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The Council for Exceptional Children, Division of Emotional and Behavioral Health's Position Statement on Solitary Confinement

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Abstract

This document, from the Council for Exceptional Children, Division of Emotional and Behavioral Health (DEBH), provides clear and compelling support for the abolishment of solitary confinement with incarcerated youth and young adults in juvenile and adult correctional facilities. This is the first position statement from DEBH on the topic, and the information includes (a) a definition of solitary confinement, (b) discussion of its use, (c) an explanation of the impacts of solitary confinement on youth, (d) identification of systemic issues that perpetuate the use of solitary confinement, (e) an examination of U.S. laws concerning the use of solitary confinement, (f) a declaration of principles, and (g) recommendations for policy and practice.

Keywords

solitary confinement, position statement

The solitary confinement of youth in U.S. juvenile justice facilities (JJF; i.e., reception/diagnostic centers, detention centers, commitment facilities, shelters, group homes, boot camps, ranch/wilderness camps, transition facilities) and adult jails and prisons (see Note 1) is a harmful practice that must be banned. The United States, Somalia, and South Sudan are the only countries that have refused to ratify the United Nations' Convention on the Rights of the Child, wherein it states that "No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment" (Article 37(a)). The links between solitary confinement and torture are clearly delineated in the United Nations Rules for the Protection of Juveniles Deprived of Their Liberty stating,

> All 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. The reduction of diet and the restriction or denial of contact with family members should be prohibited for any purpose. (United Nations General Assembly, 1990)

Numerous organizations, including the American Academy of Child and Adolescent Psychiatry (AACAP, 2012), also oppose the use of solitary confinement for incarcerated youth due to an abundance of data indicating it is counter-therapeutic and harmful (Cooper, 2017).

Solitary Confinement Defined

There are four primary types of solitary confinement of youth: (a) disciplinary solitary confinement is used as a negative consequence if a youth violates facility rules, (b) protective isolation is used to safeguard a youth from other youths, (c) administrative isolation is used when a youth arrives at a new facility or when a youth is considered to be too disruptive for continued operation of the JJF, and (d) medical isolation is used to medically treat youth or if they are a suicide risk (Coler, 2021; see Note 2). While the underlying precepts of, for example, ensuring a vulnerable youth are protected from other youth or that a youth needs some time away from other youth due to suicidal ideation or other reasons are valid, solitary confinement cannot be the remedy due to the grave harm incurred by such extreme isolation, as described in the sections below.

Regardless of the underlying reasons that a youth may be placed in solitary confinement, the physical features of the space and attributes of confinement are generally the same. Youth are held in a cell that is about 6 × 8 ft and provided

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a thin mat on which to sleep, a sink, toilet, and a slot in the door through which they are fed (American Civil Liberties Union [ACLU], 2013; Gagnon, 2020). Typically, youth are provided 1 hr of large muscle activity individually outside of their cell each day, and their time in isolation is almost completely devoid of any human interaction.

Use of Solitary Confinement

There is no national requirement for JJF to collect and report data on youth solitary confinement, and as such, data are difficult to obtain (ACLU, 2013). However, research indicates that about one-fourth of incarcerated youth experience solitary confinement (Sedlak & McPherson, 2010). Furthermore, certain incarcerated youth are disproportionately isolated. Specifically, Krezmien and colleagues (2015) reported that youth with disabilities spent more time in disciplinary isolation compared with their peers without disabilities, and students with emotional disturbance (ED) spent more time in isolation than students with other disabilities. The Bureau of Justice Statistics (Beck, 2015) further identified that "Young inmates, inmates without a high school diploma, and lesbian, gay, and bisexual inmates were more likely to spend time in . . . solitary confinement than older inmates, inmates with at least a high school education, and heterosexual inmates" (p. 1). Available information also suggests that youth commonly spend from weeks to months in solitary confinement (Human Rights Watch & ACLU, 2012).

Given the serious concerns with the use of solitary confinement in JJF, the purpose of this Position Statement is to provide the information necessary to justify and guide the abolishment of this practice with youth and young adults in JJF. In the sections that follow, we (a) discuss the negative impacts of solitary confinement, (b) explain some of the systemic issues that perpetuate the use of solitary confinement, (c) describe U.S. laws concerning the use of solitary confinement, (d) provide a declaration of principles, and (e) offer recommendations for policy and practice.

Impacts of Solitary Confinement on Youth

There is substantial evidence that solitary confinement causes serious short- and long-term harm to incarcerated youth. Areas that are negatively impacted include (a) development, (b) psychological growth, (c) education, and (d) social contact.

Developmental Impacts

During adolescence, youth experience substantial developmental changes that may be compromised as a result of solitary confinement. Specifically, significant transformation occurs physically, including growth spurts and changes in hormone levels. In addition, youth experience both cognitive and social challenges dealing with their rapid body maturation, often resulting in stress, withdrawal, and depression, which can be exacerbated by solitary confinement (Muir, 2017).

Significant alterations to the brain also occur during this time period up until about the age of 25 (Arain et al., 2013), including pronounced and prolonged changes in the frontal and parietal regions (Choudhury et al., 2006). Research on the adolescent brain suggests that conditions such as solitary confinement may impair brain development (Paruch, 2019). Brain cells are programmed to react to environmental conditions and extreme situations, including that solitary confinement, even of limited time, can alter electroencephalogram (EEG) patterns in an abnormal manner, resembling stupor and delirium (Paruch, 2019). Thus, there is compelling evidence that even short periods of isolation are likely to have long-term impacts on youth development, including alterations in brain structure and function (Clark, 2017; Cooper, 2017). This is the case regardless of the intent of isolation (e.g., punitive, safety), indicating the need for alternative procedures.

