and developmentally appropriate management techniques applie

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

Facilities should maintain staff-to-youth ratios of at least 1:8¹⁵ (ideally 1:6) during waking hours, and 1:12 during sleeping hours (counting only staff who engage in continuous and direct supervision of youth). ¹⁶

Facilities should provide staff with specialized training and ongoing coaching in age-appropriate, positive behavior-management techniques, particularly de-escalation techniques designed for youth. 17

Facilities should implement positive, rewards-based management practices that do not primarily rely on punitive discipline to manage youth behavior. 18

Facilities should provide age-appropriate education, programming, recreational activities, and other days a week, available to all

youth at all times (even when they are separated from the general population). 19

Facilities should provide access to dental, medical, and mental health services from qualified professionals with specialized training in caring for children and adolescents; these services should be available to all youth at all times (even when they are separated from the general population).²⁰

Facilities should ban the use of mechanical and chemical restraints, corporal punishment, pain compliance, stun weapons such as taxers and stun shields, and chemical agents such as pepper spray or made. ²¹

Facilities should use age-appropriate dassification and evaluation instruments to identify educational, programming, mental health and other needs and diagnoses.²²

2. BANNING SOLITARY CONFINEMENT AND STRICTLY REGULATING OTHER I SOLATION PRACTICES

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

DISCIPLINARY ISOLATION (common euphemisms punitive segregation, disciplinary custody, lock-up, room confinement): Physical and social isolation used to punish children when they break facility rules, such as those prohibiting talking back, possessing contraband, or fighting;

PROTECTIVE I SOLATION (common euphemisms protective custody, administrative confinement): Physical and social isolation used to protect a child from other children;

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

¹⁶ CTR. ON CHILDREN'S LAW AND POLICY, WHAT ARE SOME BEST PRACTICES RELATED TO SEXUAL MISCONDUCT PREVENTION, DETECTION, AND RESPONSE THAT ARE NOT INCLUDED IN THE PRISON RAPE ELIMINATION ASCIST (1998) [1998] STANDIST S (2001) [1998] (1998) [1998] STANDIST S (2001) [1998] S

¹⁷ PBSGOALS, STANDARDS, OUTCOME MEASURES, EXPECTED PRACTICES AND PROCESSES, Supra note 5; Am. CORR. ASS N, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS 4-4312 (4th ed. 2003); THE MISSOURI MODEL, Supra note 14, at 27.

¹⁸ PBSGOALS, STANDARDS, OUTCOME MEASURO

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

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

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

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

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

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

Facilities should ensure that all youth, including youth separat 1001 1t94cin T-4(of)8()-4 T-4the g70()-4(has

Facility admini

appropriately⁴¹ and/ or the approval of a facility administrator should be required to authorize the use of emergency isolation beyond 60 minutes.

Facilities should ensure that every instance of emergency isolation is documented, reviewed by facility administrators, and regularly publicly reported.⁴²

Facilities should ensure that any youth separated from general population for medical reasons is admitted to the facility infirmary by a qualified medical professional; the facility infirmary should have 24-hour staffing by qualified medical professionals and should have physicians on call 24 hours per day. 43

Youth who have expressed suicidal ideation should be engaged in social interaction and not placed in room confinement. They should be permitted to engage in programming and social activities while supervised one-on-one by qualified staff who check on the youth at least every ten minutes.⁴⁴

For a youth who has engaged in suicidal acts or other acts of self-harm, facilities should develop an individualized suicide crisis intervention plan approved by a licensed mental health dinician who has evaluated the youth. Facilities should place any youth who is actively suicidal on constant observation by a qualified staff member, or should transfer the youth to amental health facility. 45

4. REFORMING DISCIPLINARY PRACTICES

Standards and best practices for managing and caring for youth suggest that the most effective techniques rely on positive reinforcement in lieu of discipline. ⁴⁶ A range of disciplinary measures can be safely employed in conjunction with practices that promote good behavior and healthy development. Youth should never be placed in solitary confinement or isolation for purposes of punishment or discipline. Appropriate disciplinary management practices should never involve social or physical isolation, or rise to the level of solitary confinement.

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

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

Facilities should never use isolation as a punishment or disciplinary sanction for youth. 47

rule violation.48

⁴¹ PBSGOALS STANDARDS OUTCOME MEASURES EXPECTED PRACTICES AND PROCESSES SUCRAINGLE 5. at 10.

⁴² Seeid at 10; A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 179-

⁴³ See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, supra note 2, at 113.

