

Juvenile Solitary Confinement as a Form of Child Abuse

Andrew B. Clark, MD

Placing incarcerated juveniles into solitary confinement continues to occur in certain states of the United States, despite the accumulating evidence that it may cause substantial psychological damage to the teenagers who must endure it. The practice has been widely condemned by professional and human rights organizations, amid a growing appreciation of the immaturity and vulnerability of the adolescent brain. Although several states and the federal government have been successful in abolishing or dramatically reducing the use of juvenile solitary confinement, it remains common practice in many facilities. Clinicians working in correctional facilities where juvenile solitary confinement is employed are therefore faced with difficult questions of ethics, as to how best to balance their competing duties, and how to respond to such state-sanctioned ill treatment of their patients. Given the emerging consensus around the psychological damage wrought by sustained solitary confinement, clinicians may well reach the difficult conclusion that they are both legally mandated and ethically bound to file a report of suspected child abuse. Such a report would be unlikely to be investigated for administrative reasons, but it would allow clinicians to communicate the gravity of their concern effectively.

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Placing incarcerated teenagers in solitary confinement for prolonged periods is a practice that, although controversial, remains widespread throughout much of the United States¹ and Canada.² The circumstances of such confinement typically involve placement alone in a small cell for between 22 and 24 hours a day; restricted contact with staff and peers; suspension or restriction of family visits; and the absence or minimization of reading material, radio, or television. It is a form of extended sensory and social isolation. Solitary confinement is typically used for disciplinary, administrative, or personal protective reasons, and it is thought by some facility administrators to be a necessary tool for managing disruptive behaviors and for maintaining discipline and safety within a detention facility. In contrast, seclusion for therapeutic purposes is intended to insure the safety and well-being of the incarcerated teen, and provides

an enhanced level of staff attention and observation; its duration is determined by clinical assessment rather than administrative protocol.

Solitary confinement (also known as “segregation”) came into frequent use in adult and juvenile detention facilities beginning in the 1980s, accompanying the dramatic increase in the number of incarcerated persons in the United States. However, the last several years have seen a growing chorus of concern around the deleterious psychological impact of solitary confinement. Recent U.S. Supreme Court cases such as *Roper v. Simmons*³ (the 2005 case that declared the death penalty for juveniles to be a violation of the Eighth Amendment’s ban on cruel and unusual punishment), *Graham v. Florida*,⁴ and *Miller v. Alabama*⁵ have focused attention on the relative immaturity of the adolescent brain. These cases, along with the emerging developmental neuroscience that undergirds them, have helped invigorate the assertion that teenagers are especially vulnerable to the extraordinary psychological stresses associated with placement in solitary confinement. Among many other voices, the American Academy of Child and Adolescent Psychiatry issued a policy statement in 2012⁶ opposing the use of solitary con-

Dr. Clark is Director of Forensic Mental Health at Boston Medical Center, Boston, MA. Formerly, Medical Director of the Children and the Law Program, Massachusetts General Hospital, Boston, MA. Address correspondence to: Andrew Clark, MD, Department of Psychiatry, Boston Medical Center, 720 Harrison Ave, Boston, MA 02118. E-mail: andrew56clark@gmail.com.

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finement for juveniles in correctional facilities because of their developmental vulnerability. Twenty-nine states and the federal government have in recent years either prohibited the practice completely or placed significant restrictions on its use.

Yet, the practice remains common in more than 20 states and all Canadian provinces, and clinicians working in detention facilities and caring for these youths are faced with ethics and professional challenges on how best to exercise their obligations to their patients within an unfamiliar and at times antagonistic correctional culture. More generally, how should clinicians respond when their adolescent patients are subjected, under the lawful authority of the state, to what they believe to be psychologically damaging conditions?