Psychological Impacts

A substantial amount of research has documented the harmful psychological effects when individuals are deprived of sufficient social and environmental stimulation (Grassian, 2006). This body of research is derived from a combination of sources, including studies on (a) thought reform and brainwashing among prisoners of war, (b) electrophysiological changes resulting from reduced sensory input, and (c) arousal, motivation, and drive in both animals and humans (Kubzansky, 1961). Additional information has come from requisite pretrial solitary confinement in Scandinavian prisons, U.S. isolation employed during interrogations in the "war on terror," and prison isolation worldwide (Smith, 2006). Collectively, this body of data documents the detrimental psychological effects of withholding social interaction and stimulation.

Most concerning is research that suggests that youth may be particularly susceptible to psychological harm as a result of solitary confinement. As noted above, this is attributed to the immaturity of the adolescent brain, a fact supported by recent neuroscience research (ACLU, 2013; Clark, 2017). It is believed that adolescent brain immaturity renders youth less able to withstand the conditions of solitary confinement (AACAP, 2012). Furthermore, both human and animal researches demonstrate that supportive environments promote healthy brain development (e.g., Cauffman et al., 2018).

Although research in JJF is limited for ethical and other reasons, there are documented psychological effects of solitary confinement, including depression, cognitive disturbances, perceptual distortions and hallucinations, increased anxiety and nervousness, obsessive thoughts, paranoia,

revenge fantasies, rage, fear of persecution, exacerbation of pre-existing mental illness, trauma symptoms, psychosis, anger, aggression, withdrawal, self-mutilation, and suicide (ACLU, 2013; American Psychological Association [APA], n.d.; Gagnon, 2020). Furthermore, negative effects persist even after solitary confinement has ended. Compared to youth who were not isolated, those who had spent time in solitary confinement reported a greater frequency of physical, sexual, and psychological abuse from both peers and staff (APA). In addition, Hayes (2009) found a strong association between solitary confinement and suicide. Half of suicides occurred when youth were in solitary confinement, and 62% of youth committing suicide while incarcerated had a history of solitary confinement. Collectively, extrapolations from adult isolation data, extensive documentation in juvenile facilities, and emerging research support the severe psychological impact of solitary confinement.

Educational Impacts

Solitary confinement has an adverse educational impact on youth in JJF. Due to their isolation, students are deprived of meaningful interactions with peers and instructors. In addition, they experience a decrease in instructional time, reduction in opportunities to learn, and inadequate interaction with academic materials. In some facilities, youth receive course packets without instruction or adaptations with little or no feedback. Some facilities allow juveniles to contact their instructors via phone. Others close the door to education when the youth is in solitary confinement (Lee, 2016). Interactions that do exist between a student and a teacher typically last a couple of minutes, rather than an entire school day. The lack of socialization and educational support leads to processing deficiencies, limited comprehension, and learning.

Simkins et al. (2012) identifies two specific reasons for the adverse educational experiences from solitary confinement: (a) it takes away the time and opportunity from the youth to participate in academic, vocational, and instructional programs designed to rehabilitate; and (b) it increases the likelihood for adverse consequences, such as trauma, violence, and aggression, that interfere with educational performance and academic productivity. Technically, youth have the right to attend school to gain education, and punishment should not interfere with that. However, when they are isolated, they are not only deprived of educational services but also risk losing an important source of self-respect and confidence. Oftentimes, the very behaviors that precipitate the use of solitary confinement are exacerbated and lead youth toward more "acting out" or "shut down" behaviors.

As many as 30%–60% of youth in detention and secure care facilities have special education needs that significantly affect their academic, social, and emotional performance (Quinn et al., 2005). These students need intensive supports to make progress on their Individualized Education Plan (IEP) goals and their learning objectives. Without full and effective participation in instruction and special education interventions during solitary confinement, youth with disabilities are more likely to experience academic failure, ultimately impacting their ability to obtain a high school diploma.

Physical Impacts

Incarcerated youth are at a remarkably high risk for physical health disorders compared with their peers in the community, with some calling the situation a public health concern (Brusseau et al., 2018; Winkelman et al., 2017). Specifically, they have significantly higher prevalence rates of asthma, pneumonia, hypertension, and diabetes than youth in the community (Winkelman et al., 2017). Winkelman also noted that African American (AA) youth are more likely to have physical health problems than incarcerated White youth. This is troubling, given that AA youth are overrepresented in the juvenile justice system (Sickmund & Puzzanchera, 2014).

Physical health issues can be exacerbated by altered food intake and a lack of exercise during solitary confinement. In some instances, the nutritional quality of the food for youth in solitary confinement is lower than youth in the general population. Their regular meals may be replaced with "a baked nutritional loaf" or "beans and processed food" (Human Rights Watch & ACLU, 2012), and youth are not able to supplement their meals with snacks from the commissary. As a result, many youth experience hair loss and weight loss of up to 15–20 pounds in a month (Alexander, 2015; Birckhead, 2015; Human Rights Watch & ACLU, 2012). Incarcerated females may also experience loss of menstruation due to the changes in diet and increased stress associated with solitary confinement (Birckhead, 2015; Human Rights Watch & ACLU, 2012). Moreover, research suggests that youth should engage in 1 hr of moderate to vigorous physical activity each day (Brusseau et al., 2018), a situation that is difficult for youth in solitary confinement, as they are typically provided a small cage in which to spend 1 hr out of their cell each day (Applebaum, 2015).

Solitary confinement imposes additional harm to youth with mobility disabilities, such as muscle degeneration, or spinal cord injury. These youth often depend upon regular physical therapy and need exercise. When they are denied or prevented from engaging in physical exercise, they tend to develop muscle deterioration. Similarly, blind and/or deaf youth experience additional harms due to heightened sensory deprivation and mind numbness when held in solitary confinement (Morgan, 2017).

