COUNCIL OF JUVENILE CORRECTIONAL ADMINISTRATORS TOOLKIT: REDUCING THE USE OF ISOLATION

March 2015

…."Although room confinement remains a staple in most juvenile facilities, it is a sanction that can have deadly consequences…. more than 50 percent of all youths' suicides in juvenile facilities occurred while young people were isolated alone in their rooms and that more than 60 percent of young people who committed suicide in custody had a history of being held in isolation."

Lindsay M. Hayes,
Juvenile Suicide in Confinement:
A National Study. 2004

CJCA
Council of Juvenile Correctional Administrators

CCAS
Center for Coordinated Assistance to States

Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation

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March 2015

This Toolkit was prepared by the Council of Juvenile Correctional Administrators (CJCA) with support from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) through the Center for Coordinated Assistance to the States.

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Copies of this Toolkit can be downloaded at www.cjca.net

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A CJCA Toolkit: Reducing the Use of Isolation

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INTRODUCTION

The Council of Juvenile Correctional Administrators (CJCA) membership is comprised of juvenile justice system administrators and directors from across the United States who meet annually to discuss common issues, share experiences, review emerging trends, and attend workshops and seminars that promote best practice in delivery of juvenile justice services.

One of the critical issues discussed by members over the past few years is the use of isolation at correctional and detention facilities. A response to behavioral problems in many facilities has been reliance on isolation for acting out youths who are mentally challenged, chronically violent, or gang involved. Instead of being used as a last resort to protect youths from self-harm, hurting others or causing significant property damage that is terminated as soon as a youth regains control, isolation too often becomes the behavior management system by default.

Research has made clear that isolating youths for long periods of time or as a consequence for negative behavior undermines the rehabilitative goals of youth corrections. Agencies and facilities across the country are looking for help to change practices to align with the research and promote positive youth development. Many agencies have made sustainable reforms eliminating and reducing the use of isolation; at least 10 states have banned punitive solitary confinement. However others see increasing use of isolation and face significant barriers and resistance to changing the practice.

At the CJCA October 2014 Leadership Institute a panel of four state agency directors and the administrator of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) led the approximately 50 leaders in an open discussion of the need to address the use of isolation, the barriers to changing facility culture and practices, and strategies and tools that the directors used to reduce the use isolation in their facilities. The group of juvenile correctional leaders spoke frankly also about the need to develop alternative approaches to managing behavior and the difficulties they face changing staff beliefs and attitudes that isolation is a necessary management tool despite research showing it is counterproductive and harmful.

At the conclusion of the October 2014 CJCA Leadership Institute, members requested that a Toolkit be developed for states to use as a guide to reduce the use of isolation in youth correctional and detention facilities. CJCA presents this toolkit to help its members and the field reduce the use of isolation and ultimately better help youths in juvenile facilities become successful members of the community.

The CJCA Toolkit provides:

- An overview of the issue of isolation and how it is defined;
- A summary of the research substantiating the negative impacts of isolation;
- Five steps to reducing the use of isolation:
    1. Adopt a mission statement and philosophy that reflects rehabilitative goals.
    2. Develop policies and procedures for use and monitoring of isolation.
    3. Identify data to manage, monitor and be accountable for use of isolation.
    4. Develop alternative behavior management options and responses.
    5. Train and develop staff in agency mission, values, standards, goals, policies and procedures.
- Action steps for CJCA directors; and,
- Case studies from four state agencies that significantly reduced the use of isolation.

OVERVIEW OF THE ISSUE OF ISOLATION AND HOW IT IS DEFINED

Department of Justice data indicates that roughly 70,000 young people are held daily in state, county, private and federal juvenile residential facilities across the United States and that the use of isolation, including solitary confinement, in these facilities is widespread.

One of the first obstacles to changing the practice of placing youths in isolation is that there is no nationally agreed on definition of isolation and no national publication of standardized, uniform and comparable isolation data. The one program that does have standardized, uniform and comparable data, Performance-based Standards (PbS), is voluntary and not adopted in every state[1].

For the purposes of this Toolkit, isolation means: Any time a youth is physically and/or socially isolated for punishment or for administrative purposes. (This intentionally excludes protective and medical isolation.)

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[1] PbS was launched by OJJDP in 1995 to address the dangerous and ineffective conditions of confinement in juvenile facilities. CJCA was selected by OJJDP to develop national performance standards and performance outcome measures to manage facilities according to research and best practices.

Isolation has many names and many variations of location and duration:

- Solitary confinement, the most extreme form of isolation, is physical and social isolation in a cell for 22 to 24 hours per day;
- Time out, a short cooling off period in a room or other location away from the general population and/or activities;
- Room confinement, placing youths in their rooms and not allowing them to leave, whether as a punishment or administrative purpose (i.e., staff shortage);
- Seclusion;
- Special management housing units where youths are placed for disciplinary purposes that removes them from the general population. Limited programming such as education may be provided, but there is very limited out of room activity.