Impact of Solitary Confinement on Adults

Early 19th century Quaker reformers developed the practice of solitary confinement in correctional facilities to provide inmates with opportunities for sober reflection and penitence. Despite these laudatory aspirations, however, the effects were deeply discouraging. After touring a New York State prison in 1826, for example, Alexis de Tocqueville famously reported, “This trial, from which so happy a result had been anticipated was fatal to the greater part of the convicts . . . This absolute solitude . . . is beyond the strength of man. It destroys the criminal without intermission and without pity; it does not reform, it kills” (Ref. 7, p 5).

In the 1980s and early 1990s, Dr. Stuart Grassian conducted in-depth evaluations of around 200 individuals who had been kept in sustained solitary confinement in Massachusetts and California.⁸ He found that most of them manifested a distinct syndrome of dissociation, confusion, and paranoia, with a great many developing more chronic difficulties in social interaction. Craig Haney, a prominent researcher on the effects of confinement, studied 100 randomly selected inmates kept in isolation at the supermax prison at Pelican Bay, California.⁹ The great majority reported multiple signs of psychological stress, with 70 percent fearing an impending breakdown, 40 percent experiencing hallucinations, and 27 percent having suicidal thoughts. Confusion, anger, lethargy, and depression were reported by most inmates.

One of the more disturbing consistent findings associated with solitary confinement is that a highly

disproportionate number of self-mutilation incidents, suicide attempts, and completed suicides occur among prisoners who have been placed in such environments. The National Study of Jail Suicides, sponsored by the U.S. Department of Justice, found in 1988 that suicides in jails occurred at about nine times the rate of the general population, and a staggering 67 percent occurred while the inmate was in isolation. By 2010, improved training and protocols had helped change the face of jail suicides dramatically, with the rate dropping by two-thirds. Nevertheless, a disturbing 38 percent of suicides were completed by inmates in isolation.¹⁰ Of those, only 8 percent were on suicide precautions at the time of their deaths.

In 2012, the American Psychiatric Association issued a carefully worded statement noting that “Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates.”¹¹ Broader mandates have come from international and human rights organizations. The United Nations Standard Minimum Rules for the Treatment of Prisoners, revised in 2015 as the Nelson Mandela Rules,¹² prohibit indefinite or prolonged solitary isolation for anyone, as well as completely prohibiting solitary confinement for children and for individuals with mental disabilities that would be exacerbated by such measures. The United Nations Special Rapporteur on Torture has condemned prolonged solitary confinement, as well as solitary confinement for juveniles and for adults with mental illness, as cruel, inhuman, degrading, and possibly torture (Ref. 13, p 22). The National Commission on Correctional Health Care (NCCCHC), an influential organization that promulgates guidelines and offers health care accreditation for correctional facilities, adopted a position in 2016 that solitary confinement for greater than 15 consecutive days is “cruel, inhumane and degrading treatment, and harmful to an individual’s health.”¹⁴ The NCCCHC position statement also asserted that juveniles and mentally ill individuals should be excluded from solitary confinement of any duration. Some have argued that in light of what is known about the ill effects, it is time for the American Psychiatric Association to take a stronger position in advocating for a ban or limitation on solitary confinement for all inmates, and not just for those with known severe mental illness.¹⁵

Despite all of this, solitary confinement of adults remains widespread, with approximately 67,000 prisoners placed in such conditions in the United States¹ and Canada¹⁶ at any given time, many of whom are in dedicated supermax facilities (where prolonged solitary confinement is the norm). Federal courts in general have restricted their oversight to questions regarding the physical adequacy of the conditions of confinement, although class action lawsuits in several states^{17,18} have led to significant policy changes in regard to inmates with mental illness in particular.

Impact of Solitary Confinement on Juveniles

Compared with adult prisoners, substantially less data are available on the prevalence of segregation in juvenile facilities or on the psychological impact on individual teenage detainees. There are approximately 54,000 juveniles incarcerated in the United States at any given time, scattered among state, federal, and county juvenile facilities, as well as adult jails and immigration holding facilities.¹⁹ The Office of Juvenile Justice and Delinquency Prevention conducted a survey of 7,073 youths in custody in 2003, of which a quarter of detainees reported having been placed in solitary confinement at some time during their incarceration,²⁰ and in 2014 the same office reported that nearly half of juvenile detention facilities reported locking youth in some type of isolation for more than four hours at a time.²¹

For those who understand solitary confinement to be a stressful experience, it is generally thought that juveniles, by virtue of their immaturity, are not as well equipped as adults to withstand the rigors of such conditions. It stands to reason, then, that if adults are at risk of sustaining severe psychological damage as a result of such isolation, juveniles are even more likely to suffer harm.