Human and Parental Contact

According to social neuroscience research, brain health and cognition of a person are associated with social contact and social interactions in an enriched environment (Coppola,

2019). Meaningful social contact and bonds help in developing and maintaining socio-emotional skills, such as emotion regulation, that serve as a significant mediator for prosocial attitudes and behavior (Zaki & Williams, 2013). Incarcerated youth who are subjected to solitary confinement are deprived of human contact and social interaction, two critical experiences for adolescent development (Muir, 2017). Lack of social contact is related to a decline in cognitive function, which is further reflected in decreases in verbal fluency and memory recall tasks (Shankar et al., 2013).

Multisystemic approaches that incorporate family-based interventions are viewed as effective approaches for rehabilitating incarcerated youth, as they provide more focused attention to the contexts and interactions in which a youth lives. Monahan and colleagues (2011) reported that for incarcerated youth, parental visitation is associated with better mental health and a decline in youth depressive symptoms, even when the youth and parent have a strained relationship. Furthermore, familial contact is associated with incarcerated youth exhibiting fewer behavior problems and earning a higher grade point average (GPA) in school (Agudelo, 2013). Solitary confinement limits or completely disrupts youth contact with family members and prevents the opportunity for developing positive social influences and healthy development that can provide youth with the tools to deal with negative influences that they may encounter in the future.

Systemic Issues

While not a justification for the use of solitary confinement, there are systemic issues within JJF that contribute to the reliance on isolating youth. Discontinuing solitary confinement will require addressing systemic issues including (a) a lack of trained staff and their pervasive attitude that professionals must maintain a significant distance from youth and not serve as trusted adults, (b) a lack of positive behavioral interventions, and (c) inadequate mental health screening, assessment, and intervention.

Staffing

There are several staffing issues that contribute to the use of solitary confinement. First, staff and teachers are frequently unprepared to provide appropriate instruction, behavioral interventions, and mental health supports. Teachers commonly do not have the skills needed to assist incarcerated youth academically or behaviorally (Houchins et al., 2009). They lack training in evidenced-based practices that can help in preventing antisocial behaviors from occurring, promoting desirable behaviors, and reducing their reliance on solitary confinement.

Second, facilities rarely invest in building staff capacity to use alternatives, such as de-escalation, trauma-informed care, and crisis prevention techniques. Working at JJFs can be stressful and demanding, and staff may experience a phenomenon called "Corrections Fatigue," which refers to a prolonged type of fatigue generated by facing the stressors in corrections for an extended period of time (James & Vanco, 2021). As Gagnon and Swank (2021) found, professional development (PD) rarely occurred more than once per year, and it did not include recommended attributes, such as coaching, mentoring, and follow up, and was "commonly viewed as ineffective" (p. 149). Furthermore, PD participation rates for mental health–related PD topics were usually provided to only 30%–40% of professionals other than clinical directors and counselors. Teachers, correctional officers, administrators, and teaching assistants received the least PD (Gagnon & Swank, 2021). By investing in evidenced-based PD practices, JJFs can provide staff with needed skills and potentially reduce Corrections Fatigue, as well as prevent youth problem behavior that is linked to the use of solitary confinement.

Third, JJFs need to invest in developing trusting and supportive relationships between staff and youth. Sedlak (2016) reported that the overall quality of staff and youth relationships in detention and corrections falls into the "poor" category. In detention and corrections/camps, respectively, only 31% and 26% of youth see staff as a role model, 33% and 31% view staff as caring, and 45% and 41% see staff as helpful. When staff and teachers have strong, supportive relationships with their youth, they can engender appreciation for positivity and success in youth (Mathur et al., 2018). Some key responsibilities for staff and teachers to facilitate mutual respect include (a) being proactive, (b) catching youth being good, (c) encouraging positive choice and peer relationships, (d) involving family and community, and (e) listening to youth voice (Mathur et al., 2018). This promotion of staff and youth relationships has the potential to increase youth appropriate behavior and help avoid a reliance on solitary confinement.

Finally, funding is needed for JJFs so they can raise awareness about and invest in providing alternatives to solitary confinement. Cooper (2017) concluded, solitary confinement is "a byproduct both of chronic underfunding and understaffing of juvenile correctional facilities, as well as of a pervasive view among correctional officials that solitary confinement is an indispensable means of maintaining safety and order within the facilities" (p. 346).

Positive Behavioral Interventions and Supports (PBIS)

PBIS rely on a multi-tiered framework for organizing systems to address problem behavior in a preventive and instructive manner. The modest application of PBIS in JJF was reported in a study by Gagnon and colleagues (2018), wherein they found that although most JJF (83.2%) reported

using a multi-tiered framework, questions regarding implementation of components aligned with PBIS indicated (a) infrequent use of proactive interventions; (b) continued reliance on punitive consequences, particularly for youth with more serious behavioral needs; (c) limited organized planning concerning youth behavior across multiple years; and (d) insufficient staff training in behavioral and social-emotional health. Rather than a focus on proactive and positive multi-tiered systems of behavioral support, many JJF actually rely on reactive measures including fear, control, and isolation (Scott & Cooper, 2013).

Granted, there are limitations in the quality and scope of research on implementation of PBIS in JJF (Johnson et al., 2013; Sprague et al., 2020). However, PBIS is based on sound theory, is well researched in neighborhood schools, and has been adopted by several state Departments of Juvenile Justice for implementation in JJF. Moreover, the Individuals With Disabilities Education Act (IDEA, 2006) specifically states that PBIS should be considered for youth whose behavior impedes their learning or the learning of others (see § 300.324(a)(2)(i)). As such, implementation of PBIS has significant potential to make the use of solitary confinement obsolete.