> *"Our feeling was, why ever deprive yourself of a tool? Corrections is about tradeoffs, and one of the tradeoffs is if you don't use a tool like this, you disrupt the program for everybody else. If you have somebody who is messing things up so other wards who are trying to participate and deal with their issues can't do it, then what you've done is you've said "Well, we're not going to isolate this ward. In exchange we're going to let him mess up the program for 10 or 15 other guys. It's necessary for programming, it's necessary for staff safety, it's for the safety of the other wards—at times."*
>
> *Source: Craig Brown, Chief Lobbyist for the California Correctional Peace Officers Association. "Juvenile Solitary*

The opposition to reducing the use of isolation comes most vocally from staff and unions. They argue that restricting or eliminating the practice puts staff in danger and facility security at risk; it would remove a tool from their tool belt of sanctions and the youths would run the facilities. There is no research showing any of those reasons to be true.

A SUMMARY OF THE RESEARCH SUBSTANTIATING THE NEGATIVE IMPACTS OF ISOLATION

Academic research continues to show that placing incarcerated youths in isolation has negative public safety consequences, does not reduce violence and likely increases recidivism. Subjecting developing adolescents to isolation can cause permanent psychological damage and multiple studies suggest it is highly correlated with suicide. Additionally, youths who are placed in isolation can be subjected to revocation of privileges such as reduced family visitation or limited access to educational programming and classes – two practices research has shown positively impacts youths.

Research also has shown that isolation can cause serious psychological, physical, and developmental harm, resulting in persistent mental health problems, or worse, suicide. Lengthy periods of isolation can be equally traumatizing and the result is the same

serious risk to health. These risks are magnified for youths with disabilities or histories of trauma and abuse. Experts agree that adolescents are particularly vulnerable to psychological harm caused by isolation because their brains are still developing. Solitary confinement is the most harmful and extreme form of isolation and has damaging impacts (See the sidebar story: "Solitary Confinement Harms Children" for more information).

The overwhelming research that isolation, and particularly prolonged solitary confinement, can cause serious mental health-trauma, re-traumatization, depression, anxiety, psychosis, suicide, self-harm, violence and negatively impacts education, rehabilitation, physical health, family involvement and social development prompted the American Academy of Child and Adolescent Psychiatry (AACAP) to develop a policy statement opposing the use of prolonged isolation (see Appendix C for a copy of the statement). There is no research showing the benefits of using isolation to manage youths' behavior.

SOLITARY CONFINEMENT HARMS CHILDREN

Solitary confinement is well known to harm previously healthy adults, placing any prisoner at risk of grave psychological damage. Children, who have special developmental needs, are even more vulnerable to the harms of prolonged isolation.

- **Psychological Damage:** Mental health experts agree that long-term solitary confinement is psychologically harmful for adults—especially those with pre-existing mental illness and the effects on children are even greater due to their unique developmental needs.

- **Increased Suicide Rates:** A tragic consequence of the solitary confinement of youth is the increased risk of suicide and self-harm, including cutting and other acts of self-mutilation. According to research published by the Department of Justice, more than 50% of all youth suicides in juvenile facilities occurred while young people were isolated alone in their rooms, and that more than 60% of young people who committed suicide in custody had a history of being held in isolation.

- **Denial of Education and Rehabilitation:** Access to regular meaningful exercise, to reading and writing materials, and to adequate mental health care—the very activities that could help troubled youth grow into healthy and productive citizens—is hampered when youth are confined in isolation. Failure to provide appropriate programming for youth including access to legal services hampers their ability to grow and develop normally and to contribute to society upon their release.

- **Stunted Development:** Young people's brains and bodies are developing, placing youth at risk of physical and psychological harm when healthy development is impeded. Children have a special need for social stimulation and since many children in the juvenile justice system have disabilities or histories of trauma and abuse, solitary confinement can be all the more harmful to the child's future ability to lead a productive life. Youth also need exercise and activity to support growing muscles and bones.

Source: ACLU STOP SOLITARY "Ending the Solitary Confinement of Youth in Juvenile Detention and Correctional Facilities," 2015.

Conversely, research has shown that the facilities that minimally use isolation are more safe – fewer injuries to youths and staff, less suicidal behavior and overall violence – and healthier staff-youth relationships that lead to less recidivism. Research done using Performance-based Standards (PbS) data multiple times between 2007 and 2011 showed healthy staff-youth relationships and four specific practices, including placing youths in isolation, were consistent predictors of youths' odds of victimization while at the facility. The PbS findings were supported by the Pathways to Desistance Study that showed youths' positive experiences in facilities impacts their likelihood of re-offending.

