involving juvenile law.

Courts have similarly recognized that to satisfy the requirements of due process for detained youth, it is appropriate, and in fact necessary, to consider that youth have different needs and capacities than adults.¹⁴⁴ Similarly, since youth who remain in the juvenile justice system

¹³⁶ Grassian Declaration, *supra* note 79, at 33.

¹³⁷ *Id.*

¹³⁸ *Id.* at 34.

¹³⁹ *Id.*

¹⁴⁰ See *Roper v. Simmons*, 543 U.S. 551, 578 (2005) (abolishing the death penalty for all youth).

¹⁴¹ See *Graham v. Florida*, 560 U.S. 48, 74 (2010) (abolishing life without parole for juveniles who commit non-homicide offenses); *Miller v. Alabama*, 132 S. Ct. 2455, 2464 (2012) (barring mandatory imposition of life without parole for all juveniles).

¹⁴² *Miller*, 132 S. Ct. at 2464-68; *Graham*, 560 U.S. at 68; *Roper*, 543 U.S. at 569.

¹⁴³ See *J.D.B. v. N. Carolina*, 131 S. Ct. 2394, 2400-03 (2011).

¹⁴⁴ YOUTH LAW CTR., LEGAL ISSUES AND LIABILITIES IN JUVENILE CONFINEMENT FACILITIES 8 (1999) (citing *A.J. v. Kierst*, 56 F.3d 849, 854 (8th Cir. 1995) (“[T]he due process standard applied to juvenile pretrial detainees should be more liberally construed than that applied to adult detainees.”); *Bergren v. Milwaukee*, 811 F.2d 1139, 1143 (7th Cir. 1987) (“In assessing whether the treatment of

typically do not receive “convict[ions]” for their actions, freedom from unnecessary restraint requires closer scrutiny.¹⁴⁵

Rather than focusing on safeguarding children from the devastating effects of isolation, standards have historically created procedural limitations to when juvenile facilities may place youth in isolation, how they must be supervised, and the documentation required to justify their continued length of stay in isolation. More recently, however, standards developed by professional and trade organizations within the juvenile justice field have begun to provide a more comprehensive view of how isolation should be limited, with greater attention and emphasis drawn to other more effective forms of behavior management.

Recent attention has focused on the practice of isolating youth as a civil and human rights issue, with a socially and psychologically damaging impact,¹⁴⁶ which has garnered increased federal response to this practice. For example, the 2012 U.S. Attorney General’s National Task Force on Children Exposed to Violence (“Task Force”) called for strict limitations on the use of youth isolation, noting that “[n]owhere is the damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement.”¹⁴⁷ The Task Force called for abolishing correctional practices that result in trauma to children and that diminish their opportunities to become productive adults.¹⁴⁸ Similarly, the Office of Juvenile Justice and Delinquency Prevention takes the position that the isolation of children is dangerous, fails to comport with best practices, and may constitute cruel and unusual punishment if used excessively.¹⁴⁹ Moreover, the Department of Justice through its promulgation of regulations implementing the Prison Rape Elimination Act (PREA) has noted that isolation of youth in correctional facilities is not appropriate.¹⁵⁰

Continued legal challenges to the use of isolation should focus more heavily on the harmful effects of isolation practices on youth, and utilize evidence-based practices for managing behavior to more robustly apply standards, change policy, and improve litigation results.

A. *The Results of Litigation in Shaping Practices*

Litigation challenging unconstitutional conditions of confinement in juvenile facilities has resulted in remedial measures to address the use of isolation and the serious damaging effects it has on youth. Application of the Fourteenth Amendment standard to juvenile cases concerning the use of isolation has, in many circumstances, resulted in the determination that such practices are a violation of the Due Process Clause. Some courts, however, have applied the Eighth Amendment standard of cruel and unusual punishment. Several of these cases are discussed below, including findings made by the United States Department of Justice Office of Civil Rights through its CRIPA enforcement authority.

the detained juvenile satisfies the requirements of due process, it is quite appropriate—indeed necessary—to consider that in such an environment juveniles may indeed have different needs and more importantly, different capacities than adults.”)

¹⁴⁵ *Santana v. Collazo*, 714 F.2d 1172, 1179 (1st Cir. 1983).

¹⁴⁶ See generally *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Subcomm. on the Constitution, Human Rights and Civil Rights of the S. Comm. on the Judiciary*, 112th Cong. (2012) (providing notice of the subcommittee hearing and including a list of witnesses); *2012 U.S. Senate Hearing: Archive of Written Testimony*, SOLITARY WATCH, <http://solitarywatch.com/resources/testimony/2012-senate-hearing-archive-written-testimony/> (last visited Mar. 8, 2014) (providing the written testimony submitted by organizations and groups including the Children’s Law Center, Inc., the Center for Children’s Law and Policy, the Juvenile Justice Initiative, the Pacific Juvenile Defender Center, and the Youth Law Center).

¹⁴⁷ ROBERT L. LISTENBEE, JR. ET AL., REPORT OF THE ATTORNEY GENERAL’S NATIONAL TASK FORCE ON CHILDREN EXPOSED TO VIOLENCE 178 (2012), <http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf>.

¹⁴⁸ *Id.* at 22.

¹⁴⁹ See Letter from Robert L. Listenbee, Adm’r, Office of Juvenile Justice & Delinquency, to Jesselyn McCurdy, Senior Legis. Counsel of the Am. Civil Liberties Union (July 5, 2013).

¹⁵⁰ *Id.* at 3.

1. Fourteenth Amendment Due Process of Law

Although some courts have recognized Eighth Amendment protection for juveniles in isolation, a number of federal circuits today analyze isolation claims under the protections of the Due Process Clause of the Fourteenth Amendment.¹⁵¹ In *Ingraham v. Wright*, the Supreme Court determined that the Eighth Amendment protection against cruel and unusual punishment only applies to individuals who have received a criminal conviction.¹⁵² Importantly, the Supreme Court has not specifically addressed what standard governs the use of isolation for juveniles adjudicated delinquent. Many circuits that have reviewed the issue, however, have determined that since juvenile offenders have not been “convicted” of a crime, the Fourteenth Amendment requirement of due process of law, rather than the Eighth Amendment protection against cruel and usual punishment, is the appropriate standard.¹⁵³

Three separate due process tests have been recognized in juvenile isolation cases. First, if the use of isolation amounts to punishment or there is no rational basis for the deprivation, then its use may be a violation of due process. Secondly, if the isolation is considered to be unduly restrictive to a youth’s freedom of movement and is not reasonably related to the legitimate security needs of the institution, it violates due process. Finally, some courts have recognized a juvenile’s right to treatment created by the rehabilitative function of the juvenile court. Jurisdictions that recognize this right, therefore, can find isolation to be a violation of due process when it creates conditions that do not amount to treatment.

i. Courts have considered whether the use of isolation is punitive

In *Bell v. Wolfish*, the Supreme Court held that because due process does not allow punishment of a person who has not been convicted of a crime, conditions to which pretrial detainees are subjected cannot amount to punishment.¹⁵⁴ In order for a detention condition to be considered punitive, the facility officials must have shown an expressed intent to punish, or there must be no rational basis for the deprivation.¹⁵⁵ As long as the restriction is “reasonably related to a legitimate government objective” and is not excessive in light of that objective, then the restriction will not be considered punitive.¹⁵⁶

Several courts have applied the standard set forth in *Bell* and found that the use of isolation was punitive in nature. In *R.G. v. Koller*, for example, a district court in Hawaii considered whether the protective isolation of lesbian, gay, bisexual, or transgender (LGBT) juveniles violated the Fourteenth Amendment.¹⁵⁷ The court determined that, under *Bell*, the isolation was punishment because it was excessive and could not “be viewed in any reasonable light as advancing a legitimate nonpunitive governmental objective.”¹⁵⁸

Similarly, in *Morgan v. Sproat*, the Southern District of Mississippi enjoined isolation practices as a violation of due process rights where youth with disciplinary problems were placed

¹⁵¹ See *Alexander S. v. Boyd*, 876 F. Supp. 773, 795-96 (D.S.C. 1995).