Mental Health Screening, Assessment, and Services

Youth placed in juvenile facilities experience mental health issues at a much higher rate than the general adolescent population. For example, research suggests that between 67% (Washburn et al., 2008) and 90% (Drerup et al., 2008) meet criteria for at least one mental health issue, such as depression, anxiety, or conduct disorder, with the majority meeting criteria for more than one. The rate of mental disorders among incarcerated youth is about 3 times that of youth in the community (Shufelt & Cocozza, 2006). Furthermore, Sedlak and McPherson (2010) conducted interviews with 7,073 youth in juvenile correction facilities and found that 70% reported having experienced a traumatic event, 52% felt lonely much of the time, 26% felt life was not worth living, and 22% reported trying to die by suicide. These data reveal a high-risk population with significant unmet mental health needs. Unfortunately, widespread systemic problems with mental health screening, assessment, and intervention within JJF contribute to the reliance on solitary confinement.

The first step in ensuring incarcerated youth have access to appropriate mental health services is to screen them upon intake and throughout their incarceration. The purpose of screening is to identify youth that are at high risk and need further evaluation, as well as those with mental health problems who require immediate support (Skowyra & Cocozza, 2007). Although intake screening is a common practice in JJF, a national survey revealed that rarely are youth re-screened during their stay (Swank & Gagnon, 2017). This is a significant concern because of the likelihood of mental health problems increasing during incarceration (Lambie & Randell, 2013). For instance, Moore and colleagues (2015) found a 25% increase in suicidal thoughts among incarcerated youth who reported suicidal behavior prior to placement. Without repeated mental health screenings, JJFs could be derelict in the identification of youth in need of a comprehensive assessment or services.

In addition to screening, comprehensive assessment is needed to fully understand the extent of incarcerated youth mental health concerns and to determine appropriate interventions (Swank & Gagnon, 2017; Underwood et al., 2006). Broadly, JJFs appropriately rely on a variety of data sources, as well as biopsychosocial interviews and psychometrically sound assessments (Swank & Gagnon, 2017). One potential concern is that a wide range of formal assessments are used across facilities, indicating the potential need for a more systematic approach and the development of industry standards.

With respect to mental health services, there is essentially no research that provides a comprehensive view of programming in JJFs. A survey by Swank and Gagnon (2016) sheds some light on the nature of mental health services in such settings. Respondents, representing 94 JJFs across 42 states and the District of Columbia, largely (76%) reported the provision of evidence-based interventions for mental health problems. At the same time, 79% indicated the need for additional training to improve mental health interventions. Furthermore, there was mandatory individual counseling in only 50% of facilities. Only one-third of facilities had mandatory family counseling, and about half of clinical directors believed that it adequately met the needs of youth.

A collateral concern is the absence of data to ascertain the quality of mental health services (Desai et al., 2006). Data indicating the majority of staff report the need for training (Swank & Gagnon, 2016) suggest that they may not be adequately prepared to deliver quality services. If programs and interventions are implemented with low integrity, they are likely to be ineffective. In addition, it is unclear whether services are delivered at the recommended dosage that is required for effectiveness. Taken together, the concerns with mental health screening, assessment, and services indicate a system that is derelict in identifying and meeting the needs of incarcerated youth, which most assuredly leads to youth problem behavior and the reactive implementation of solitary confinement.

U.S. Laws Concerning the Use of Solitary Confinement

IDEA and Solitary Confinement

IDEA regulations are perhaps the most problematic legal justification for the use of solitary confinement with youth with disabilities. IDEA (2006) states,

> The IEP team of a child with a disability who is convicted as an adult under State law and incarcerated in an adult prison may modify the child's IEP or placement if the State has demonstrated a bona fide security or compelling penological interest that cannot otherwise be accommodated. (§ 300.324(d)(ii)(2))

The first point to make is that this notion of penological interests is only relevant for youth who have been convicted and are serving time in an adult prison. Unfortunately, the argument of compelling penological interest is often informally and inappropriately used to place youth in solitary confinement in JJF and adult detention facilities. Certainly, the safety of incarcerated youth and staff is of paramount importance. However, in addition to restrictions about for whom this provision applies, it is also critical to note that modifications to an IEP or change of placement do not imply solitary confinement should be used. As noted in the First Step Act of 2018, there are alternatives to solitary confinement (and these are required for youth in federal prisons).

Additional limitations to the notion of compelling penological interests relate to the key words in IDEA (2006) that compelling penological interests are relevant if they "cannot otherwise be accommodated" (§ 300.324(d)(2)). As in the case of Buckley v. State Correctional Institution-Pine Grove and Pennsylvania Department of Corrections (2015) specialized housing, a blanket facility policy cannot be used as the basis for use of solitary confinement, without consideration of the IEP modifications that are needed for the youth. Specifically, there must be evidence of the provision of research-based behavioral interventions and necessary related services (e.g., counseling services, psychological services) to a youth with disabilities as well as data on the effectiveness of the interventions and implementation of any needed modifications to the services. For example, PBIS needs to be implemented to promote prosocial behavior and avoid serious behavioral issues (see IDEA, § 300.324(a)(2)(i)). Also, if a youth is a danger to himself or herself or others and needs a change of placement, a functional behavior assessment and manifestation determination should be conducted and behavior intervention plan should be implemented and adapted, if necessary, based on data (see IDEA, § 300.530). It is undeniable that situations occur within JJFs where youth need to be separated from the general population if they are a danger to themselves or others. However, again, it should be clarified that separating a youth from the general population does not imply the need for solitary confinement.