"You literally are locking a child down with nothing to do, with no interaction, for 22, 23, 24 hours a day. In some ways, it's common sense to look at the denial of education, the denial of drug treatment, the denial of adequate mental health care that exists in solitary confinement, and think to yourself 'Well, what's going to be the result for that kid? How could anything positive ever come from such treatment?' And the answer is, it doesn't."
Bart Lubow, Annie E. Casey Foundation

Source: "Juvenile Solitary Confinement: Modern-Day 'Torture' in the US", by Gary Gately, March 5, 2014.

CJCA POSITION ON THE USE OF ISOLATION

The Council of Juvenile Correctional Administrators believes that isolating or confining a youth in his/her room should be used only to protect the youth from harming him/herself or others and if used, should be for a short period and supervised.

CJCA believes that all jurisdictions should have a written policy that limits the use of isolation to situations involving a serious threat by a youth to harm oneself or others, the authority that must approve its use, for what duration of time, appropriate and adequate staff to monitor the youth with appropriate follow up and review. CJCA supports the following guidelines for the use of isolation:

1. The use of isolation should be a last resort only after verbal de-escalation techniques are employed to defuse a situation;

2. All staff should be trained in use of Isolation policy;

3. Isolation may not be used as punishment;

4. Staff must request permission to use room confinement from higher managers in a facility;

5. Residents on 'suicide watch' may never be placed in isolation;

6. Any use of isolation beyond 15-minutes must be recorded in incident reports;

7. Duration of isolation must be recorded;

8. Medical and Mental Health staff should be included in the intervention; and

9. Use of isolation report should be completed and reviewed at program and higher administrative levels.

FIVE STEPS TO REDUCE THE USE OF ISOLATION

The following five steps to reduce the use of isolation were compiled based on the national body of research that supports positive youth development and the harms of using isolation, best practices used by four states that have reduced the use of isolation (see Appendix B State Examples) and the national discussion held at the 2014 CJCA Leadership Institute.

1. Adopt a mission statement and philosophy that reflects rehabilitative goals;
2. Develop policies and procedures for use and monitoring of isolation;
3. Identify data to manage, monitor and be accountable for use of isolation;
4. Develop alternative behavior management options and responses; and,
5. Train and develop staff in agency mission, values, standards, goals, policies and procedures.

Reducing the use of isolation successfully and sustainably requires a holistic approach to agency reform and culture change, starting with the leadership.

Step 1: Adopt a Mission Statement and Philosophy that Reflects Rehabilitative Goals

Agency chief executive officers must lead the change in agency and facility culture. The first step is to examine the agency's overall vision, mission, goals and values for delivery of services to youth. These statements should reflect the philosophy of the jurisdiction, and the philosophy should be reflected in all operations throughout the facility. Policies and procedures associated with the use of isolation have to tie back into the overall vision and mission of the system and facility. States that have adopted a mission and philosophy of therapeutic rehabilitation of youth do not rely on isolation because isolating youth does not support the mission and philosophy of rehabilitation.

GUIDELINES TO REDUCE ISOLATION

- Develop immediate correction actions.
- Develop graduated sanction grid.
- Conversion to trauma – informed care – calming rooms (60% reduction of room confinement).
- Make facilities more home like.
- Policy and procedures clearly articulated.
- Alternatives for staff when serious incidents take place.
- Collaborative problem solving
- Explosive child – what are the pre-cursors? triggers?
- Clinical interventions based on scientific and behavioral research.
- Utilize various levels of treatment based on development levels.
- Relapse prevention programming.
- Staff, Youth and Family Input
- Research and implement "Best Practices".
- Educate leadership, stake holders and staff.
- Stakeholder support.
- Continuous improvement and measurement.

Source: CJCA Leadership Institute. October 2014.

The Oregon Youth Authority (OYA) adopted a model of Positive Human Development, which is reflected in all aspects of operations and service delivery. The use of isolation, particularly punitive isolation, is not consistent with the mission, vision and values outlined by OYA.

Oregon Youth Authority

Mission → **Vision** ← **Values**

OYA protects the public and reduces crime by holding youth offenders accountable and providing opportunities for reformation in safe environments.

Youth who leave OYA go on to lead productive crime-free lives.

OYA's core values are: Integrity, Professionalism, Accountability, and Respect.

| Highly effective and efficient organization | Integrated safety, security and youth reformation system | Engaged, healthy and productive youth | Engaged, culturally competent and successful workforce | Collaborative communicative and transparent leadership |

Culture → Positive Human Development

Source: Oregon Youth Authority, 2015.