¹⁵² See *Ingraham v. Wright*, 430 U.S. 651, 671 (1977); *Gary H. v. Hegstrom*, 831 F.2d 1430, 1431-32 (9th Cir. 1987); *Hewett v. Jarrard*, 786 F.2d 1080, 1084-85 (11th Cir. 1986); *Santana v. Collazo*, 714 F.2d 1172, 1179 (1st Cir. 1983); *Milonas v. Williams*, 691 F.2d 931, 942 n.10 (10th Cir. 1982) (all holding that due process rather than cruel and unusual punishment was the appropriate standard to review the constitutionality of the use of juvenile isolation).

¹⁵³ YOUTH LAW CTR., *supra* note 144, at 5; see also *Alexander S.*, 876 F. Supp. at 795 (“[T]he court has determined that the Due Process Clause of the Fourteenth Amendment, which implicitly encompasses the protections of the Eighth Amendment, is the appropriate standard for reviewing the conditions at the DJJ facilities. Adoption of the more stringent Due Process Clause is appropriate in this case because the juveniles incarcerated at DJJ facilities have, with few exceptions, not been convicted of a crime; rather, they have merely been adjudicated to be juvenile delinquents.”).

¹⁵⁴ *Bell v. Wolfish*, 441 U.S. 520, 535-37 (1979).

¹⁵⁵ *Id.* at 538-39.

¹⁵⁶ *Id.* at 539.

¹⁵⁷ *R.G. v. Koller*, 415 F. Supp. 2d 1129, 1156 (D. Haw. 2006).

¹⁵⁸ *Id.*

in cells without adequate treatment or counseling services, staff did not know why youth were confined, youth ate meals in their cells, and youth were only let out to take showers.¹⁵⁹ In *Pena v. New York State Division for Youth*, the Southern District of New York likewise found that isolation caused “clearly anti-therapeutic hostility and frustration,” and limited its use to six hours, except “in the most extreme circumstances.”¹⁶⁰

Under their purview, correctional agencies have a legitimate interest and an affirmative duty in maintaining safety and order within facilities. Reliance on the use of isolation practices, however, may actually make facilities more dangerous and less orderly than facilities with effective behavioral management systems. This is discussed further in the section on Performance-based Standards below.

ii. Courts have examined whether the use of isolation is unreasonably restrictive

Other challenges to isolation practices under the Fourteenth Amendment have been based on the proposition that youth who have not been convicted of crime have a constitutionally protected interest in freedom from unnecessary bodily restraint. If a state can address the sources of the youth's behavior problems without extensive isolation, then isolating the youth when other measures are available may be unreasonable.¹⁶¹ In *Youngberg v. Romeo*, the Supreme Court held that civilly committed persons had a liberty interest in, among other things, “reasonably nonrestrictive confinement conditions.”¹⁶² Unreasonably restrictive conditions of confinement “unduly restrict the juveniles’ freedom of action and are not reasonably related to legitimate security or safety needs of the institution.”¹⁶³

To determine whether conditions are unreasonably restrictive, a court must examine whether the people involved in the decision-making regarding the conditions of confinement exercised professional judgment.¹⁶⁴ Accordingly, “[t]he level of restraint to be used for each juvenile should be based upon some rational professional judgment as to legitimate safety and security needs.”¹⁶⁵ Conditions amounting to a “substantial departure from accepted professional judgment, practice, or standards” violate detained children's due process rights.¹⁶⁶

The *Koller* court also applied the *Youngberg* standard to the LGBT youth placed in isolation. Relying on expert testimony that “long-term segregation or isolation of youth is ... well outside the range of accepted professional practices,” the court concluded that the facility's use of isolation was not “within the range of acceptable professional practices.”¹⁶⁷ Considering the *Bell* and *Youngberg* standards together, the court held that the facility's protective use of isolation was a violation of the youths' right to due process of law.¹⁶⁸

The application of accepted professional standards should be used to limit time in isolation, to focus on eliminating harmful effects, and to ensure a range of better behavior management tools are used in the alternative. *Santana v. Collazo's* language about the reasonableness of restricting or eliminating isolation with “additional individual attention” invites

¹⁵⁹ *Morgan v. Sproat*, 432 F. Supp. 1130, 1138-40 (S.D. Miss. 1977).

¹⁶⁰ *Pena v. N.Y. State Div. for Youth*, 419 F. Supp. 203, 210 (S.D.N.Y. 1976).

¹⁶¹ *Santana v. Collazo*, 714 F.2d 1172, 1182 (1st Cir. 1983).

¹⁶² *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982).

¹⁶³ *Alexander S. v. Boyd*, 876 F. Supp. 773, 797 (D.S.C. 1995).

¹⁶⁴ *Youngberg*, 457 U.S. at 321; see also *Overton v. Bazzetta*, 539 U.S. 126, 132 (2003) (according substantial deference “to the professional judgment of prison administrators, who bear a significant responsibility for defining the legitimate goals of a corrections system and for determining the most appropriate means to accomplish them”).

¹⁶⁵ *Alexander S.*, 876 F. Supp. at 787.

¹⁶⁶ *Youngberg*, 457 U.S. at 321.

¹⁶⁷ *R.G. v. Koller*, 415 F. Supp. 2d 1129, 1154-55 (D. Haw. 2006).

¹⁶⁸ *Id.* at 1155-56.

discussion of other effective behavior management techniques and operational changes.¹⁶⁹ For example, one study that examined the relationships between safety, order, and security outcome measures revealed that the characteristics of youth in a particular facility are less of a determining factor than the staff and facility policies and practices.¹⁷⁰ The study also found that one of the most important predictors of safety in juvenile facilities includes the relationships between staff and youth.¹⁷¹ By its nature, the practice of isolation strains relationships between youth and staff, and can further endanger staff as well as youth.

iii. Courts have examined whether the use of isolation can be considered in the context of treatment

Some courts have recognized that youth who are adjudicated delinquent in the juvenile justice system have a constitutional right to receive a disposition that provides them with rehabilitative treatment. This right to treatment is also implicit in the Due Process Clause and has been recognized by federal courts across the country. A child's right to treatment stems from the unique nature of the juvenile justice system. Because the juvenile system is focused on rehabilitation rather than punishment, children are not afforded the same level of procedural protections provided to those who face criminal charges.¹⁷² Rather, the due process standard for juvenile proceedings is simply "fundamental fairness."¹⁷³

Some courts recognize the right to treatment as an element of due process, hinging on the concept that juveniles have different needs and capacities than their adult counterparts, and the rehabilitative nature of the juvenile court.¹⁷⁴ Because "it would be anomalous to find treatment and rehabilitation of an offender as relevant goals during pre-dispositional phases of the juvenile process but not as to the post-dispositional period," children who are incarcerated by the juvenile court have a right to receive treatment during their incarceration.¹⁷⁵ Detaining a child "under a juvenile justice system absent provisions for the rehabilitative treatment of such youth is a violation of due process rights guaranteed under the Fourteenth Amendment."¹⁷⁶

In *Morgan*, the court prohibited the use of isolation for youth with mental retardation and mental illness.¹⁷⁷ The *Morgan* court enjoined defendants from isolating youth "whose psychological, emotional or intellectual status make isolation inappropriate."¹⁷⁸ The court reasoned that because the purpose of incarcerating children is treatment and rehabilitation, due process requires that the conditions and programs in the institution be reasonably related to treatment and rehabilitation.¹⁷⁹

In enforcing this constitutional right to treatment, "courts have not attempted to define the particular treatment program which is appropriate for specific individuals, but instead have required certain fundamental conditions in an institution which will allow adequate treatment to take place."¹⁸⁰ The first of these "fundamental conditions" is that "the institution's entire

¹⁶⁹ *Santana v. Collazo*, 714 F.2d 1172, 1182 (1st Cir. 1983).

¹⁷⁰ PERFORMANCE-BASED STANDARDS, *supra* note 11, at 7.

¹⁷¹ *Id.*

¹⁷² *McKeiver v. Pennsylvania*, 403 U.S. 528, 547 (1971).

¹⁷³ *Id.* at 544.