The First Step Act of 2018

Little legislation has addressed the solitary confinement of youth. To date, only a handful of states have instituted any restrictions concerning juvenile solitary confinement; however, they are predominantly related only to punitive solitary confinement and are so fraught with loopholes that its use continues (Lee, 2016). While not specific to youth with disabilities, one positive advancement is the First Step Act of 2018 (P. L. 115-391, 2018), which prohibits the use of *room confinement* (i.e., solitary confinement) for youth in federal prison. In sum, the act restricts the use of isolation as a punitive measure and allows separation of the youth only if he or she presents an immediate danger to self or others. A decision to isolate a youth must adhere to the following criteria: (a) be preceded, as appropriate, by less-restrictive evidence-based interventions that may include opportunities for a youth to talk with a mental health professional; (b) include informing the youth of the reasons for isolation, that release is contingent upon self-control, and that the length of time will not exceed prescribed time limits; and (c) not exceed 3 hr for a youth who is at risk for harming others and 30 min for a youth at risk for harming himself or herself. If a youth is not in control after the established times, the youth will be internally or externally transferred to a location that meets the youth's needs but does not require isolation or is moved to another appropriate location by a mental health professional. Finally, consecutive isolations that are not in the spirit of the law are prohibited. While only focused on federal prisons, the First Step Act of 2018 provides a much-needed blueprint for states to improve policies and practices related to solitary confinement.

In essence, the First Step Act replaces solitary confinement with behavioral and mental health interventions and what could be interpreted as a limited form of seclusion. In its position statement on the topic, the Council for Children With Behavior Disorders (Freeman et al., 2021; now Division of Emotional and Behavioral Health [DEBH]) defined seclusion as "the involuntary confinement of a student alone in a room or area from which the student is physically prevented from leaving" (p. 2). Although the aforementioned restrictions in the First Step Act limit the length of seclusion, DEBH is against the use of seclusion and maintains that it should not replace solitary confinement. Rather, in alignment with the original intent of JJF to serve as programs for rehabilitating youth, facilities must function as therapeutic programs that teach and promote positive prosocial youth behavior via PBIS, as well as provide trauma-informed care, appropriate special education and related services, mental health screening/assessments/interventions, and employ an appropriate number of adequately trained staff. Facilities must also implement a variety of alternatives to solitary confinement or seclusion that includes teaching youth self-calming skills and supports to use these skills prior to, during, and after a crisis.

Summary

Solitary confinement has no behavioral or therapeutic benefit, nor is there evidence that it makes facilities safer

(Shames et al., 2015). Rather, it results in severe short- and long-term negative effects in terms of the developmental, psychological, educational, physical, and social well-being of youth. Moreover, youth with educational disabilities and mental health disorders are at greater risk for negative impacts. Solitary confinement also interrupts the provision of services to which youth are legally entitled and commonly halts important communication and contact between an incarcerated youth and his or her family. It is, therefore, the unequivocal position of DEBH that the use of solitary confinement for youth and young men and women with and without disabilities up to the age of 25 should immediately cease. As has been heretofore described, changes are necessary in policy and practice to make the discontinuation of solitary confinement a reality.

Declaration of Principles

- "Solitary confinement is an affront to the humanity and vulnerability of any child" (Human Rights Watch & ACLU, 2012, p. 75).
- Consistent with the United Nations Human Rights Council, Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Mendez, 2011), solitary confinement should be abolished, and while removal from the milieu may be necessary to maintain the safety of youth and staff, solitary confinement or seclusion should not be the remedy. The use of any such removal must never be used as punishment. Moreover, it should only be maintained until a youth is no longer an imminent physical threat to himself or herself or others or, in keeping with the First Step Act of 2018, never exceeds 3 hr under any circumstances.
- Incarcerated youth have a right to uninterrupted education/special education services, career and technical training, mental health services, behavioral interventions and supports, physical activity, other rehabilitative activities, and opportunities to socialize with others, as well as regular contact with family.
- Given current research on adolescent and young adult brain development, recommendations for policy and practice concerning solitary confinement must include youth and young adults up to the age of 25 years.

Recommendations

Policy Changes

- Federal legislation is needed that clearly defines solitary confinement and its iterations (i.e., punitive, administrative, protective, medical). Without a single federal definition, there is the risk that there will be a rebranding or relabeling (e.g., separation, retreat) with no appreciable difference from the current attributes of solitary confinement (Birckhead, 2015).
- Federal legislation is needed that clearly bans the solitary confinement of youth and young adults under the age of 25. Because the use of solitary confinement is a human rights issue, federal legislation should address the patchwork of state and local laws and facility policies that allow for varied practices and that include loopholes facilities rely on to maintain the practice (Basso, 2018; Lee, 2016). Moreover, consideration of current research on brain development necessitates that the policies address youth and young adults up to the age of 25.
- Federal legislation should be written with the understanding that the current First Step Act of 2018 (P. L. 115-391, 2018), while a significant step forward, actually supplants solitary confinement with behavioral and mental health interventions and seclusion. It is important to recognize that seclusion should also be systematically discontinued, as it is a concerning practice that has the potential to seriously harm youth (see DEBH Position Statement on Seclusion and Restraint).
- Privately run and local, regional, and state-operated JJFs need to create funding mechanisms that ensure adequate quality and numbers of general and special education teachers, psychology and counseling staff, medical professionals, security personnel, and transition specialists to ensure the provision of adequate services and that solitary confinement is not utilized out of desperation.
- State-level requirements are needed to ensure the transparent collection and public dissemination of data on all behavioral incidences and punishments within JJF, as well as documentation of programs and procedures that support youth behavioral and mental health needs.
- State and local oversight is needed to ensure JJFs are held accountable for devising and implementing a comprehensive plan for training all staff that come in contact with youth, including information related to disabilities, youth development and mental illness, behavior and cognitive-behavioral approaches, de-escalation skills, cultural competence, trauma-informed approaches, and conflict-resolution skills (Fettig, 2017).