⁴⁴ Seeid at 120.

⁴⁵ Seeid at 119.

⁴⁶ See e.g., THE MISSOURI MODEL, supra note 14.

⁴⁷See A Guide to Juvenile Detention Reform: Juvenile Detention Facility Assessment 2014 Update, supra note 2, at 177; Standardsfor Health Services in Juvenile Detention and Confinement Facilities, supra note 6, at standard Y-39.

⁴⁸ See, e.g., 28 C.F.R. § 115.78(c), 115.378(c) (2012).

when a youth being disciplined comes to pose an imminent threat to self or others, or exhibits suicidal behavior or commits acts of self-harm, or when a medical professional concludes that the youth cannot be safely managed by non-medical staff, that youth must be transferred to a medical or mental health unit or facility for care and supervision by mental health professionals.⁴⁹

If a facility has not yet abolished the use of solitary confinement/isolation for punishment or disciplinary purposes, it should ensure that any disciplinary sanctions are preceded by due process. Due process must include effective notice of th()>Tm()|TJETBTa06 63edormipli6(c)5(lue)-3(ve)-5med of mehe4(l)-64-3(i)|TJETBTa06 63edormipli6(c)5(lue)-3(ve)-5med of mehe4(l)-64-3(i)|TJETBTa06 63edormipli6(c)-5(lue)-3(ve)-5med of mehe4(l)-64-3(i)|TJETBTa06 63edormipli6(c)-5(lue)-3(lue)-5(lue)-

professional condudes cannot be managed by non-medical staff—be transferred to a medical or mental health unit or facility for care and supervision by mental health professionals.⁵³

A goal of mental health care and services should be to manage youth in the general population whenever possible.

Young people with mental health problems who are identified as likely to benefit from a higher level of staff interaction and individualized attention, services and programming should not be subjected to significant levels of social and physical isolation.

Facilities should recognize when young people have histories of trauma and ensure that they do engage in practices that further traumatizes youth in their custody.

Facilities should ensure that youth identified as requiring a higher level of staff interaction and individualized attention, services and programming receive levels of programming, services, and staff interaction equal to or greater than youth in the general population.

Facilities should ensure that any separation implemented for treatment purposes is documented, reviewed by facility administrators, and regularly publicly reported.⁵⁴

6. REFORMING PROTECTIVE I SOLATION PRACTICES

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

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

Facilities should ensure that youth separated due to a current need for protection are not subjected to social and physical isolation.⁵⁵

Facilities should ensure that youth separated due to a current need for protection receive levels of programming, including education and recreation, services, medical and psychological care and check-ins, and staff interaction equal to youth in the general population.⁵⁶

Facilities should ensure that alternative housing is identified for youth with a current need for protection within 4 hours.⁵⁷

Facilities should ensure that any separation implemented for protective purposes does not constitute social isolation or solitary confinement, and that it is documented, reviewed by facility administrators, and regularly publicly reported.⁵⁸

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7. REFORMING MEDICAL I SOLATION PRACTICES

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

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

Youth should receive a medical assessment upon entering the facility which screens for tuberculosis and other communicable diseases. 59

Youth must be engaged in social interaction not isolated while being assessed (such as while a tuberculosis skin test is being employed) and must have an opportunity to participate in activities and programming.

Youth with medical conditions can be separated from the general population in a medical unit but must be engaged in social interaction not isolated while being treated and must have an opportunity to participate in activities and programming.

Youth identified as having been exposed to serious communicable diseases, such as infectious tuberculosis, can be separated from the general population (such as in a negative airflow room) in a medical unit but should be managed in medical facilities that provide specialized care. Youth so separated must be engaged in social interaction not isolated while being treated and must have an opportunity to participate in activities and programming.

When youth are placed in medical isolation they must be checked frequently for changes in physical and mental status and accommodated in a room with, at a minimum: a separate toilet; hand-washing facility; soap dispenser; and single service towels. 61

8. REFORMING I SOLATION PRACTICES

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

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

Youth at risk of self-harm must be engaged in appropriate activities and programs. 62

Youth at risk of suicide must be engaged in social interaction not isolated and must have an opportunity to participate in activities and programming. 63

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⁵⁹ See A GUIDE TO JUVENILE DETENTION REFORM: JUVENILE DETENTION FACILITY ASSESSMENT 2014 UPDATE, SUDTA NOTE 2, at 107.

⁶⁰ CENTERS FOR