

Restrictive Housing in Juvenile Correctional Settings

Definitions

Restrictive housing is a broad term that covers several types of housing statuses and is often used interchangeably with “seclusion,” “isolation,” or “segregation.” The *NCCHC Standards for Health Services in Juvenile Detention and Confinement Facilities* uses the following definition in standard Y-E-09 Segregated Juveniles:

Segregated juveniles are those isolated from the general population and who receive services and activities apart from other juveniles. Facilities may refer to juveniles housed in such conditions as being in administrative segregation, protective custody, solitary confinement, or disciplinary segregation. For the purposes of this standard, the living and confinement conditions define the segregated status, not the reason a juvenile was placed in segregation. (NCCHC, 2015)

Solitary confinement, “the most extreme form of isolation, is physical and social isolation in a cell for 22 to 24 hours per day” (Council of Juvenile Correctional Administrators, 2015).

Another type of restrictive housing, medical isolation, may be used to physically and socially isolate individuals in the context of contagious disease, such as with COVID-19. Although standard Y-E-09 and this position statement do not directly apply to medical isolation, similar principles should be followed (see statement #5 below).

Introduction

NCCHC asserts that “juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration” (NCCHC, 2016). However, the practice of juvenile solitary confinement and broader forms of restrictive housing still occurs today. A 2015 survey of solitary confinement rules in juvenile justice systems revealed that 47% of juvenile detention centers reported locking youth in some type of isolation for more than 4 hours at a time (Lowenstein Center, 2016). Given the widespread use of restrictive housing and the well-understood negative health impacts of these practices, it is imperative that juvenile correctional facilities work to reduce or eliminate the use of restrictive housing and establish clear protocols for the rare instances when isolation is deemed essential (e.g., medical necessity) to ensure safety for youth.

Background

The majority of the literature focuses on the impacts of solitary confinement on adults and describes anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, and psychosis among other symptoms, as well as increased levels of self-harm and suicide (World Health Organization, 2014). Based on developmental brain science and the impact of adverse childhood experiences on the physical, mental, and behavioral health of children and adolescents, the American Academy of Child and Adolescent Psychiatry has asserted that, “Due to their development vulnerability, juvenile offenders are at particular risk for such adverse reactions [as found in adults]” (2012). The impacts of restrictive housing measures on incarcerated youth are demonstrated most devastatingly in the research on suicide. Although recent data are lacking, a national survey published in 2009 (Hayes) reported that 62% of juvenile suicide victims had a history of room confinement and 50% were on room confinement status at the time of death.

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The negative health outcomes associated with restrictive housing practices demonstrate the urgent need to reduce or eliminate the use of restrictive housing and to establish clear guidelines.

Position Statement

1. The practice of restrictive housing should not be used in juvenile corrections.
 - a. Restrictive housing should never be used as a disciplinary or punitive measure under any circumstances.
 - b. Restrictive housing should never be used as a response to minor infractions.
 - c. Restrictive housing should never be instituted because of staffing shortages, for administrative convenience, or for retaliation.
2. The following measures should be considered as alternatives to restrictive housing:
 - a. Facilities that house juveniles should maintain clear policies and procedures around safe, trauma-informed, and developmentally sensitive behavioral management.
 - b. Staff must have the training and resources to utilize therapeutic strategies such as:
 - i. Trauma-informed de-escalation techniques
 - ii. One-on-one time with a staff member engaging in an activity separate from the general population (e.g., outside recreation, journaling, calling family or loved ones)
 - iii. Carefully described consequences such as the use of verbal reprimands, loss of privileges, and work duty
 - iv. Option for youth to voluntarily lock themselves in their cells to avoid situations of conflict (with appropriate monitoring and precautions to minimize risk for self-harm)
 - v. Access to mental health professionals and others trained in conflict resolution
 - vi. Evidence-based interventions based on such principles as motivational interviewing and cognitive-behavioral or dialectical-behavioral therapy
 - c. Facilities should repurpose unused cells and other spaces as soothing de-escalation rooms that youth may use when needed.
 - d. Facility programming should be robust in order to reduce idleness that may lead to conflict between youths by increasing access to groups, recreation, and other activities.
3. In the rare event that restrictive housing is deemed necessary to maintain safety after all alternative therapeutic strategies and de-escalation techniques have been exhausted, these minimum steps must be taken to ensure the health and well-being of juveniles:
 - a. Policies must outline clear and effective behavior management protocols that prevent or limit the use of restrictive housing, and must align with relevant laws, regulations, and ethical standards. Any use of restrictive housing must occur in accordance with those policies.
 - b. Restrictive housing should never be assigned for a fixed period of time. As soon as the youth is determined to no longer be of risk to self or others, isolation should be terminated.
 - c. Clear communication that is developmentally and linguistically appropriate must be provided to the youth as to why restrictive housing is being used, what specifically is involved in the restriction, and what criteria will be used to determine an endpoint to the restrictive housing.
 - d. Custody or administrative staff must communicate the same to members of the youth's medical and mental health treatment team upon initiation of restrictive housing.
 - e. Medical clearance for restrictive housing must be obtained prior to a youth being placed whenever possible, otherwise within one hour of placement, to ensure that any underlying medical or psychiatric