Recently, three prominent U.S. Supreme Court Cases regarding juveniles and crime, *Roper v. Simmons* (2005),³ *Graham v. Florida* (2010),⁴ and *Miller v. Alabama* (2012),⁵ highlighted the Court's recognition of the immaturity of the adolescent brain, based in part on the emerging neuroscience regarding brain development in adolescence.²² However, the specific factors that the Court attended to in these cases were teens' increased vulnerability to peer influences, heightened impulsiv-

ity, and greater amenability to rehabilitation compared with adults, none of which bear directly on the question of a teenager's capacity to withstand solitary confinement. As with adults, courts have not weighed in to significantly limit the use of solitary confinement in juveniles.

The empirical research on youths in solitary confinement, although limited, has been disquieting. In a survey of 100 completed suicides in juvenile detention facilities, Lindsay Hayes found that 50 percent occurred at a time when the juveniles were confined to their rooms, with only 17 percent of the deceased on suicide precaution status at the time of their deaths.²³ Similarly, a study of all acts of self-harm occurring in the New York City jail system between 2010 and 2012 found that assignment to solitary confinement and age less than 19 years were the two strongest correlates for such behavior.²⁴ The authors speculated that many of the lower lethality acts of self-harm by younger inmates were performed in an attempt to avoid placement in the solitary unit, perhaps speaking to their level of desperation at the prospect of isolation.

There are some indirect but convergent lines of research pointing to the heightened vulnerability of adolescents compared with adults under such difficult circumstances. For one, neuroscience research on animal models indicates that adolescence may be a time of increased neuronal and hormonal reactivity to stress and that adolescent animals may be particularly sensitive to the stress of social isolation, with long-lasting effects on brain structure and function.²⁵ Second, the large Adverse Childhood Experiences study, correlating childhood adverse experiences with a multitude of later life pathologies, indicates that the number of reported childhood adverse experiences correlates strongly with later suicide attempts and that adolescents in particular are much more likely than adults to attempt suicide in the context of early life stressors, perhaps due to their greater vulnerability.²⁶ Finally, research on the psychological well-being of repatriated prisoners of war from the Vietnam conflict has consistently found that older age at capture is strongly associated with increased resilience to the experience of prolonged isolation and torture, with the presumption that the increased maturity and experience of older soldiers helped them withstand the extraordinary strains of captivity.²⁷

Decline in Juvenile Solitary Confinement

Most recently, President Obama in 2016 adopted recommendations from the Department of Justice and issued a ban on juvenile solitary confinement in federal facilities,²⁸ because of the potential for “devastating, lasting psychological consequences.”²⁹ Similarly, many states in recent years have abolished or placed restrictions on the use of solitary confinement for punitive purposes, while generally retaining the option of using segregation for administrative reasons. In a 2016 survey, 29 states or jurisdictions were noted to prohibit punitive juvenile solitary confinement, 15 states placed some limits on the practice (typically restricting it to a maximum of three to five days), and 7 states or jurisdictions had no limits in place or allowed indefinite extensions with administrative approval (Table 1).³⁰

The overuse of solitary confinement has been described as a final common pathway for several inadequacies in correctional settings, including deficient screening and identification of mental illness, access to mental health care, and marginalization of mental health staff.³¹ Front line staff who have come to rely on solitary confinement as a primary behavioral management technique are often resistant to limitations on its use. Those states that have successfully reduced their reliance on juvenile solitary confinement, therefore, have done so through a comprehensive and dedicated process of setting rehabilitative goals, developing new policies and procedures, monitoring data, and training staff in alternative behavioral management responses. The Council of Juvenile Correctional Administrators, working with the U.S. Department of Justice, has consolidated the lessons learned from those experiences into a toolkit for reducing the use of isolation.³²