¹⁷⁴ *Bergren v. City of Milwaukee*, 811 F.2d 1139, 1143-44 (7th Cir. 1987).

¹⁷⁵ *Nelson v. Heyne*, 355 F. Supp. 451, 459 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352 (7th Cir. 1974).

¹⁷⁶ *Pena v. N.Y. State Div. for Youth*, 419 F. Supp. 203, 207 (S.D.N.Y. 1976).

¹⁷⁷ *See Morgan v. Sproat*, 432 F. Supp. 1130, 1140 n.15 (S.D. Miss. 1977) (citing *Welsch v. Likins*, 373 F. Supp. 487, 503 (1974) and *New York State Ass'n for Retarded Child. v. Rockefeller*, 357 F. Supp. 752, 768 (E.D.N.Y. 1973)).

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 1135 (citing *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), which held that due process required the nature and duration of a mentally retarded man's civil commitment to "bear some reasonable relation to the purpose for which the individual is committed").

¹⁸⁰ *Id.* at 1140.

program must be geared to meet the individual needs of each student.”¹⁸¹ In *Nelson v. Heyne*, the court determined that although the facility had adopted a differential treatment program for youth in isolation that required the development of Individualized Treatment Programs (ITPs), the program “appear[ed] to be more form than substance” and the “implementation of the program [fell] far short of its goals.”¹⁸² Accordingly, in order to provide the constitutionally required level of treatment to isolated youth, a facility must create and *actually implement* an effective, individualized treatment program for each child.

The second fundamental condition of a constitutional treatment program is that “[t]he institution must employ sufficient numbers of qualified professional and support personnel to enable it to provide the individualized programs found to be appropriate for each student.”¹⁸³ To provide adequate treatment for youth in such facilities, sufficient staff must include a combination of psychologists, psychiatrists, “qualified counselors to implement the treatment program and to provide individual and group counseling,” and outside experts as needed for specialized services.¹⁸⁴

Finally, due process requires that the institution “provide an environment which is conducive to rehabilitation as well as sufficient programs, including education, vocational training, and recreation, to enable the students to obtain the necessary skills to return to society.”¹⁸⁵ Courts have found that conditions of confinement in isolation units are unconstitutionally non-rehabilitative, and in some cases, actually “anti-rehabilitative.”¹⁸⁶ The isolation unit the *Affleck* court deemed “anti-rehabilitative” afforded the confined children no outdoor exercise, an hour-and-a-half of education on weekdays, and generally only allowed the youth out of their rooms for daily showers and to get their meal trays, though their meals were eaten in their rooms.¹⁸⁷ The court also concluded that the conditions of confinement in a similar unit in the same facility were “detrimental to rehabilitation.”¹⁸⁸ On this unit, the confined children were rarely allowed outside for exercise, were given no vocational training or arts and crafts programming, were provided with only an hour of educational programming on weekdays, and spent their free time watching television, roaming the hall, playing cards, or doing calisthenics.¹⁸⁹ Therefore, the conditions of an isolation unit must provide sufficient training and programming aimed at rehabilitating the children and preparing them to become productive members of society upon their release.

Accordingly, in determining whether use of isolation on juvenile delinquents violates due process, most courts evaluate whether the restriction was punitive, and if the use of isolation was unreasonably restrictive. Some courts, however, also determine whether the use of isolation is a violation of a juvenile’s right to treatment, while others have not gone that far.¹⁹⁰ The due process analysis is thus different from the standards employed when an Eighth Amendment application is made regarding juvenile conditions, as discussed below.

¹⁸¹ *Id.* (citing *Nelson v. Heyne*, 491 F.2d 352, 360 (7th Cir. 1974)).

¹⁸² *Nelson v. Heyne*, 355 F. Supp. 451, 460 (N.D. Ind. 1972), *aff’d*, 491 F.2d 352 (7th Cir. 1974).

¹⁸³ *Morgan*, 432 F. Supp. at 1141 (citing *Martarella v. Kelley*, 349 F. Supp. 575, 601 (S.D.N.Y. 1972)).

¹⁸⁴ *Id.* at 1143.

¹⁸⁵ *Id.* (citing *Inmates of Boys’ Training Sch. v. Affleck*, 346 F. Supp. 1354, 1369-70 (D.R.I. 1972)).

¹⁸⁶ *Inmates of Boys’ Training Sch. v. Affleck*, 346 F. Supp. 1354, 1367 (D.R.I. 1972).

¹⁸⁷ *Id.* at 1359.

¹⁸⁸ *Id.* at 1369.

¹⁸⁹ *Id.* at 1361.

¹⁹⁰ *See, e.g., Santana v. Collazo*, 714 F.2d 1172, 1175-76 (1st Cir. 1983) (holding that a juvenile does not have a constitutional right to rehabilitative treatment).

2. Eighth Amendment Cruel and Unusual Punishment

The Eighth Amendment forbids the federal government from inflicting “cruel and unusual punishments.”¹⁹¹ To determine whether a condition of confinement rises to the level of cruel and unusual punishment, the condition must be an “unnecessary and wanton infliction of pain[.]”¹⁹² both objectively and subjectively.¹⁹³ The objective component requires that a deficiency be a “sufficiently serious”¹⁹⁴ deprivation that lacks “the minimal civilized measure of life's necessities”¹⁹⁵ in order to violate the Eighth Amendment.¹⁹⁶ However, even if a condition of confinement is serious enough to invoke the protection of the Eighth Amendment, it is not considered cruel and unusual punishment unless the responsible parties subjectively imposed the condition with deliberate indifference to the prisoner's well being.¹⁹⁷

Solitary confinement is not per se a violation of the Eighth Amendment.¹⁹⁸ Successful Eighth Amendment claims against the use of solitary confinement with adults have often focused on the specific conditions to which an individual is subjected and not the fact of solitary confinement.¹⁹⁹ Some courts have found that excessive isolation of juvenile delinquents is in violation of the Eighth Amendment.²⁰⁰ Courts are permitted to consider the increased impact of isolation on youth in determining the severity of the deprivation,²⁰¹ but there is no separate cruel and unusual punishment standard applicable to juvenile delinquents.

Therefore, the Eighth Amendment protection against cruel and unusual punishment can extend to the use of isolation for youth. In order to prove a violation, however, youth must be able to show both that the deprivation denied them a necessity of civilized life, and that the facility staff acted with deliberate indifference to their welfare by placing them in isolation.²⁰² Courts that have recognized Eighth Amendment rights for youth have applied the same criteria as would be applied to adult inmates, affording no changes or adjustments to the standard for the differences between adults and children. This exceptionally high standard protects youth from

¹⁹¹ U.S. CONST. amend. VIII.

¹⁹² *Gregg v. Georgia*, 428 U.S. 153, 173 (1976).

¹⁹³ *Wilson v. Seiter*, 501 U.S. 294, 298 (1991).

¹⁹⁴ *Id.*

¹⁹⁵ *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981).

¹⁹⁶ *Wilson*, 501 U.S. at 298.

¹⁹⁷ *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (concluding “that deliberate indifference to serious medical needs of prisoners constitutes ‘unnecessary and wanton infliction of pain’ . . . proscribed by the Eighth Amendment”).

¹⁹⁸ *Ford v. Bd. of Managers of N.J. State Prisons*, 407 F.2d 937, 940 (3d Cir. 1969).

¹⁹⁹ See, e.g., *McCray v. Sullivan*, 509 F.2d 1332, 1334-37 (5th Cir. 1975) (holding that isolation is not per se unconstitutional, but in determining that this particular instance of isolation violated the plaintiff's rights under the Eighth Amendment, the court considered factors such as hygiene, exercise, the availability of visitation, and the existence of a rehabilitation program).