States that provide "evidence-based" therapeutic treatment programming use youth-centered therapeutic treatment models that do not support the use of isolation, particularly as a punitive measure. Typical practices of youth-centered therapeutic treatment facilities include:

- Maintain staff-to-youth ratios of at least 1:8 (ideally 1:6) during waking hours, and 1:12 during sleeping hours (counting only staff engaged in continuous and direct supervision of youth).
- Provide staff with specialized training and ongoing coaching in age-appropriate, positive behavior-management techniques, particularly de-escalation techniques designed for youth.
- Incorporate positive, rewards-based management practices that do not primarily rely on punitive discipline to manage youth behavior.
- Provide age-appropriate education, programming, recreational activities, and other services that take up a significant proportion of the youth's waking hours, seven days a week, available to all youth at all times (even when they are separated from the general population).
- 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).
- Ban the use of mechanical and chemical restraints, corporal punishment, or other such punitive measures.
- Conduct classification and evaluations on youth to identify educational, programming, mental health and other needs and diagnoses.

If an agency's mission is therapeutic rehabilitation of youths, use of isolation will be greatly reduced or eliminated based on the overwhelming evidence that isolation is harmful to youths and does not support therapeutic treatment goals.

Step 2: Develop Policies and Procedures for Use and Monitoring of Isolation

It is important to have clearly stated policies and procedures related to any use of isolation. Policies and procedures should define when isolation can be used; the duration; review process and protocols; programming and services; staff communications; alternatives; and reporting procedures.

Once policies and procedures have been adopted, staff training—initial and ongoing—will be required to uniformly implement the policies. Facility directors must monitor and enforce compliance with policies and procedures related to the use of isolation. Facility directors can't assume or take for granted that all staff are complying with

policies and procedures. Staff must be held accountable for consistently implementing policies and procedures, and monitoring of the use of isolation and outcomes is critical.

The Indiana Department of Correction, Division of Youth Services (DYS) revised its Use of Isolation Policy to limit its use and duration. Any youth held in isolation is assessed hourly with a goal of returning the youth to program as soon as he or she is ready to return. Indiana DYS, which reduced the use of isolation with positive outcomes as a result, points to the importance of getting staff input when revising policies and procedures related to the use of isolation.

The Massachusetts Department of Youth Services (DYS) has developed a model policy for the use of isolation (see Appendix B State Examples). The policy was developed in response to suicides at agency facilities while youths were confined in their rooms. It took DYS several years working with the officers' union, providing training and sharing data that demonstrated the facilities were not any more dangerous but in fact more safe. Critical steps for implementation were:

1. Identify data to manage, monitor and be accountable for use of isolation;

2. Develop alternative behavior management options and sanctions; and,

3. Train staff and monitor compliance.

Step 3: Identify Data to Manage, Monitor and be Accountable for Use of Isolation

Once policies are established data must be identified that measures how the policies are implemented. The data selected should accurately reflect the intention and direction of the policies and be collected, analyzed and used to monitor how well the policies are being implemented and the changes in use and duration of isolation. Data provides the picture of what is happening in facilities and allows directors and leaders to take a look at what the quality of life is in facilities and determine if it meets their expectations and goals. Often simply collecting data and sharing the results starts to shift practices.

MEASURING AND MONTIORING THE USE OF ISOLATION

- When used and when <u>not</u> used
  - Low level interventions, high level interventions and behavioral characteristics
- Day of week
  - Time of day; staff on duty
- Location of Incident
- Use of Alternatives
  - Verbal de-escalation, calming rooms, other alternatives
- Assaults
- Workers Compensations
- Youth on staff assaults
- Average daily population

The only standardized national data on use of isolation was developed by CJCA as part of the Performance-based Standards (PbS) program. PbS is a data-driven improvement model that collects and reports both quantitative administrative record data and qualitative survey data from youths, staff and families to provide a holistic and comprehensive picture of the conditions of confinement and quality of life in secure facilities for young offenders. PbS' primary purpose is to provide facility and agency leaders and staff with national standards to guide operations, implement best practices that best serve youth, staff and families and to continuously monitor daily activities and culture within facilities using performance outcome measures. As of October 2014, 159 facilities in 32 states participated in PbS: 96 correction, 48 detention and 15 assessment[2].