Changes in Practice

JJFs need to

- ensure youth access to adequate and uninterrupted education/special education, mental health services (e.g., individual, group, and family therapy, transition

services), career and technical training, PBIS, physical activity, and other rehabilitative activities, as well as regular contact with family.
- ensure an appropriate number of qualified staff at all times and increase youth access to mental health professionals during times when youth are volatile (e.g., following court appearances), if a crisis appears imminent, during a crisis, and following a crisis.
- provide an environment that takes into consideration youth development and is trauma-informed (Simkins et al., 2012).
- provide a system of graduated sanctions for problem behavior and a program of rewards for appropriate behavior within a multi-tiered system of PBIS.
- collect, analyze, and use behavioral data (including conducting functional behavior assessment) to generate and modify behavioral interventions and supports for youth.
- teach youth social skills and self-calming skills and reinforce use of these skills.
- prior to, during, and following times of crisis, provide opportunities and support for youth to enact prosocial coping skills (e.g., listening to music, watching television, doing a puzzle, reading a book) and provide a "calm area" where a youth can regain self-control (Atencio & Yordy, 2018; Bertsch, 2018).
- provide opportunities for graduated reengagement of a youth into the general population, following a situation where he or she needs time to calm down and regain self-control.

Author's Note

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Notes

1. Throughout the position statement, JJF (juvenile justice facility) is used for ease. However, we acknowledge that this term indicates the aforementioned variation in juvenile justice facilities as well as youth housed in adult jails and prisons.
2. The use of "solitary confinement" and "isolation" is used interchangeably throughout the position statement.

References

Agudelo, S. V. (2013, April). *The impact of family visitation on incarcerated youth's behavior and school performance* [Issue brief]. Vera Institute of Justice. https://www.vera.org/downloads/Publications/the-impact-of-family-visitation-on-incarcerated-youths-behavior-and-school-performance-findings-from-the-families-as-partners-project/legacy_downloads/impact-of-family-visitation-on-incarcerated-youth-brief.pdf

Alexander, E. (2015). This experiment, so fatal: Some initial thoughts on the strategic choices in the campaign against solitary confinement. *UC Irvine Law Review*, *5*(1), 1–39. https://scholarship.law.uci.edu/ucilr/vol5/iss1/3/

American Academy of Child and Adolescent Psychiatry. (2012). *Solitary confinement of juvenile offenders*. https://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx

American Civil Liberties Union. (2013). *Alone & afraid: Children held in solitary confinement and isolation in juvenile detention and correctional facilities*. https://www.aclu.org/sites/default/files/field_document/alone_and_afraid_complete_final.pdf

American Psychological Association. (n.d.). *Solitary confinement of juvenile offenders*. https://www.apa.org/advocacy/criminal-justice/solitary.pdf

Applebaum, K. L. (2015). American psychiatry should join the call to abolish solitary confinement. *The Journal of the American Academy of Psychiatry and the Law*, *43*, 406–515. http://jaapl.org/content/43/4/406

Arain, M., Haque, M., Johal, L., Mathur, P., Nel, W., Rais, A., Sandhu, R., & Sharma, S. (2013). Maturation of the adolescent brain. *Neuropsychiatric Disease and Treatment*, *3*, 449–461. http://doi.org/10.2147/NDT.S39776

Atencio, H., & Yordy, K. (2018, October). Idaho: Efforts to reform restrictive housing. In *Working to limit restrictive housing: Efforts in four jurisdictions to make changes* (pp. 5–7). The Association of State Correctional Administrators & the Liman Center for Public Interest Law at Yale Law School. https://law.yale.edu/sites/default/files/documents/pdf/Liman/asca_liman_2018_workingtolimit.pdf

Basso, B. (2018). Solitary confinement reform act: A blueprint for restricted use of solitary confinement of juveniles across the states. *Seton Hall Law Review*, *48*, 1601–1625. https://scholarship.shu.edu/shlr/vol48/iss4/24/

Beck, A. J. (2015, October). *Use of restrictive housing in U.S. prisons and jails, 2011–2012 (NCJ249209)*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/urhuspj1112.pdf

Bertsch, L. (2018). Reflections on North Dakota's sustained solitary confinement reform. In *Working to limit restrictive housing: Efforts in four jurisdictions to make changes* (pp. 5–8). The Association of State Correctional Administrators and the Linam Center for Public Interest Law at Yale Law School. https://law.yale.edu/sites/default/files/documents/pdf/Liman/asca_liman_2018_workingtolimit.pdf

Birckhead, T. R. (2015). Children in isolation: The solitary confinement of youth. *Wake Forest Law Review*, *50*(1), 1–71. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2512867

Brusseau, T. A., Burns, R. D., & Hannon, J. C. (2018). Physical activity and health-related fitness of adolescents within the juvenile justice system. *BioMed Research International, 2018*, Article 9710714. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6076947/pdf/BMRI2018-9710714.pdf

Buckley v. State Correctional Institution-Pine Grove and Pennsylvania Department of Corrections, 98 F.Supp.3d 704, No. 1:13-cv-2022. (2015). https://www.leagle.com/decision/infdco20150414b52

Cauffman, E., Fine, A., Mahler, A., & Simmons, C. (2018). How developmental science influences juvenile justice reform. *UC Irvine Law Review*, *8*(1), 21–40. https://scholarship.law.uci.edu/cgi/viewcontent.cgi?article=1306&context=ucilr

Choudhury, S., Blakemore, S.-J., & Charman, T. (2006). Social cognitive development during adolescence. *Social Cognitive and Affective Neuroscience*, *1*, 165–174. https://doi.org/10.1093/scan/nsl024

Clark, A. B. (2017). Juvenile solitary confinement as a form of child abuse. *The Journal of the American Academy of Psychiatry and the Law*, *45*, 350–357. http://jaapl.org/content/45/3/350.long

Coler, L. M. (2021). Isolated and forgotten: End the use and practice of solitary confinement in the juvenile justice system. *Thurgood Marshall Law Review*, *45*(2), 93–116.