Characteristics of Juvenile Inmates

One potential rationale to support the placement of juveniles in solitary confinement is that the select individuals who are so placed are “super predators,” and among “the worst of the worst.”³³ The moral aspect of this assertion is that these individuals have relinquished any claim to special consideration due to the depravity of their behavior, which implicitly characterizes solitary confinement as an additional form of punishment beyond incarceration itself. The psychological aspect is that such youths are too callous for isolation to be able to effect much damage. However, what is known about the pathways to sol-

Table 1 Jurisdictions Prohibiting, Limiting, or Allowing Use of Punitive Solitary Confinement in Juvenile Correctional Facilities³⁰

Prohibit the Use of Punitive Solitary Confinement	Limit Time Spent in Punitive Solitary Confinement (Six Hours to 90 Days)	Place No Limit on, or Allowing Indefinite Extension of, Punitive Solitary Confinement
Alaska	California	Alabama
Arizona	Delaware	Georgia
Arkansas	Indiana	Iowa
Colorado	Kentucky	Kansas
Connecticut	Louisiana	Michigan
Florida	Minnesota	
	Mississippi	
Hawaii	Nevada	Texas
Idaho	North Carolina	
Illinois	Rhode Island	Wyoming
Maine	South Dakota	
Maryland	Virginia	
Massachusetts	Washington	
	West Virginia	
Missouri	Wisconsin	
Montana		
Nebraska		
New Hampshire		
New Jersey		
New Mexico		
New York		
North Dakota		
Ohio		
Oklahoma		
Oregon		
Pennsylvania		
South Carolina		
Tennessee		
Utah		
Vermont		
Washington, DC		

itary confinement is that there are manifold reasons why a youth might be so placed, including disruptive or uncooperative behavior; suspicion of being a gang member; or being in need of protection (such as gay or transgendered youth), developmentally disabled, or mentally ill. Indeed, many of the youths who end up in solitary confinement are those least capable, for any number of reasons, of making a successful institutional adjustment.

Studies of detained youth indicate that most report a history of abuse and neglect and have exceptionally high rates of psychiatric illnesses and comorbidities, including PTSD, depression, and psychosis, as well as substance abuse and disruptive behavior disorders.^{34,35} Rather than a population of “super predators,” incarcerated youth appear as a group to be disadvantaged, damaged, and disturbed, and therefore likely to bring an array of vulnerabilities to their experiences of incarceration.

The Clinician's Dilemma

Mental health professionals in correctional settings provide much-needed care to a greatly underserved population, often working under stressful conditions. In choosing how best to respond when their patients are placed in solitary confinement, or otherwise institutionally ill-treated, clinicians must balance their professional duties toward their patients with their competing duties toward the safety of the facility and the importance of their working alliance with the facility's administration and staff. Health care professionals in correctional settings are embedded in a foreign culture, where institutional priorities may conflict with, and often trump, the clinical needs of individual patients.

Guidelines put forth by the World Health Organization³⁶ and the NCCHC¹⁴ recommend that clinicians play no role in clearing adult inmates as fit for placement in solitary confinement or in implementing disciplinary actions in any respect. Rather, the guidelines recommend that clinicians try to ensure that such inmates, once placed, are provided close oversight and appropriate care, with particular attention to the increased risk of suicide associated with such a placement. In addition, the NCCHC recommends that health care staff advocate on behalf of inmates whose mental health deteriorates while in solitary confinement and advocate to bring facilities' practices into line with international standards.