PbS facilities collect information about the use of isolation and room confinement by reviewing all incident reports during two data collection months per year. PbS' advisors established a comprehensive definition of isolation that includes any instance a youth is confined alone for cause or punishment for 15 minutes or more in his or her sleeping room or another room or separation unit. Exceptions are made for protective isolation, medical isolation or when requested by a youth. The time measured begins when the youth is placed in the room and continues until he or she leaves, including sleeping time when extending overnight. PbS' growth model reports isolation data twice a year for continuous measuring and improving.
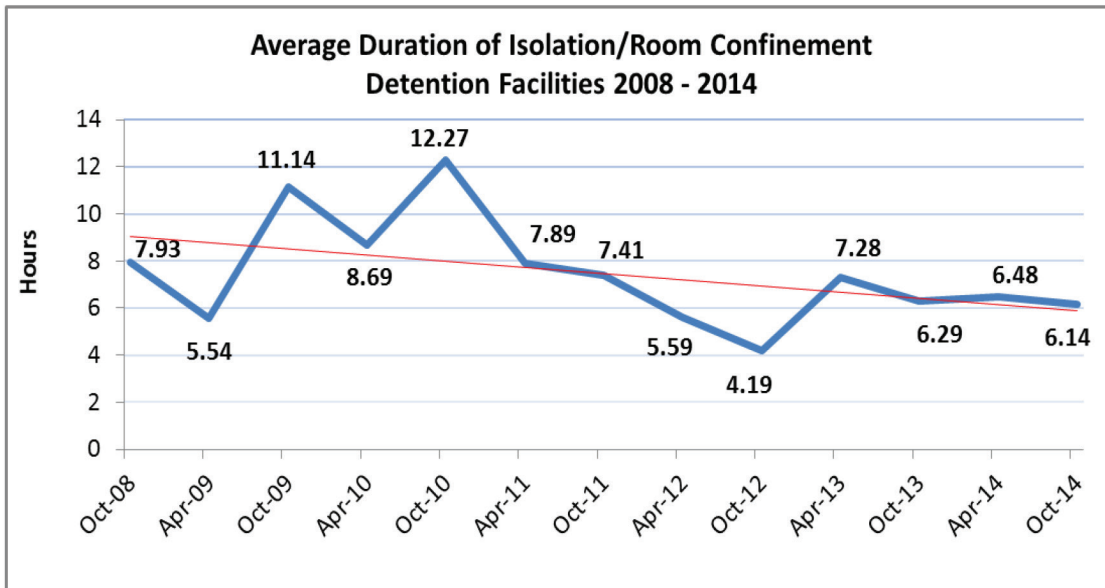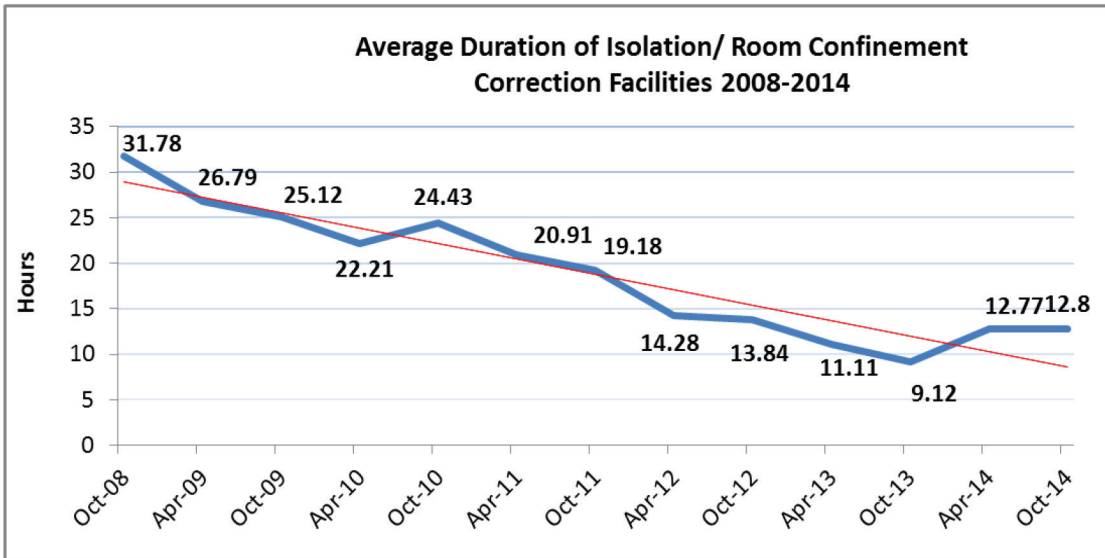
PbS facilities monitor four outcome measures of isolation and confinement:
- Number of cases of isolation, room confinement and segregation/special management unit is used;
- Average duration of uses of isolation, room confinement and segregation/special management unit;
- Percent of cases terminated in four hours or less; and,
- Percent of cases terminated in eight hours or less.

Over time, PbS participants have shown marked decrease in use of isolation, especially the length of time youths are isolated. In 2008, the average time a youth was in isolation in a correction facility was about 32 hours; in 2014, the average time was almost one-third of that about 12 hours. A similar reduction was shown by the PbS detention centers; the all-time high of 12 hours average time a youth spent isolated was cut in half to 6 hours in 2013 and held steady since. As the case studies in Appendix B show, PbS data is a key tool to create culture change, manage safe facilities and achieve positive outcomes in the use of isolation.

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[2] PbS Perspective January 2015.

Greater transparency and data reporting are definitely key components of implementing change and reducing the use of isolation. PbS provides a tool for comprehensively measuring and monitoring the use of isolation. States should collect and analyze data on the current use of isolation in order to inform a comprehensive plan to reduce or eliminate the use of isolation. Once a plan is in place, data and trends should be continually monitored to determine if goals are being achieved.