Cooper, A. Q. (2017). Beyond the reach of the constitution: A new approach to juvenile solitary confinement reform. *Columbia Journal of Law and Social Problems*, *50*, 343–377.

Coppola, F. (2019). The brain in solitude: An (other) eighth amendment challenge to solitary confinement. *Journal of Law and the Biosciences*, *6*(1), 184–225. https://doi.org/10.1093/jlb/lsz014

Desai, R. A., Goulet, J. L., Robbins, J., Chapman, J. F., Migdole, S. J., & Hoge, M. A. (2006). Mental health care in juvenile detention facilities: A review. *Journal of the American Academy of Psychiatry and the Law*, *34*, 204–214. http://jaapl.org/content/34/2/204

Drerup, L. C., Croysdale, A., & Hoffmann, N. G. (2008). Patterns of behavioral health conditions among adolescents in a juvenile justice system. *Professional Psychology: Research and Practice*, *39*, 122–128. https://doi.org/10.1037/0735-7028.39.2.122

Fettig, A. (2017). The movement to stop youth solitary confinement: Drivers of success & remaining challenges. *South Dakota Law Review*, *62*, 776–796.

First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194. (2018). https://www.congress.gov/115/plaws/publ391/PLAW-115publ391.pdf

Freeman, J., Peterson, R., Kern, L., Mathur, S. R., Barber, B., Power, M., & Perea, M. (2021). CCBD's position on eliminating the use of seclusion in educational settings. *Behavioral Disorders*. Advance online publication. https://doi.org/10.1177/01987429211033548

Gagnon, J. C. (2020). The solitary confinement of incarcerated American youth during COVID-19. *Psychiatry Research, 291*, Article 113219. https://doi.org/10.1016/j.psychres.2020.113219

Gagnon, J. C., Barber, B. R., & Soyturk, I. (2018). Positive behavior interventions and supports implementation in secure care juvenile justice schools: Results of a national survey of school administrators. *Behavioral Disorders*, *44*, 3–19. https://doi.org/10.1177/0198742918763946

Gagnon, J. C., & Swank, J. (2021). A national survey on mental health professional development in juvenile justice facilities: Implications for youth reentry. *Behavioral Disorders*, *46*, 149–162. https://doi.org/10.1177/0198742920911183

Grassian, S. (2006). Psychiatric effects of solitary confinement. *Washington University Journal of Law & Policy*, *22*, 327–380. https://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24

Hayes, L. M. (2009, February). *Juvenile suicide in confinement: A national survey (NCJ 213 691)*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. https://www.ojp.gov/pdffiles1/ojjdp/213691.pdf

Houchins, D. E., Puckett-Patterson, D., Crosby, S., Shippen, M., & Jolivette, K. (2009). Barriers and facilitators to providing incarcerated youth with a quality education. *Preventing School Failure*, *53*, 159–166. https://doi.org/10.3200/PSFL.53.3.159-166

Human Rights Watch & American Civil Liberties Union. (2012). *Growing up locked down: Youth in solitary confinement in jails and prisons across the United States*. Human Rights Watch. https://www.aclu.org/files/assets/us1012webwcover.pdf

Individuals With Disabilities Education Act, 34 C.F.R. pts. 300 and 301. (2006). https://sites.ed.gov/idea/files/finalregulations.pdf

James, K., & Vanco, E. (2021). *The impacts of solitary confinement*. Vera Institute of Justice. https://www.vera.org/downloads/publications/the-impacts-of-solitary-confinement.pdf

Johnson, L. E., Wang, E. W., Gilinsky, N., He, Z., Carpenter, C., Nelson, C. M., & Scheuermann, B. K. (2013). Youth outcomes following implementation of universal SW-PBIS strategies in a Texas secure juvenile facility. *Education and Treatment of Children*, *36*(3), 135–145.

Krezmien, M. P., Travers, J., Valdivia, M., Mulcahy, C., Zablocki, M., Ugurlu, H. E., & Nunes, L. (2015). Disparate disciplinary confinement of diverse students in juvenile corrections. In B. G. Cook, M. Tankersley, & T. J. Landrum (Eds.), *Advances in learning and behavioral disabilities* (Vol. 28, pp. 273–290). Emerald Group.

Kubzansky, P. E. (1961). The effects of reduced environmental stimulation on human behavior: A review. In A. D. Biderman & H. Zimmer (Eds.), *The manipulation of human behavior* (pp. 1–18). Wiley.

Lambie, I., & Randell, I. (2013). The impact of incarceration on juvenile offenders. *Clinical Psychology Review*, *33*, 448–459. http://doi.org/10.1016/j.cpr.2013.01.007

Lee, J. (2016). Lonely too long: Redefining and reforming juvenile solitary confinement. *Fordham Law Review*, *85*, 845–876. https://ir.lawnet.fordham.edu/flr/vol85/iss2/19

Mathur, S. R., Griller Clark, H., LaCroix, L., & Short, J. (2018). Research-based practices for reintegrating students with EBD from the juvenile justice system. *Beyond Behavior*, *27*(1), 28–36. https://doi.org/10.1177/1074295617728508

Mendez, J. (2011, August 5). *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (U.N.G.A. Doc. A/66/268)*. United Nations Human Rights Council. https://documents-dds-ny.un.org/doc/UNDOC/GEN/N11/445/70/PDF/N1144570.pdf?OpenElement