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conditions are safely managed without acute risk of harm to the youth. This clearance will include an in-person assessment by a qualified health care professional or a designated “health-trained child care staff” per the NCCHC standards with phone back-up from the on-call qualified health care professional. If an in-person assessment cannot occur within one hour, an on-site or on-call qualified health care professional should review the youth’s available medical records. If a comprehensive mental health assessment has not yet been conducted for the youth, this must be done within the first 24 hours in restrictive housing.

- f. The medical clearance should include specific consideration of risks for suicide, trauma, and other underlying medical or mental health conditions, and consultation with appropriate medical and mental health professionals must occur when indicated to minimize risk of harm to the youth.
 - g. Ongoing routine monitoring for medical and psychiatric status must occur by a qualified health care professional or a designated “health-trained child care staff” with phone back-up from the on-call qualified health care professional, at minimum twice daily in person and as needed for condition change.
 - h. If a qualified health care professional deems further medical or psychiatric attention is needed, transfer to a medical or mental health unit should occur immediately.
 - i. Custody staff should conduct frequent checks, at least every 15 minutes, for any youth in restrictive housing.
 - j. The youth must maintain access to all standard rights, including but not limited to adequate nutrition, communication with attorneys and family, educational programming, daily exercise of large muscles and outdoor time, access to reading and legal materials, and access to medical and behavioral health care.
 - k. A clear exit strategy from restrictive housing must be included in the protocol and communicated with the youth and with staff members.
 - l. An individualized behavioral management plan should be developed for any youth for whom restrictive housing interventions are used more than once in 6 months.
4. Documentation and Monitoring
 - a. Any restrictive housing placement of 4 hours or longer should be considered a reportable event and thoroughly documented. Facilities may choose to use a lower threshold.
 - b. For youth placed in restrictive housing for more than 1 day, administration should convene a multidisciplinary team meeting to review the case and develop a safety/treatment plan.
 - c. Restrictive housing events should be documented in a daily list that includes the youth’s age, gender, and race; the start date; and the number of hours or days in restrictive housing. The list should be provided daily to the medical department and the facility administration. At least monthly, facility administrators should review the list to ascertain when practices are inappropriate, are ineffective, or have negative consequences.
 - d. Use of restrictive housing should be tracked to include monitoring for racial disparities. Staff training around use of restrictive housing must include steps to mitigate disproportionate use for racial minorities.
 5. If medical isolation is necessary for infection control purposes, steps to take include continual reevaluation for safe management in the least restrictive alternative setting as soon as possible, close monitoring for medical and psychological concerns during isolation, and access to as much programming and contact with family and providers as possible given the specific situation, as well as meeting standard Y-B-01 Infection Prevention and Control Program from the NCCHC standards.

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Endorsed by:

The American Academy of Pediatrics

The Society for Adolescent Health and Medicine

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