The American Psychiatric Association Code of Ethics does not address the question of solitary confinement,³⁷ although it does prohibit its members from participating in either executions or torture in any way. The American Psychological Association, in a 2015 Amendment to its Ethical Principles of Psychologists and Code of Conduct, reaffirmed its stance against psychologists' participation, either directly or indirectly, in the "cruel, inhumane or degrading treatment or punishment of detainees."³⁸

Just as teenagers present with unique needs and vulnerabilities, clinicians caring for them in correctional settings face a somewhat different set of ethics challenges compared with working with adults. The Code of Ethics of the American Academy of Child and Adolescent Psychiatry⁶ highlights the psychiatrist's duty of nonmaleficence (do no harm), incorporating the responsibility to try to reduce the harmful effects of the behavior of others, including community and social effects. In addition, the child

psychiatrist is expected to strive to minimize injustices to which an adolescent or child might be exposed. Legally, health care workers in all settings are required to report instances of abuse and neglect on behalf of their minor clients. Overall, mental health clinicians working with incarcerated youths are expected to exercise a degree of protection and advocacy on their behalf that is greater than that expected for adult patients. When working with children in correctional settings, therefore, the ethics knot is pulled a little tighter. If we bear a special responsibility and legal requirement for protecting the welfare of our patients and if our patients are especially vulnerable to the damages of segregation, what then can we do in the face of legal, state-sanctioned actions that we believe to be likely to harm the teenagers in our care?

One approach in the situation of juvenile solitary confinement would be for clinicians to excuse themselves completely from any involvement in the practice and perhaps choose not to work in such settings at all. This stance would be analogous to the position of the American Medical Association in regard to capital punishment and torture, given how incompatible such conditions are to their roles as healers, it is not possible for physicians to participate in these actions without compromising their ethical integrity.^{39,40} Indeed, many groups such as the ACLU and the United Nations Special Rapporteur on Torture have suggested that subjecting a juvenile to solitary confinement can be a form of torture.¹³ If accepted as accurate, this position may well lead a clinician to an ethically reflective decision to withdraw from the work altogether.

Nevertheless, detained youths are in great need of effective mental health services, and youths placed in segregation are probably at their time of greatest need for close mental health contact; forgoing those services may be a high cost to this vulnerable group. Dvoskin, for example, argues that when good clinicians quit working in bad systems, it is the clients, and not the system, that ultimately suffers.⁴¹

Alternatively, clinicians may continue to provide optimal care while choosing to advocate with and educate facility administrators and other decision-makers, and they may perhaps collaborate with organizations working toward the goal of the total abolition of this practice. This approach has the benefit of allowing clinicians to remain engaged with their patients, sustain their work in the facility, and demon-

strate a respect for laws, while simultaneously seeking to build consensus for change. Yet, to be involved in a system that ill treats its patients as a matter of policy is, by definition, an ethics challenge. For example, if a psychiatrist were to follow closely the inmates placed in segregation, carefully monitoring for signs of distress, it might allow jail administrators to console themselves and others that the psychological risks were being effectively mitigated, thereby helping to perpetuate the practice. Or, if psychiatrists assume the role of alerting jail administration to certain inmates in segregation who appear to be suffering psychological deterioration, they tacitly fail to advocate on behalf of other of their patients who are somewhat more resilient but suffering nevertheless.

Another approach, not inconsistent with continuing to provide good clinical care, would be for clinicians to file a report of suspected child abuse for every known instance of a juvenile placed in solitary confinement who manifests signs of deterioration or who appears to be at significant risk. Indeed, in light of what is known about the impact of solitary confinement in youths, and in the context of their legal reporting requirement, such an approach might seem unavoidable.