Monahan, K. C., Goldweber, A., & Cauffman, E. (2011). The effects of visitation on incarcerated juvenile offenders: How contact with the outside impacts adjustment on the inside. *Law and Human Behavior*, *35*, 143–151. https://doi.org/10.1007/s10979-010-9220-x

Moore, E., Gaskin, C., & Indig, D. (2015). Attempted suicide, self-harm, and psychological disorder among young offenders in custody. *Journal of Correctional Health Care*, *21*, 243–254. https://doi.org/10.1177/1078345815584849

Morgan, J. (2017). *Caged in: Solitary confinement's devastating harm on prisoners with physical disabilities*. American Civil Liberties Union. https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf

Muir, C. (2017). Protecting America's children: Why an executive order banning juvenile solitary confinement is not enough. *Pepperdine Law Review*, *44*, 153–195. http://digitalcommons.pepperdine.edu/plr/vol44/iss1/4

Paruch, D. (2019, November). Banishing juvenile solitary confinement: A call to reform Michigan's practices. *Children's Law*, *40*, 1–4. http://www.michbar.org/file/barjournal/article/documents/pdf4article3801.pdf

Quinn, M., Rutherford, R., Leone, P. E., Osher, D., & Poirier, J. (2005). Youth with disabilities in juvenile corrections: A national survey. *Council for Exceptional Children*, *71*, 339–345. https://doi.org/10.1177/001440290507100308

Scott, T. M., & Cooper, J. (2013). Tertiary-tier PBIS in alternative, residential, and correctional school settings: Considering intensity in the delivery of evidence-based practice. *Education and Treatment of Children*, *36*, 101–119.

Sedlak, A. J. (2016). *Survey of youth in residential placement: Conditions of confinement*. Westat. https://www.ojp.gov/pdffiles1/ojjdp/grants/250754.pdf

Sedlak, A. J., & McPherson, K. S. (2010, May). *Conditions of confinement: Findings from the survey of youth in residential placement. Juvenile Justice Bulletin* (pp. 1–15). U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. https://www.ojp.gov/pdffiles1/ojjdp/227729.pdf

Shames, A., Wilcox, J., & Subramanian, R. (2015, May). *Solitary confinement: Common misconceptions and emerging safe alternatives*. Vera Institute of Justice. https://www.vera.org/downloads/publications/solitary-confinement-misconceptions-safe-alternatives-report_1.pdf

Shankar, A., Hamer, M., McMunn, A., & Steptoe, A. (2013). Social isolation and loneliness: Relationships with cognitive function during 4 years of follow-up in the English Longitudinal Study of Ageing. *Psychosomatic Medicine*, *75*(2), 161–170. https://doi.org/10.1097/PSY.0b013e31827f09cd

Shufelt, J. L., & Cocozza, J. J. (2006, June). *Youth with mental health disorders in the juvenile justice system: Results from a multistate prevalence study*. National Center for Mental Health and Juvenile Justice Research and Program Brief. https://www.unicef.org/tdad/usmentalhealthprevalence06(3).pdf

Sickmund, M., & Puzzanchera, C. (Eds.). (2014). *Juvenile offenders and victims: 2014 national report*. National Center for Juvenile Justice. https://www.ojjdp.gov/ojstatbb/nr2014/downloads/NR2014.pdf

Simkins, S., Beyer, M., & Geis, L. M. (2012). The harmful use of isolation in juvenile facilities: The need for post disposition representation. *Washington Journal of Law & Policy*, *38*, 241–287. https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1019&context=law_journal_law_policy

Skowyra, K. R., & Cocozza, J. J. (2007). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. National Center for Mental Health and Juvenile Justice. http://www.ncmhjj.com

Smith, P. S. (2006). The effects of solitary confinement on prison inmates: A brief history and review of the literature. *Crime and Justice*, *34*, 441–528. https://doi.org/10.1086/500626

Sprague, J., Jolivette, K., Boden, L. J., & Wang, E. (2020). Implementing facility-wide positive behavior interventions and supports in secure juvenile correction settings: Results of an evaluation study. *Remedial and Special Education*, *41*, 70–79. https://doi.org/10.1177/0741932519897135

Swank, J., & Gagnon, J. C. (2016). Mental health services in juvenile correctional facilities: A national survey of clinical staff. *Journal of Child & Family Studies*, *25*, 2862–2872. https://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf

Swank, J., & Gagnon, J. C. (2017). A national survey of mental health screening and assessment practices in juvenile correctional facilities. *Child and Youth Care Forum*, *46*, 379–393. https://doi.org/10.1007/s10566-016-9379-5

Underwood, L. A., Phillips, A., Von Dresner, K., & Knight, P. D. (2006). Critical factors in mental health programming for juveniles in corrections facilities. *International Journal of Behavioral Consultation and Therapy*, *2*(1), 107–140.

United Nations General Assembly. (1990). *United Nations Rules for the Protection of Juveniles Deprived of their Liberty: Adopted by the General Assembly resolution 45/113, December 14, 1990*. https://www.un.org/ruleoflaw/files/TH007.PDF

Washburn, J. J., Teplin, L. A., Voss, L. S., Simon, C. D., Abram, K. M., & McClelland, G. M. (2008). Psychiatric disorders among detained youths: A comparison of youths processed in juvenile court and adult criminal court. *Psychiatric Services*, *59*, 965–973. https://doi.org/10.1176/appi.ps.59.9.965

Winkelman, T. N. A., Frank, J. W., Binswanger, I. A., & Pinals, D. A. (2017). Health conditions and racial differences among justice-involved adolescents, 2009–2014. *Academic Pediatrics*, *7*, 723–731.

Zaki, J., & Williams, W. C. (2013). Interpersonal emotion regulation. *Emotion*, *13*(5), 803–810. https://doi.org/10.1037/a0033839