Average Duration of Isolation/ Room Confinement Correction Facilities 2008-2014

Average Duration of Isolation/Room Confinement Detention Facilities 2008 - 2014

Step 4: Develop Alternative Behavior Management Options and Responses

At the CJCA 2014 Leadership Institute, members identified and discussed core components and approaches necessary to develop alternative behavior management options to using isolation:

- Strength-based assessments
- Positive reinforcement
- Pro-social skills development
- Individual goal setting
- Research and evidenced-based interventions
- Youth voice
- Staff voice
- Staff training
- Staff buy-in
- Transparency and communication
- Clear and consistent policies and procedures
- Family engagement
- Measuring and monitoring results

The group also identified five proven interventions used by agencies that have successfully reduced or eliminated the use of isolation:

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Effective Practices in Community Supervision (EPICS)
- Collaborative Problem Solving (CPS)
- Trauma-Informed Care (TIC)
- Motivational Interviewing (MI)

Additional effective strategies to respond to difficult and escalating behavior discussed included developing interventions along a continuum of responses to de-escalate behavior in a way that supports rehabilitative goals, is developmentally appropriate and results in better outcomes and keeping youths busy and engaged in programming.

Isolation also can be reduced by behavior management strategies that prevent the misbehavior from happening using a system of rewards and incentives. Research shows punishment, including isolation, is not effective in changing behavior and that youths learn best when given opportunities to do the right thing and behave appropriately.

Rewards and incentives that provide those opportunities are used widely across the country in various ways. For example, points, levels and phase systems that recognize when youths do something well. The key to successful reward and incentive systems are clear and clearly communicated expectations and rules and the consistent application of the rewards or incentives.

See box "Rewards and Incentives" for creative ideas shared at the 2014 CJCA Leadership Institute.

REWARDS AND INCENTIVES

- Special personal hygiene items
- Lunch with staff
- Day with superintendent
- Mentoring
- Extra gym time
- More visitation, allow friends
- Wear own clothes
- Late nights
- More library time/multipurpose affinity time
- Coupons – trade for points
- Weekly activity posted so kids know what they are working for
- Random events – i.e., ice cream cart, pizza, movies.

Step 5: Train and Develop Staff in Agency Mission, Values, Standards, Goals, Policies and Procedures

Safe and healthy facility cultures are established and sustained by positive and nurturing staff-youth relationships. Placing a youth in isolation creates many reasons for youths and staff not to engage: mistrust, anger, power and unfairness. Creating positive and nurturing relationships with youths in custody requires staff who can respond appropriately to the needs of youths. Staff who are not adequately trained and supervised to manage a population of young offenders tend to rely on isolation and punitive responses that worsen the facility conditions and culture. Research has shown that in facilities where most staff feel adequately trained and supervised, there are fewer incidences of negative behavior, incidents and punishment.

Training staff has played a major role in transforming systems from the adult correctional model to the developmentally-appropriate, rehabilitative model. Some training suggested at the 2014 CJCA Leadership Institute was:

1. Cross training of treatment and direct care staff to bridge the gaps often between staff in different areas (direct care, clinical, recreation for example)

2. Trauma Informed Care and Conflict Resolution to better address the majority of youths in facilities who have experienced trauma and traumatic stress that can be exacerbated by inappropriate treatment

3. Communication interventions, not physical interventions

4. Adolescent brain development

5. Individual characteristics and treatment needs of youths

In Alaska, which has greatly reduced the use of isolation, staff are trained in the following areas:

- How traumatic childhood experiences impact the youth's developing brain;

- How trauma impacts the youth's behavior and response to stress;

- How to enhance the youth's ability to regulate his / her own emotions and improve coping skills; and

- The importance of healthy relationships with healthy adults in healthy environments.

Supervision practices successful in reducing the use of isolation focused on evaluating and de briefing with staff when an incident occurs.

CONCLUSION AND ACTION STEPS FOR AGENCY ADMINISTRATORS

Agency leaders who have reduced or even eliminated the use of isolation advice that change can't be implemented overnight—real change will take time. Changing the way systems respond to youths' acting out and misbehavior demands a holistic approach. Agency administrators need to analyze the system starting with the overarching mission and vision, ensuring consistency by aligning the policies governing isolation practices and holding staff accountable for implementing the policies as intended by measuring what is actually happening in the facilities. The negative impact of isolation should drive the resolve to create culture change and evidence that reducing and eliminating isolation leads to decreases in violence, staff and youth incidents, aggression and other negative outcomes should persuade staff.

The agency administrators must lead the change by:

- Making a compelling case for change,
- Engaging staff in the process of culture change,
- Providing tools and training to develop the skill set staff need to make the change,
- Utilizing outcome data to measure the impact of policy change; and,
- Sustaining the culture change.