Solitary Confinement as Child Abuse

Medical and mental health clinicians caring for incarcerated juveniles are mandated reporters of suspected abuse and neglect in every state. Reporting laws make no exceptions for the location of the practice or the circumstance of the care being provided in a state sanctioned facility. Although states differ in the particulars of their statutory language, almost every state includes emotional abuse as one type of reportable maltreatment, with the typical definition being, "Injury to the psychological capacity or emotional stability of the child, as evidenced by an observable or substantial change in behavior, emotional response, or cognition," and injury as evidenced by "anxiety, depression, withdrawal or aggressive behavior."⁴² Similarly, the American Professional Society on the Abuse of Children has defined psychological maltreatment as "acts of omission or commission that are judged by professional expertise and community standards to be psychologically damaging, and that damage the behavioral, affective, cognitive and physical functioning of the child." Examples of such acts include isolating, shaming, and ignoring children (Ref. 43, p 126). It would seem at a mini-

mum, therefore, that juveniles who manifest signs of psychological deterioration or distress in the context of being placed in solitary confinement would meet the criteria in most or all states for having suffered emotional abuse, triggering a mandate for a report from their treating clinicians. Further, the very act of placing a juvenile in sustained solitary confinement would arguably constitute a reasonable cause to believe that abuse was taking place, and it would therefore fall under the reporting statutes of most or all states.

Metal Cage Scenario

Imagine a case of an industrious parent who built a small metal cage in his cellar, confining his wayward teenage child there virtually around the clock, passing meals through a slit in the door and rarely exchanging words. Our outrage in such a case would be palpable and pure, and our course of action clear. Why would this behavior so clearly be considered abusive, while the same treatment inside the walls of a detention facility is considered less so?

Reporting

The reasons not to report may include the futility of such a move, given that the facility is operating under state approval and that child protective services have limited authority in such circumstances. It is not likely that a child protective services department would attempt to investigate or intervene in the lawful actions of a juvenile justice department, particularly if both functions were carried out by the same agency. Further, filing a report of suspected child abuse in this context is potentially quite inflammatory, and it may irreparably damage the hard-earned trust between the clinician and the administration. Although all mandated reporting statutes provide immunity for liability to anyone making a report in good faith,⁴⁴ that may not effectively protect the employment status of an individual making such a report in this circumstance. Given the value of the work being done, these outcomes may in the near term do more harm than good to youths in need of protection and treatment.

There are, however, three primary, compelling reasons for clinicians to file a child abuse report on behalf of their juvenile patients in solitary confinement, after having consulted the statutes in their particular state. For one, they are arguably required to do so by statute and may face criminal sanctions as

well as civil liability for any harm suffered by the youths if they do not act. More broadly, in the context of their mandated reporting duties, clinicians need to file a report of suspected child abuse to have their expressions of concern taken seriously. In this sense, a decision to not file communicates a clinical judgment that the treatment in question does not rise to the level of abuse, effectively muffling any systemic concerns raised by the clinician. Finally, filing a report of suspected abuse would be instrumental in conceptualizing juvenile segregation as abusive and would help bring the teenagers' health and safety closer to the center of the debate. Doing so may help to crystallize and communicate what appears to be an emerging consensus in the field regarding the psychological damage associated with such placement, gain the attention of administrators and policy makers, and help to claim those confined youths as well within the scope of our concern.

If individual clinicians were to take on the professional risks associated with filing a child abuse report in such circumstances, the active and vocal support of their various professional organizations and other advocacy groups would be enormously helpful.

Conclusion

Juvenile solitary confinement continues to be used in correctional facilities for punitive or administrative reasons in certain of the United States, despite the growing evidence that it may cause substantial and lasting damage to the teenagers who must endure it. The practice has been widely condemned by professional and human rights organizations and even characterized as a form of psychological torture. Clinicians working in such facilities are faced with difficult questions as to how best to balance their competing duties and how to provide ethically sound care within such settings.

Many clinicians may choose to not work in such ethically compromising positions, whereas others may continue to strive to provide optimal care in juvenile detention facilities under challenging circumstances. Given the accumulating evidence around the immaturity of the adolescent brain and the likely psychological damage associated with juvenile solitary confinement, a clinician in such circumstances may well reach the uncomfortable conclusion that they are both legally mandated and ethically bound to file a report of suspected child abuse. The

specific outcome of such an action may be unknown, but it could reasonably be hoped that the filing would more emphatically communicate the clinician's protective concerns and more effectively highlight the needs and vulnerabilities of the teenagers involved.

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