²⁰⁰ See *Morgan v. Sproat*, 432 F. Supp. 1130, 1140 (S.D. Miss. 1977) (holding that use of isolation for longer than twenty-four hours or for reasons other than protecting oneself or others from an immediate physical threat constitutes cruel and unusual punishment); *Pena v. N.Y. State Div. for Youth*, 419 F. Supp. 203, 207 (S.D.N.Y. 1976) (explaining that because youth have the right to treatment, use of isolation is cruel and unusual punishment when it is punitive rather than therapeutic); *Morales v. Turman*, 364 F. Supp. 166, 174 (E.D. Tex. 1973) (finding that isolation of juveniles without “any legislative or administrative limitation on the duration and intensity of the confinement” was cruel and unusual punishment); *Nelson v. Heyne*, 355 F. Supp. 451, 456 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352 (7th Cir. 1974) (holding that use of isolation cottages for extended periods of time with minimal contact with treatment staff and no academic services was cruel and unusual); *Inmates of Boys' Training Sch. v. Affleck*, 346 F. Supp. 1354, 1359, 1366-67 (D.R.I. 1972) (finding that systematic isolation in rooms with nothing but a toilet and a mattress was cruel and unusual punishment when youth were provided with no more than one and a half hours of education a day and no exercise); *Lollis v. N.Y. State Dep't of Soc. Servs.*, 322 F. Supp. 473, 476-77, 482-83 (S.D.N.Y. 1970) (holding that isolation of a fourteen-year-old in a small room without a mattress during the day, books, or any other recreation for two weeks was cruel and unusual punishment).

²⁰¹ See, e.g., *Lollis*, 322 F. Supp. at 480 (examining the affidavits submitted by seven experts that unanimously condemned the use of extended isolation on children because it was “cruel and inhuman” and “counterproductive to the development of the child” in determining whether the use of isolation was in violation of the Eighth Amendment prohibition against cruel and unusual punishment).

²⁰² *Wilson v. Seiter*, 501 U.S. 294, 298-99 (1991).

only the most extreme conditions and the most heinous treatment by staff members, and may not afford sufficient relief for juveniles suffering the adverse effects of isolation practices.

The recent Supreme Court trend reframing the treatment of youth “suggest[s] that developmental immaturity may necessitate different treatment of adolescents under the Eighth Amendment.”²⁰³ Using the construct of developmental immaturity as a guide, application of the Eighth Amendment should extend beyond adolescent sentencing and include further consideration of conditions analysis. One author suggests that framing Eighth Amendment claims to incorporate the development status of an adolescent could create a juvenile deliberate indifference standard, requiring courts to consider “(1) the seriousness of the harm in light of juvenile vulnerability; and (2) the intent of the correctional official in light of the heightened duty to protect juveniles.”²⁰⁴

Youth who are subjected to harsh penalties associated with solitary confinement may be more likely to experience negative emotions that can undermine their sense of self-worth; thus, the “seriousness of the harm” test for juveniles must account for the unique juvenile vulnerability to harm in confinement.²⁰⁵ Similarly, a modified juvenile standard under the Eighth Amendment concerning deliberate indifference should necessitate a more objective, rather than a subjective standard, since juvenile corrections staff should be trained and expected to understand that young people have a “unique vulnerability to harm” and staff should act accordingly.²⁰⁶

3. The Civil Rights of Institutionalized Persons Act

The Civil Rights of Institutionalized Persons Act (CRIPA) establishes federal authority to remedy the deprivation of constitutional or federal statutory rights of incarcerated individuals, and allows the Attorney General (AG) to inspect facilities, send findings letters to state or local government officials regarding the conditions it observes at each, and, in cases in which facilities violate certain provisions of CRIPA, to initiate civil actions on behalf of the United States.²⁰⁷ The Department of Justice (DOJ) recognizes that disciplinary matters resulting in isolation require adequate due process protections, and that such restrictions on liberty must come with significant oversight and regulation.²⁰⁸

Several findings letters by the DOJ have noted the damaging effects of isolation on youth, and note that isolation “should be used only to control behavior that poses a clear and present danger”²⁰⁹ and that the “routine and improper use of an isolation unit in a state facility may constitute cruel and unusual punishment.”²¹⁰ In establishing these restrictions, the AG took the harmful effects of isolation into consideration, stating that “[y]outh with mental health problems that result in disruptive and/or self-destructive behaviors are transferred routinely to . . .

²⁰³ See Levick et al., *supra* note 24, at 293, 300-07, 321 (analyzing *Roper v. Simmons*, 543 U.S. 551 (2005), *Graham v. Florida*, 560 U.S. 48 (2010), and *J.D.B. v. N. Carolina*, 131 S. Ct. 2394 (2011)).

²⁰⁴ *Id.* at 313.

²⁰⁵ *Id.*

²⁰⁶ *Id.* at 314.

²⁰⁷ 42 U.S.C.A. § 1997a(a) (West 2014); *Rights of Persons Confined to Jails and Prisons*, U.S. DEP'T OF JUST., <http://www.justice.gov/crt/about/spl/corrections.php> (last visited Mar. 2, 2014).

²⁰⁸ Letter to Governor of Ind., *supra* note 124, at 6.

²⁰⁹ Letter from Deval L. Patrick, Assistant Att'y Gen., to Mike Foster, Governor of La. 9 (Oct. 3, 1996), available at <http://www.justice.gov/crt/about/spl/documents/lajuvfind2.php>.

²¹⁰ Letter from Thomas E. Perez, Assistant Att'y Gen., to Michel Claudet, President, Terrebonne Parrish Juvenile Detention Ctr. 5 (Jan. 18, 2011), available at http://www.justice.gov/crt/about/spl/documents/TerrebonneJDC_findlet_01-18-11; see also Letter from Ralph F. Boyd Jr., Assistant Att'y Gen., Ronnie Musgrove, Governor of Miss. 5 (June 19, 2003), available at http://www.justice.gov/crt/about/spl/documents/oak_colu_miss_findinglet.pdf (“Oakley and Columbia do not have any system of positive incentives to manage youth, but instead rely on discipline and force. This leads to unconstitutionally abusive disciplinary practices such as hog-tying, pole-shackling, improper use and overuse of restraints and isolation, staff assaulting youth, and OC spray abuse.”).

restrictive units where they experience prolonged periods of isolation and deprivation of a number of services without needed treatment for their underlying mental health problems.”²¹¹ This letter further stated that isolation was “counterproductive to treatment needs” because “[m]any of these youth increased their self-mutilation and disruptive behaviors as a result of increased isolation.”²¹²

Other DOJ findings letters have focused on requiring that youth receive procedural due process procedures, such as a hearing, before being placed in punitive isolation.²¹³ These findings letters recognized the harmful effects of isolation. They found the lack of procedural due process even more concerning than the negative consequences the use of isolation had on youth.²¹⁴ At the Hawaii Youth Correctional Facility, for example – where isolated youth used plastic shards, paper clips, and other similar items to carve their flesh, leaving scars on their hands, arms, and faces – the findings letter placed significant focus on the lack of due process procedures provided to these youth.²¹⁵

Therefore, procedural due process protections that place controls on the use of isolation and limit admissions, duration, and other deprivations are essential. Such procedures may be used, however, to legitimize what is otherwise unnecessary and excessive isolation. Additionally, these procedures may not adequately take into consideration the harm that may arise from even short-term usage. Thus, findings should place the most significant weight on harmful effect, and gauge procedural protections based on that factor.

B. Standards Created by Professional and Trade Organizations

Numerous professional and trade organizations have established guidelines for the use of isolation in juvenile detention and correctional facilities. Although these standards are not legally binding on states, they can be instructive to courts in determining what is required by “accepted professional judgment, practice, or standards,” and to facility administrators in adopting appropriate policies and procedures.²¹⁶ While these standards often emphasize the protective value of providing procedural due process, the incorporation of evidence-based practices and adolescent development concepts into their application can and should be part of the analysis when applying such standards. Examples of some of these standards and their application follow.

1. Council of Juvenile Correctional Administrators, Performance-based Standards (PbS)

²¹¹ Letter from Isabelle Katz Pinzler, Acting Assistant Att’y Gen., to Mike Foster, Governor of La. (June 18, 1997), available at <http://www.justice.gov/crt/about/spl/documents/lajuvfind1.php>.

