PEDIATRICS PERSPECTIVES

Children and Solitary Confinement: A Call to Action

Mikah Owen, MD, MPH, Jeffrey Goldhagen, MD, MPH

In 2011, the United Nations (UN) issued a report calling for the abolishment of solitary confinement for juveniles because it "can amount to torture or cruel, inhuman or degrading treatment."[1] Although there is no universal definition of solitary confinement, the report defines it as "the physical and social isolation of individuals who are confined to their cell for 22 to 24 hours a day."[1] Juvenile detention facilities often use similar practices, isolating children for many, but <22 hours.[2] While isolated, "children are regularly deprived of the services, programming, and other tools they need for healthy growth, education, and development."[2]

Despite the UN report, the United States continues to apply the use of juvenile solitary confinement and isolation. Disturbingly, no federal statutes limit or prevent application of these practices to juveniles, and the majority of states do not have laws that explicitly limit their use.[2] Most commonly, these solitary confinement and isolation practices are left to the discretion of juvenile housing facilities that vary in type (detention, group, residential treatment centers) and staff/resident ratios. These facilities, whether public or private, generally operate outside the purview of public accountability.

The extent to which solitary confinement and isolation of children is used in the United States is largely unknown, because correctional (juvenile and adult) facilities are not required to report such information to the public. Furthermore, no legal requirements exist at the federal or state levels to report why or how long a child is held in solitary confinement or isolation. In 2010, the Office of Juvenile Justice and Delinquency Prevention was able to provide limited data that painted a dismal picture.[3]

- Thirty-five percent of youth in custody reported being held in solitary confinement or isolation.
- Eighty-seven percent reported being isolated for 2–24 hours.
- Fifty-five percent reported being isolated for >24 hours.

These data understate the use of juvenile solitary confinement and isolation because they do not include juveniles held in adult facilities. Although federal guidelines recommend that youth held in isolation

Department of Pediatrics, University of Florida College of Medicine–Jacksonville, Jacksonville, Florida

Dr Owen conceptualized the article and did the background research to articulate the basics of the problem, drafted the original manuscript, and edited the manuscript; Dr Goldhagen reviewed and revised the original manuscript, providing more in depth analyses of the scope of the problem, and helped articulate the role of pediatricians in advocating for the abolishment of solitary confinement in children; and both authors approved the final manuscript as submitted.

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Address correspondence to Mikah Owen, MD, MPH, Department of Pediatrics, University of Florida College of Medicine–Jacksonville, 841 Prudential Dr, Suite 1330, Jacksonville, FL 32207. E-mail: mikah.owen@jax.ufl.edu

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for >2 hours see a counselor,[4] 52% of youth isolated for >2 hours report they did not have access to counseling.[3] Furthermore, juvenile detention facilities are not required to publicly report why a child is placed in solitary confinement or isolation. Facilities generally justify such confinement for disciplinary action, protective isolation, administrative isolation, or medical isolation.[2] Although short periods of isolation may be appropriate in some cases, children are often placed in isolation unnecessarily and for prolonged periods of time.[2]

The effects of solitary confinement on adult prisoners include hallucinations, anxiety, major depression, poor impulse control, and suicide attempts.[1] Although the consequences of solitary confinement and isolation of children have not been extensively studied, based on knowledge of brain development 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]."[5] This vulnerability is suggested by a national study of incarcerated juvenile suicide that found 62% of suicide victims had a history of being held in isolation before taking their life.[6] Although this study does not prove causality, the association is alarming and warrants investigation.

The health and mental health status of incarcerated youth has been well described by the American Academy of Pediatrics (AAP).[7] However, the AAP has not issued a formal statement or addressed the impact of solitary confinement and isolation on children and youth. The following recommendations provide a framework for action for the AAP, pediatricians, child advocates, and advocacy organizations.

At the national level, we recommend that the AAP and national organizations committed to child advocacy:

- Call for a ban on the use of solitary confinement and similar forms of isolation of children and adolescents in the United States and internationally.
- Advance statutory and rule requirements in all jurisdictions for adult and juvenile correctional facilities to report data on the use of solitary confinement and isolation of youth. Such data should detail the reasons and length of time a child was held in solitary confinement or isolation, possible alternative measures, and what treatment was provided afterward. Detailed reports on solitary confinement and isolation should be available to parents or guardians.
- Generate and issue standards for providing, monitoring, and reporting of health and mental health services for children and youth subjected to solitary confinement or isolation.
- Lobby for unrestricted public access to all information related to these matters.

At the regional level, we recommend chapters of the AAP, pediatricians, child advocates, and advocacy organizations:

- Work with juvenile detention facilities in their community to identify and report on the practice of solitary confinement and isolation.
- Take a leadership role in working with juvenile and adult detention systems to eliminate these practices by pursuing alternative strategies, including prohibiting or limiting the time of solitary confinement and isolation for disciplinary reasons, requiring these practices be approved by high-level administrators, and developing programs to address behavioral issues through "more humane and holistic approaches that largely preclude the 'need' for isolation."[2] Several states have already implemented these changes.[2]
- Ensure that children who have experienced solitary confinement or isolation receive immediate and ongoing mental health care in the detention facilities and after discharge.
- Collaborate with regional organizations to expand their communities' capacities to prevent and treat the impact of trauma in children.
- Implement standards for physical and mental health services for incarcerated youth as detailed in the 2011 AAP policy statement.[7]
- Give voice to youth who have themselves been subjected to solitary confinement or isolation.

At the local level, we recommend pediatricians and child advocates:

- Familiarize themselves with the epidemiology and impact of childhood trauma on health and well-being across the life course. Resources to do so are available at the AAP Web site (Resilience Project, www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience) and the Centers for Disease Control and Prevention Web site (Adverse Childhood Experiences, http://www.cdc.gov/violenceprevention/acestudy).
- Screen children for a history of trauma by using the Adverse Childhood Experiences Questionnaire (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Clinical-Assessment-Tools.aspx) and involvement in the juvenile or adult justice system,

particularly their exposure to solitary confinement and isolation.

- Refer at-risk youth to mental and behavioral health providers skilled in the care of childhood trauma.
- Work to establish their practices as trauma-informed venues for the care of children. The AAP Resilience Project defines a trauma-informed practice as "an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma" and provides resources to guide pediatricians in developing trauma-informed practices.

President Obama has recently taken an important step in advocating for incarcerated youth by issuing a ban on solitary confinement for juvenile offenders in the federal prison system. He poignantly articulated the problem when he wrote, "How can we subject prisoners to unnecessary solitary confinement, knowing its effects, and then expect them to return to our communities as whole people? It doesn't make us safer. It's an affront to our common humanity."[8] The ban, though historic, is largely a symbolic measure because few juveniles are confined in federal prisons. However, it may serve as a national model for juvenile detention facilities and as an impetus for ongoing reforms to the juvenile justice system.

Incarcerated youth are among the most vulnerable populations in the United States. Many are victims of complex and unrelenting forms of trauma. Policies allowing their solitary confinement or isolation contribute to ongoing trauma and violate their protection, promotion, and participation rights as delineated in the UN Convention on the Rights of the Child (http://www.unicef.org/crc). As pediatricians and child advocates we have individual and collective responsibilities to speak for children and youth who have not been heard and to provide them venues to speak for themselves. We must stand with them and call for the abolishment of solitary confinement and isolation of incarcerated youth.

ABBREVIATIONS

AAP: American Academy of Pediatrics
UN: United Nations

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