The following action steps for leaders in youth correctional agencies are recommended to guide reform and reduce and/or eliminate the use of isolation:

- Align policy and procedures with rehabilitative vision, mission and goals of the agency;
- Screen and assess youths upon intake with a validated risk and needs assessment instrument (s) to determine housing and specific treatment needs;
- Analyze intake data to track and understand the changing demographics of the adolescent offender population entering youth corrections;
- Develop treatment programs based on the treatment profile of youths in the facility;
- Create separate, specialized units for youths with serious mental health problems, youths with substance use issues and juvenile sex offenders;
- Ensure that the staffing for these specialized units meets the clinical level of need for the youths;
- Employ evidence-based programs to treat youths along the continuum of programs they experience;
- Develop staff training programs that adequately prepare staff to manage and treat high risk/high needs offenders;
- Develop multidisciplinary staff teams whose members work closely together and support one another;
- Constantly monitor facility culture and make adjustments to keep facilities safe;
- Regularly survey staff to determine if they feel adequately equipped to work effectively with the existing youth population;
- Involve families in treatment planning and implementation for their children;
- Incorporate positive youth development principles and practices in facilities;
- Utilize volunteers to normalize facility culture and enrich programming;
- Adequately prepare youths for reentry so they can return to the community ready to succeed as adults;
- Concurrently prepare communities for the reentry of youths, especially those with ongoing behavioral needs; and
- Adopt a performance management system such as Performance-based Standards (PbS) that collects and analyzes outcome data from programs and uses the data to lead and manage change.

See Appendix A for two states (Oregon and Indiana) that have worked to change the culture of youth corrections and provide insight into how they were able to bring about culture change, enhance the philosophy of youth rehabilitation, and as a result reduce the use of isolation.

APPENDIX A - TIPS FROM AGENCY DIRECTORS THAT HAVE REDUCED THE USE OF ISOLATION

OREGON YOUTH AUTHORITY
REDUCING ISOLATION AND CREATING CULTURE CHANGE

Why Culture Change and What is the Role of Leadership in Shifting Culture?

**Culture**: is the set of values, guiding beliefs, understanding, and ways of thinking that is shared by members of an organization. The purpose of culture is to provide members with a sense of organizational identity and values.

As new research evolves, we need to align our practices with our desired outcomes. As our understanding of the system and our role in creating better outcomes changes, our culture also needs to change in order to align with best practices and minimize the probability of potential harm to the development of youth we serve.

Five specific roles of leaders:
1. Make a compelling case for change on two levels.
    - Moral case – the trauma of isolation itself; the potential for future victims of crime and an increase of recidivism that might result
    - Business case – cost of maintaining status quo of isolation use: more injuries to youths and staff and longer lengths of stay for youths.

2. Engage staff in the process of culture change. Helping staff see that change is the right thing to do, not that they just have to follow a new policy directive. Does this change create a safer work environment? Develop an action plan and involve staff so they can own the plan and take pride in improvements that follow

3. Provide tools, training and skills that staff need to make the change. Staff need to be involved in the change process from conceptualization through implementation. Realize and share with staff that there will be setbacks along the way. Persistence and patience are essential.

4. Use outcome data to measure the impact of a policy change. Provide data on the use of isolation before new policy directive is implemented; measure use of isolation regularly after new policy is put into place to demonstrate to staff and others the impact of isolating fewer youths. Show return on investment and celebrate success.

5. Sustain the culture change. The agency's leadership team must be fully involved in the implementation process. Build relationships with the staff; listen to their fears and concerns; speak with them frequently and provide guidance in carrying out new policies. Leaders must model the change and walk the talk.

Source: "Why Culture Change and What is the Role of Leadership in Shifting Culture?" Fariborz Pakseresht, Director, Oregon Youth Authority. October 2014.

INDIANA DIVISION OF YOUTH SERVICES (DYS)
REDUCING ISOLATION AND CREATING CULTURE CHANGE

What are the components of culture change?

We can't reduce the use of isolation without changing the culture. The biggest obstacle to overcome is staff fear for safety. Staff feel safe when they use isolation; they are conditioned to respond through the use of isolation. Leadership must change their philosophy and entrenched mindset. Staff must believe in what the leader is undertaking and, most importantly, believe that the changes will result in positive outcomes and a safer environment for both staff and youth.