²¹² *Id.*

²¹³ See Letter to Governor of Ohio, *supra* note 124, at 15 (noting that to protect the constitutional and statutory rights of confined youth, the facility must, at a minimum, “[e]nsure that youth are provided with safe living conditions and are protected from abuse, use of excessive force, undue seclusion, and undue restraint” and “[d]evelop policies and procedures to ensure that seclusion and restraint are only used in appropriate, documented, instances by trained staff”); Letter to Governor of Mich., *supra* note 30; Letter from Alexander Acosta, Assistant Att’y Gen., to Robert L. Ehrlich, Jr., Governor of Md. 12 (Apr. 9, 2004), available at http://www.justice.gov/crt/about/spl/documents/cheltenham_md.pdf; Letter from Alexander Acosta, Assistant Att’y Gen., to Janet Napolitano, Governor of Ariz. 18 (Jan. 23, 2004) [hereinafter Letter to Governor of Ariz.], available at http://www.justice.gov/crt/about/spl/documents/ariz_findings.pdf; Letter from Ralph F. Boyd, Jr., Assistant Att’y Gen., to Kenny Guinn, Governor of Nev. 5 (Nov. 12, 2002), available at http://www.justice.gov/crt/about/spl/documents/nevadayouth_center.php. All of these letters find the solution to overuse of isolation to be the development and implementation of adequate due process protections before placing youth in punitive isolation or holding youths in protective isolation for more than twenty-four hours.

²¹⁴ See, e.g., Letter to Governor of Ariz., *supra* note 213 (“[T]he State’s institutions appear to ignore completely the adverse psychological side effects of prolonged isolations and, *more importantly*, seem to have adopted no standards governing when such lock downs may be validly employed.”) (emphasis added).

²¹⁵ Letter from Bradley J. Schlozman, Acting Assistant Att’y Gen., to Linda Lingle, Governor of Haw. 18 (Aug. 4, 2005), available at http://www.justice.gov/crt/about/spl/documents/hawaii_youth_findlet_8-4-05.pdf (“HYCF appears to ignore completely the adverse psychological side effects of prolonged isolation and, *more importantly*, seems to have adopted no standards governing when such confinement procedures may be validly employed.”) (emphasis added).

²¹⁶ *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982).

The Office of Juvenile Justice and Delinquency Prevention launched PbS in 1995 in response to its 1994 Conditions of Confinement Report documenting “deplorable conditions” in its study of one thousand juvenile facilities.²¹⁷ PbS is a “set of goals and standards that facilities and agencies should strive to meet,” along with “[t]ools to help facilities achieve these standards through regular self-assessment and self-improvement” mechanisms.²¹⁸ PbS generates data that helps to evaluate performance over time and compares similar facilities.²¹⁹

PbS views isolation as a “reportable event,” and limits its use significantly.

PbS 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 PbS event and is documented.²²⁰

PbS does not condone the use of isolation for punishment purposes.²²¹

2. American Correctional Association

The American Correctional Association (ACA) has established standards regarding the conditions and administrative processes of juvenile detention facilities to which agencies must adhere in order to receive ACA accreditation.²²² ACA policies recognize that children and youth have distinct personal and developmental needs.

These standards permit removal of youth from general population who threaten the secure and orderly management of the facility by placing them in special units.²²³ The standards recognize three types of removal practices:

Disciplinary Room Confinement: ACA standards limit disciplinary room confinement to five days, and require visual checks by staff every fifteen minutes, along with daily visits by personnel from administration, clinical, social work, religious, and/or medical units.²²⁴ Youth in disciplinary room confinement must be afforded living conditions and privileges earned that approximate those in general population.²²⁵

Protective Custody: ACA standards limit protective custody to those circumstances where youth need protection from others and then only until another alternative permanent housing option is found.²²⁶ The standards require that continued protective custody should not extend beyond seventy-two hours without approval of the facility administrator, and special management plans should be created for these youth to ensure continuous services and programming.²²⁷

²¹⁷ *Performance-based Standards (PbS)*, PBS LEARNING INST., <http://pbstandards.org/initiatives/performance-based-standards-pbs> (last visited Nov. 18, 2013).

²¹⁸ *Id.*

²¹⁹ PERFORMANCE-BASED STANDARDS, *supra* note 11, at 3.

²²⁰ PBS LEARNING INST., REDUCING ISOLATION AND ROOM CONFINEMENT 2 (2012), http://pbstandards.org/uploads/documents/PbS_Reducing_Isolation_Room_Confinement_201209.pdf [hereinafter REDUCING ISOLATION].

²²¹ *Id.*

²²² AM. CORR. ASS'N, PUBLIC CORRECTIONAL POLICY ON JUVENILE JUSTICE (2007); *see also Standards and Accreditation, Seeking Accreditation*, AM. CORRECTIONAL ASS'N, <https://www.aca.org/standards/seeking.asp> (last visited Mar. 8, 2014) (explaining the requirements of the accreditation process for agencies including an evaluation and standards compliance audit).

²²³ AM. CORR. ASS'N, *supra* note 7, at 51.

²²⁴ *Id.* (Standards 4-JCF-3C-03, 4 JCF-3C-04).

²²⁵ *Id.*

²²⁶ *Id.* (Standard 4-JCF-3C-02).

²²⁷ *Id.*

Special Management: ACA standards limit the use of special management to high-risk youth who cannot control assaultive behavior or present a danger to themselves.²²⁸ ACA suggests that youth in these units should benefit from an individualized and constructive behavior management plan that allows for individualized attention.²²⁹ Placements must be reviewed within seventy-two hours.²³⁰

3. Juvenile Detention Alternatives Initiative

The Juvenile Detention Alternatives Initiative (JDAI) is a model developed by the Annie E. Casey Foundation designed to reduce unnecessary juvenile detention placements, reduce disproportionate minority contacts, and provide safe alternatives to incarceration.²³¹ The JDAI project also provides a set of standards and facility assessments for juvenile detention facilities to evaluate and improve their conditions, including isolation practices.²³²

JDAI standards distinguish between “isolation” and “room confinement.” Isolation is defined as “placing a youth in a room because of his or her *current* acting out behavior” and limiting at an absolute maximum of four hours.²³³ The standard also restricts the use of isolation to instances where the “youth’s behavior threatens imminent harm to self or others or serious destruction of property,” only after exhaustion of less restrictive de-escalation techniques, and for no longer than necessary for the youth to regain control.²³⁴ In addition to limiting the circumstances under which isolation can be used, JDAI standards require supervisory levels of approval after one hour, medical monitoring “at least once every hour the youth is in isolation,” and only in rooms which meet specific requirements in the standards.²³⁵ If the youth has not gained control after the four-hour limit, or a mental health professional determines the level of crisis service is not available within the facility, the youth should be transferred to a medical unit or mental health facility.²³⁶

Room confinement, on the other hand, is defined as a disciplinary sanction requiring a youth to remain in a room after a rule infraction, and is limited to an absolute maximum of seventy-two hours.²³⁷ As a sanction, if room confinement lasts longer than four hours, the facility must afford a due process hearing within twenty-four hours of the incident and before placing the youth in room confinement.²³⁸ The facility should not routinely subject youth to more than twenty-four hours in room confinement, and any time beyond that should be only for the most egregious violations.²³⁹ Similarly, a facility administrator must approve room confinement practices if they are used for longer than forty-eight hours, and must be monitored every fifteen minutes by staff.²⁴⁰ Other programming and basic rights are assured to the youth, including daily education, showers, exercise, parental and attorney visits, personal hygiene items, reading materials, and religious services.²⁴¹

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Juvenile Detention Alternatives Initiative*, ANNIE E. CASEY FOUND.,

<http://www.aecf.org/MajorInitiatives/JuvenileDetentionAlternativesInitiative.aspx> (last visited Nov. 18, 2013).

²³² *Juvenile Det. Alt. Initiative Facility Site Assessment Instrument 48 (2006)*, available at

<http://www.cclp.org/documents/Conditions/JDAI%20Standards.pdf>.

²³³ *Id.* at 44 (emphasis in original).

²³⁴ *Id.*

²³⁵ *Id.* at 45.

²³⁶ *Id.*

²³⁷ *Id.* at 48.

²³⁸ *Id.* at 47.

²³⁹ *Id.* at 48.

²⁴⁰ *Id.* at 48-49.

²⁴¹ *Id.* at 47-48.

JDAI also mandates that youth who are at risk of harm should be “engage[d] in appropriate activities and programs that will raise their self-esteem and reduce the risk of further self-harming behavior,”²⁴² and youth who are at risk for suicide must not be isolated, but rather engaged in social interactions allowing them to participate in school and other activities.²⁴³ Therefore, the conditions self-assessment instrument provided to JDAI sites is a good tool for jurisdictions that wish to significantly reduce or eliminate the use of isolation, and can help to improve upon policies and practices for better behavior management.

4. Department of Justice Standards for the Administration of Juvenile Justice

In 1980, the DOJ issued standards related to a broad range of issues in the juvenile justice system.²⁴⁴ DOJ standards provide that “[j]uveniles 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.”²⁴⁵ The standards restrict room confinement to a maximum of twenty-four hours, and view isolation as “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.”²⁴⁶ The DOJ standards mandate at least daily examination by a physician, as well as twice-daily examinations by a childcare worker or other treatment staff.²⁴⁷ The standards further require educational materials and other services, in addition to recreation and outdoor exercise, if the youth is confined in a room for more than twelve hours.²⁴⁸

5. Applicable Federal Health Care Laws and Regulations

Federal laws pertaining to the rights of residents in health care facilities that receive federal funds also restrict involuntary isolation. The Children’s Health Act of 2000²⁴⁹ limits the use of isolation by prohibiting punitive practices to be used for the purpose of discipline or convenience, and allowing isolation only to 1) ensure the physical safety of the resident, staff member, or others, and 2) with a written order of a physician or licensed practitioner that “specifies the duration and circumstances under which the restraints are to be used.”²⁵⁰

Similarly, regulations that implement health and safety requirements of the Social Security Act restrict the use of involuntary isolation in medical facilities.²⁵¹ Such regulations prohibit the use of isolation used for coercion, discipline, convenience or retaliation, and allow such practices only when 1) less restrictive interventions have been determined to be ineffective, 2) to ensure the immediate safety of the patient, staff member or others, and 3) for only so long as necessary.²⁵² Under this regulation, the limitation on the use of isolation is twenty-four hours, although individual instances of involuntary isolation for children and adolescents between nine and seventeen years old may only be renewed at two-hour increments.²⁵³ Additionally, a medical professional must evaluate the individual within one hour of isolation, document the individual’s behavior and interventions used, examine alternatives and less restrictive interventions, review

²⁴² *Id.* at 18.

²⁴³ *Id.* at 19.

²⁴⁴ See generally OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, *supra* note 31.

²⁴⁵ *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ Children’s Health Act of 2000, Pub. L. No. 106-310, § 591(a), 114 Stat. 1101.

²⁵⁰ 42 U.S.C.A. § 290ii(b) (West 2014).

²⁵¹ See generally 42 C.F.R. § 482.13 (2014) (implementing 42 U.S.C. §§ 1395x, 1861(e)(9)(A)).

²⁵² *Id.* § 482.13(e).

²⁵³ *Id.* § 482.13(e)(8)(i).

the conditions or symptoms that warranted the use of isolation, and indicate the individual's response, including the rationale for continued isolation.²⁵⁴

6. American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry (AACAP) issued a policy statement in 2012 opposing the use of isolation for juveniles and urging that any youth confined for more than twenty-four hours be evaluated by a mental health professional.²⁵⁵ This statement recognized the potential psychiatric consequences of prolonged isolation, including depression, anxiety, and psychosis, and noted particular adverse reactions by youth as a result of their developmental vulnerability.²⁵⁶

The AACAP created parameters for the use of isolation on youth within psychiatric institutions. These standards allow for isolation only when "necessary to ensure the safety of the patient and others, for prevention of significant damage to the program and property, and after documented failure of less restrictive interventions."²⁵⁷ A verbal or written order for isolation is limited to one hour for children under the age of nine, two hours for youth from age nine to seventeen, and four hours for individuals eighteen and older.²⁵⁸ An in-person reevaluation must occur every two hours for patients under eighteen and every four hours for those over eighteen.²⁵⁹ The patient's family must also be promptly notified of the initiation of isolation.²⁶⁰ The youth should only remain in isolation long enough to regain self-control, once he or she has calmed down, the isolation should be terminated.²⁶¹

The AACAP standards also focus on the use of isolation in correlation with psychiatric treatment and preventative measures, emphasizing that "[d]iagnosing and treating the underlying psychiatric illness are essential to the management of aggressive behavior."²⁶² Additionally, after a youth is removed from isolation, a staff member should review the event with him or her, and work with the youth to prevent a reoccurrence of the aggressive behavior.²⁶³

7. International Conventions on the Rights of Children

Prohibitions on the use of isolation for youth have been addressed at the international level as well. The United Nations Convention on the Rights of the Child is an international human rights treaty that seeks to protect the rights of children for those countries in which it is adopted.²⁶⁴ The United States is one of two members of the United Nations that has not ratified the treaty.²⁶⁵ The United Nations Committee on the Rights of the Child requires that disciplinary measures "be consistent with upholding the inherent dignity of the juvenile and the fundamental objectives of institutional care."²⁶⁶ Moreover, the United Nations strictly forbids disciplinary

²⁵⁴ *Id.*

²⁵⁵ *Solitary Confinement of Juvenile Offenders*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx (last visited Nov. 22, 2013).

²⁵⁶ *Id.*

²⁵⁷ Kim J. Masters et al., *Practice Parameter for the Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions, with Special Reference to Seclusion and Restraint*, 41 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 4S, 7S (Supp. 2002).

²⁵⁸ *Id.* at 15S.

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ *Id.*

²⁶² *Id.* at 10S.

²⁶³ *Id.* at 20S.

²⁶⁴ Jenni Gainborough & Elisabeth Lean, *Convention on the Rights of the Child and Juvenile Justice*, LINK, Summer 2008, at 1, 1.

²⁶⁵ *Id.* Note that the United States has signed but not ratified this Convention; thus, while it is obligated not to undermine the object and purpose of the Treaty, it is not specifically bound by its terms. *Id.* The only other country that has not ratified the Treaty is Somalia, which is currently operating without a functional central government. *Id.*

²⁶⁶ U.N. Comm. on the Rights of the Child, General Comment No. 10, ¶ 89, U.N. Doc. CRC/C/GC/10 24 (Apr. 25, 2007).

measures, such as closed or solitary confinement, that may compromise a child's physical or mental health or well-being.²⁶⁷ The United Nations also recommends that children be placed in a physical environment that is "in keeping with the rehabilitative aims of residential placement."²⁶⁸ Staff must also consider the youth's "needs for privacy, sensory stimuli, opportunities to associate with their peers, and to participate in sports, physical exercise, in arts, and leisure time activities."²⁶⁹

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty were approved by the United Nations General Assembly in 1990, and supported by the United States.²⁷⁰ These minimum standards for the protection of youth in correctional facilities prohibit solitary confinement, although distinguish it from brief interventions such as a "time out."²⁷¹ The Rules state, "[a]ll disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned."²⁷²

The international attention focused on eliminating the use of isolation for children is notable and recognizes the rehabilitative nature of the juvenile justice system. For this reason, continued application of international principles for the treatment of children is an important tool for advocates seeking to restrict and/or abolish this practice within their own jurisdictions.

IV. STRENGTHENING POLICY AND PRACTICE TO REPLACE THE USE OF ISOLATION

While standards vary as to their limitations and specificity about the use of isolation, it is clear that research and analysis of best practices around behavior management can be better incorporated into the application of existing standards. Evidence-based and research-supported work in the juvenile justice field has evolved substantially and created better tools for facility management focused on improving outcomes. These tools can have a significant impact on the safe and effective management of youth behaviors and minimize the need for punitive practices such as isolation.

A. *Facilities Should Adopt a System of Effective Behavior Management Practices to Replace the Use of Isolation*

Juvenile facilities can decrease dependence on the use of isolation by developing a full range of effective behavior management alternatives, focusing on positive reinforcement rather than punishment as the primary method of discipline and control.

Performance-based Standards are one mechanism for monitoring the behavior management practices of a facility, including programming, following rules and responses to misconduct, and the use of isolation, room confinement and special management units.²⁷³ The PbS goal for facility order is "[t]o establish clear expectations of behavior and an accompanying system of accountability for youths and staff that promote mutual respect, self-discipline and order."²⁷⁴ Since its inception in 1995, PbS has helped to change recording practices on the use of

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ *Id.*

²⁷⁰ U.N. Rules for the Protection of Juveniles Deprived of their Liberty, G.A. Res 45/113, U.N. Doc. A/Res/45/113 (Dec. 14, 1990).

²⁷¹ *Id.*

²⁷² *Id.* at ¶ 67.

²⁷³ See generally PERFORMANCE-BASED STANDARDS, *supra* note 11.

²⁷⁴ REDUCING ISOLATION, *supra* note 220, at 3. Note that PbS advisors define isolation as "any instance where a youth is confined alone for cause or punishment for 15 minutes or more in his or her sleeping room or another room or separation unit. Exceptions are

isolation from number of days to number of hours spent in isolation.²⁷⁵ A recent report notes that very few state agencies have policies that permit extended time in isolation, and the majority of these agencies limit the amount of time youth may spend in isolation to as little as three hours and up to a maximum of five days.²⁷⁶ The PbS Learning Institute reports that between 2008 and 2012, the average time youth spent in isolation declined in all PbS facilities, including both short term detention and longer term correctional facilities.²⁷⁷ During that period, “[c]orrections facilities more than cut in half the average time a youth spent in isolation and room confinement.”²⁷⁸ “During that same time period, the percent of cases of isolation and room confinement ending in four hours or less increased” and the percent of cases ending in eight hours or less increased.²⁷⁹ The use of PbS can help the field by providing resources, networking and site specific coaching that can enable facilities to better implement behavior management best practices in lieu of using isolation.

PbS recommends a range of activities and measures for facilities that can create better systems of behavior management and limit or eliminate the use of isolation. These include:

- A strong “behavior management system that relies on rewards and incentives”;
- Isolation should only be used to “neutralize out-of-control behavior and redirect it into positive behavior and should not be used as punishment”;
- Staff training should include a curriculum that focuses on adolescent development and stresses “the value of positive over negative reinforcement” with youth;
- Staff training should include “the negative repercussions and ineffectiveness of long-term isolation and the rationale for” shortening the length of time in isolation;
- The facility should have policies governing the duration of isolation and room confinement;
- The facility should review events and incidents resulting in isolation to examine other more appropriate responses, length of isolation and how youth was monitored; and
- The facility should have an oversight agency to conduct regular reviews of isolation inclusive of the monitoring of youth while in isolation.²⁸⁰

PbS outcome measures were designed by the Council of Juvenile Correctional Administrators (CJCA) after an analysis of eighteen juvenile civil rights investigations and cases during a ten-year period.²⁸¹ The resulting outcome measures address the most serious trends found by the Department of Justice Office of Civil Rights as the basis of CRIPA violations.²⁸² The effective use of PbS can also reduce the likelihood of civil rights violations and increase the

made for protective isolation, medical isolation or when requested by a youth.” *Id.* Time is measured from the time the youth is placed in the room until he or she leaves, including sleeping time when extending overnight. *Id.*

²⁷⁵ *Id.* at 4.

²⁷⁶ *Id.* at 4.

²⁷⁷ This may be attributable to concerns linking suicide risk and the use of isolation which stemmed from the release of “Juvenile Suicide in Confinement: A National Survey” in 2009. *Id.* “The report highlighted many of the dangerous practices that are most likely to lead to suicide in youth facilities, one of which was confining them alone in their room.” *Id.*

²⁷⁸ *Id.*

²⁷⁹ *Id.*

²⁸⁰ PBS LEARNING INST., PBS GOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES 8, 10 (2007), <http://sccounty01.co.santa-cruz.ca.us/prb/media%5CGoalsStandardsOutcome%20Measures.pdf>.

²⁸¹ PBS LEARNING INST., MAPPING PERFORMANCE-BASED STANDARDS AND CIVIL RIGHTS INVESTIGATIONS 1 (2013), http://pbstandards.org/cjcaresources/158/PbS_CivilRightsInvestigations_201303.pdf.

²⁸² *Id.*

likelihood that facilities function at high operational expectations that comply with or exceed Constitutional minimums.

B. The Application of Professional Standards on the Use of Isolation in Juvenile Facilities Should Include Robust Use of Evidence-Based Practices and Harm Analysis

Among the most progressive policy reforms in recent years is the focus on evidence-based practices that emphasize “effective treatments, services, and supports for youth and their families.”²⁸³ Due to the increased availability of empirical data and the development of new, systematic techniques to analyze that data, an expansive body of research and analysis regarding the effectiveness of programming for youth offenders has recently become available.²⁸⁴ While standards vary as to the purpose, timing, supervision, and restrictiveness for the use of isolation, the fact that isolation is not an evidence-based approach to managing behavior is significant.²⁸⁵ The foundation of what constitutes “a substantial departure from accepted professional judgment, practice, or standards,” and thus violates detained youth’s due process rights, should not be measured solely by whether practices comport with juvenile justice standards, as previously identified in this paper.²⁸⁶ Rather, professional judgment can and should be tied to evidence-based practices, which have been credibly assessed against a set of targeted outcomes.

Where isolation is used even on a limited basis, facilities must have detailed operating procedures in place that clearly define the purpose and scope. Room confinement, rather than isolation in physically and socially isolated areas, should be used only as a last resort, when all other less restrictive techniques have failed, and the youth continues to pose a safety or security risk.²⁸⁷ Disciplinary isolation should not be employed as punishment for rule violations. As soon as the youth regains control and is no longer a threat, he or she should be released from isolation.²⁸⁸ While standards vary as to the length of time permissible, some state regulations require limits as low as three hours.²⁸⁹ Frequent visual checks should be required, as well as documentation as to the youth’s wellbeing and condition generally.

When youth need to be separated for safety reasons, this should be limited to keeping youth in their rooms instead of placing them in a separate isolation unit. Allowing juveniles to remain in their own rooms will shield them from some of the harmful effects of isolation caused

²⁸³ LIPSEY ET AL., *supra* note 22, at 9.

²⁸⁴ *Id.* at 12.

²⁸⁵ Finke, *supra* note 40, at 186, 187, 189.

²⁸⁶ Youngberg v. Romeo, 457 U.S. 307, 321 (1982).

²⁸⁷ See, e.g., Commonwealth of Mass. Dep’t of Youth Servs., Official Policy: Involuntary Room Confinement, Policy No. 03.03.01(a) 1 (2013) (“Room confinement may only be used when less restrictive interventions have failed and for the least amount of time required for the youth to regain self-control.”); 55 PA. CODE § 3800.202(b) (2000) (“[A] restrictive procedure [seclusion] may be used only to prevent a child from injuring himself or others.”); MULTNOMAH CNTY. DEP’T OF CMTY. JUSTICE, POLICY AND PROCEDURES: JUVENILE SERVICES-DETENTION, SECLUSION 1 (2007) (“[T]he designated Seclusion Room on each unit is only utilized under extreme situations in which: 1) a youth has physically attacked another person and is resisting staff interventions, 2) a youth is destroying county materials and property, 3) a youth is disregarding the sleeping house of his/her peers by banging or yelling in his/her assigned room, or 4) a youth has attempted to escape the facility and is resisting staff interventions. Any youth escorted to Seclusion will remain in this capacity for only as long as disruptive, destructive or violent behavior exists.”).

²⁸⁸ See Masters et al., *supra* note 257, at 6S.

²⁸⁹ See e.g., 55 PA. CODE § 3800.274(17)(ii), (vi) (requiring approval from a licensed physician, physician’s assistant, or registered nurse before isolating for more than four hours, and a court order for more than eight hours in any forty-eight-hour period); Commonwealth of Mass. Dep’t of Youth Servs., *supra* note 287, at 5-6 (requiring authorization from Program Director, Assistant Program Director, or Clinical Director for any use of isolation up to three hours; authorization from the Regional Director of Operations for four to nine hours; and authorization from the Regional Director for ten to twelve hours); MULTNOMAH CNTY. DEP’T OF CMTY. JUSTICE, *supra* note 287, at 2 (requiring the continued need for seclusion be assessed every thirty minutes, rarely to exceed one hour); see also Masters et al., *supra* note 257, at 6S (limiting seclusion time to two hours for youth up to age seventeen, and four hours for individuals age eighteen or older without re-evaluation).

by sensory deprivation.²⁹⁰ Facilities should ensure that youth in isolation receive required services, such as education, mental health, and medical care. These services should be provided out of the room unless the youth poses an immediate and significant threat.

The rehabilitative nature of the juvenile justice system necessitates continued application of best practices and research to inform practice. Any use of isolation must be balanced against the possible harm to the youth that may occur as a result. Youth with mental illnesses, ADHD, depression, and anxiety, in particular, may experience deterioration in mental status, including an increase in negative and aggressive behaviors, withdrawal, or suicidal ideation.²⁹¹ Youth without prior diagnoses of mental illness may exhibit similar symptoms as a result of isolation.²⁹² Young people who have experienced trauma may be re-victimized as a result. Because isolation practices lack any foundation as evidence-based behavior management, its use, especially among youth who are developmentally vulnerable, is inappropriate and counterproductive.

Facilities should be required to collect data and ensure accountability of the use of isolation through quality assurance and quality improvement measures. PbS is one good mechanism to document such practices. Management should closely scrutinize isolation practices with an eye toward reducing the use of the practice, and build in sufficient training, staff support and alternative behavioral management strategies.

Policy and procedures must be more explicit in providing more and better behavior management options. Language such as “used only as a last resort” and “when all other less restrictive techniques have failed” must be accompanied by a robust list of other ways in which staff can utilize alternatives and build from a strength based rewards system rather than the subjective assessment of individual staff. What constitutes a continued safety or security risk must also be qualified, based upon appropriate assessment tools, and continually reviewed. Such broad language found in some standards should be viewed skeptically given the broad range of effective behavior management principles available to juvenile justice practitioners.

C. Effective Mental Health Policies and Practices Are Essential to Manage the Most Difficult and Violent Youth

Access to quality mental health services and appropriate behavioral health staff in juvenile correctional facilities varies widely. Although most facilities provide some mental health services, barriers to treatment often include lack of quality programming, limited mental health services training available to correctional staff, and a lack of coordination among services within the correctional setting and the community.²⁹³

The literature suggests that little is known about how correctional facilities manage youth with psychiatric disorders who are extremely disruptive and/or violent. While such youth may be placed in specialized units, often referred to as special management units, or intensive management units, little is known about the number of such programs, their operational aspects, or how juveniles are referred to such programs.²⁹⁴

Youth may be referred to special management units without having appropriate diagnostic work to identify their behavioral health needs. Rather than providing a setting that can focus on underlying causes and psychosocial factors of behavior, these facilities primarily focus

²⁹⁰ See Grassian, *supra* note 33, at 345 (detailing the visual, auditory, tactile, and olfactory distortions and illusions resulting from sensory deprivation).

²⁹¹ *Id.* at 350.

²⁹² *Id.* at 354.

²⁹³ Joseph J. Cocozza & Kathleen R. Skowrya, *Youth with Mental Health Disorders: Issues and Emerging Responses*, JUV. JUST., April 2000, at 3, 7.

²⁹⁴ Cowles & Washburn, *supra* note 47, at 44.

on controlling disruptive behavior and deterring future violence and disruption.²⁹⁵ The use of isolation and restraint in a psychiatric context is based upon the need for protection of the juvenile and others; conversely, disciplinary units rely on this as a sanction for rule breaking, so the duration may be longer or predetermined as a “sentence.”²⁹⁶

If an intensive management unit is used for youth with significant mental health needs, it should be viewed as similar to an acute care residential psychiatric unit. Research suggests that four interrelated functions should be built into the program: 1) that the unit provide a safe and secure setting for those youth who cannot be safely maintained within the general population; 2) that the unit would provide treatment designed to stabilize the presenting behavioral problems of the youth and return them to baseline functioning; 3) youth should return to general population as quickly as possible; and 4) guidance should be provided to staff in general population units to where these youth are returned.²⁹⁷ Special management units should not become the dumping grounds for youth who are severely mentally ill, and for whom appropriate mental health care is not being provided. Facilities should acknowledge through quality assurance measures how such units are being utilized, and either restrict admissions for youth with serious mental health issues, or ensure that the unit has a strong behavioral health component and highly skilled behavioral health staff to focus on stabilization and return to general population.

D. Broader Approaches to Avoiding Isolation Should Be Explored

In addition to improving and clarifying the standards, policies, and procedures for when isolation can be used, facility administrators should also explore alternatives that prevent the use of isolation altogether. The juvenile justice system can decrease dependence on isolation by increasing the availability of alternatives to secure confinement. Overuse of secure detention creates crowded facilities, and research indicates that isolation rates are higher at crowded facilities due to inadequate staffing.²⁹⁸ Because staff in crowded facilities may not have the time to anticipate and prevent explosive behavior in advance, their reliance upon the use of isolation to control behavior is more likely.²⁹⁹ Youth in overcrowded facilities are also more likely to request placement in isolation because they feel unsafe or are unable to cope with the minimal privacy in the general population.³⁰⁰

Finally, in order for these changes to be successful, facilities should seek to hire and train staff, and especially supervisors, who are committed to the purpose of rehabilitating youth. Unfortunately, many institutional practices reflect a devaluation of the juveniles who are placed in facilities, which can create “a significant barrier to treating youth with respect and meeting their individual needs.”³⁰¹ However, negative attitudes on the part of staff result from the failure to understand better alternatives, and can be improved through training.³⁰² By educating staff about appropriate ways to manage behavior and emphasizing the individual value of each child, juvenile facilities can help ensure that staff follows policies and remain committed to the rehabilitation of each youth.

²⁹⁵ *Id.* at 45.

²⁹⁶ *Id.*

²⁹⁷ *Id.* at 46.

²⁹⁸ DALE G. PARENT ET AL., OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, CONDITIONS OF CONFINEMENT: JUVENILE DETENTION AND CORRECTIONS FACILITIES RESEARCH REPORT 8 (1994); *see also* SUE BURRELL, ANNIE E. CASEY FOUND., 6 PATHWAYS TO JUVENILE DETENTION REFORM: IMPROVING CONDITIONS OF CONFINEMENT IN SECURE JUVENILE DETENTION CENTERS 14 (1999) (“Unnecessary detention almost inevitably contributes to crowding, and crowded facilities have a much harder time meeting legal and professional standards for confinement.”).

²⁹⁹ *See* BURRELL, *supra* note 298, at 6.

³⁰⁰ *Id.* at 18.

³⁰¹ *Id.* at 35.

³⁰² *Id.* at 33.

V. CONCLUSION

Isolation is an emotionally, psychologically, and often physically harmful technique that is significantly and inappropriately overused in juvenile facilities to control behavior. The current legal and professional standards must assure procedural due process protections for youth placed in isolation. These standards must also be applied with greater attention to evidence-based practices, which are effective in managing behaviors, and incorporate a stronger harm-based analysis. Challenges to the use of isolation, under the Fourteenth or Eighth Amendment rubrics, can be supported by tools such as PbS and the application of effective behavior management techniques that call into question the use of isolating youth as unnecessary and harmful. Identifying harmful effects on youthful offenders, particularly those who are especially vulnerable because of prior traumatization, mental health issues, and immaturity, is critical to inform professional judgment and in the appropriate application of standards.

Isolation does not have the purported benefits of safety, punishment, or deterrence in juvenile facilities. Its use has been imported from the adult system and has been proven to be harmful and costly. The continued use of this practice should be closely examined and additional research and models of behavior management should be encouraged. The field of juvenile corrections is increasingly embracing the use of evidence-based and research-informed practices. It is time to utilize this research base to eradicate the harmful use of socially isolating youth who are entitled to treatment and rehabilitation in the juvenile justice system.