Steps to take in changing the culture of an organization:

1. Review hiring practices. What type of staff is the agency hiring to work directly with youths? Aim to hire staff who desire to make a difference in the lives of youths.
2. Invest in staff training and education. Training that is rooted in the theory of adolescent development will better prepare staff to work effectively with youths who are experiencing physical, sexual and emotional changes in their lives. Staff must be trained in adolescent development in order to work effectively with this population.
3. Treat youths fairly; reward positive behavior and ensure due process when holding youths accountable for negative behavior. Staff must fully understand the behavior modification program.
4. Staff must understand and commit to carrying out the mission of the agency
5. Share data on the impact of policies and procedures with staff, especially regarding the use of force, restraints and isolation. Staff must understand the reasons behind the changes taking place, without a full understanding, they will always resist the change.
   a. Research has shown that excessive use of isolation creates an unsafe environment; and
   b. The use of less isolation creates safer environments with fewer injuries to youth and staff. (IN PbS data)
6. Leaders need to spend time building relationships with staff. Learn who is on board with culture change, who is opposed and who is on the fence. Leaders should influence those on the fence.
7. Leadership team must be entirely committed to culture change, any one lone dissenter can seriously impede the progress.
8. Staff must understand why the organization is changing the culture and envision the impact of change, viz., creation of a safer facility for youths, staff and visitors.

Three turning points that helped Indiana DYS facilitate change:
1. PbS gave us tools to engage staff in culture change by sharing the biannual site report that contained four outcome measures on the use of isolation and by involving them in developing Facility Improvement Plans for outcomes that needed improvement.

2. Introducing and training staff in Trauma Informed Care and Motivational Interviewing helped staff see youths they were caring for in a new light as victims of neglect and abuse when they were children.

INDIANA DIVISION OF YOUTH SERVICES (DYS)
REDUCING ISOLATION AND CREATING CULTURE CHANGE
(continued)

Three turning points that helped Indiana DYS facilitate change:

3. Family engagement – historically DYS has shied away from involving family members in their children's rehabilitation.
   a. Bring families in, get them involved, they need to be as invested as we are; they begin to trust staff and build relationships with staff – then the kids start to see staff differently;
   b. Utilize family members, staff and volunteers in conflict resolution strategies;
   c. Less isolation and more family engagement leads to less restraint and isolation; which leads to less injuries to youth and staff; which leads to increased staff morale, dependability, and increased staff to youth ratio; which leads to improved atmosphere and climate, which ultimately leads to sustained culture change. Not just culture of the facility, but the culture of state government as well.

Source: CJCA Leadership Institute, October 2014.
Mike Dempsey, Executive Director, Indiana Division of Youth Services

APPENDIX B - EXAMPLES FROM STATES THAT HAVE REDUCED THE USE OF ISOLATION

MASSACHUSETTS

Reducing the Use of Isolation
Massachusetts Department of Youth Services

Background/Issues:
The Massachusetts Department of Youth Services (DYS) drew on the findings of "Juvenile Suicide in Confinement: A National Survey" by Lindsay M. Hayes, a report commissioned by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) published in 2009 to change its policy and practices using room confinement and/or isolation of youths.

DYS participates in the Performance-based Standards (PbS) program, a continuous improvement system launched by OJJDP specifically to address safety, health and quality of life issues in youth facilities identified as problematic in the 1994 Conditions of Confinement Study.

Standards:

PbS standards are clear: isolating or confining a youth to his/her room should be used only to protect the youth from harming himself or others and if used, should be brief and supervised. Any time a youth is alone for 15 minutes or more it is a reportable PbS event and is documented. PbS reports isolation, room confinement and segregation/special management unit data together to draw attention to practices that are inappropriate, ineffective and can have deadly consequences, as cited in Hayes' study.

Process and Changes:

Below is the list of specific changes introduced by DYS to reduce isolation. Changes were made in four areas:

- Policy
- Training
- Practice
- Programming

Policy
- Room confinement policy was revised in the context of not being used as punishment and in relation to suicide prevention;
- Room confinement may be used for the following reasons only:
  - To calm a youth who is exhibiting seriously disruptive or dangerous behavior;
  - For population management;
  - For the safety and security of a youth; and
  - For investigation of an incident.
- Room confinement may not be used for:
  - As a consequence for non-compliance;
  - Punishment;
  - Harassment; or
  - In retaliation for any youth conduct.
- Staff must request permission to use room confinement from higher managers in facility;
- Residents on "suicide watch" are never allowed to be placed in isolation regardless of circumstances;
- Extension of room confinement beyond three hours must be approved by regional administrator or designee;
- Room confinement report must be completed daily and forward to regional administration;
- Use of room confinement is reviewed at the program and regional levels.

Training
- All staff are trained in the "Use of Isolation" policy;
- All staff are trained in Juvenile Suicide Prevention, which has a use of confinement risk for actively suicidal youth component.

Practice

▪ Developed an "Exit Strategy" to facilitate timely removal of youth from room confinement:

 • Staff apply DYS de-escalation, behavior management and conflict resolution techniques to help a resident process disruptive and dangerous behaviors and out of room confinement.

 • Youth in room confinement are engaged at least once every 30 minutes of confinement;

 • Each engagement of youth must be by a direct care staff not involved earlier and a clinical staff member.

Programming

▪ "Learning Exercises" – a strategy for interventions over a period of time that promotes a better understanding of one's behavior and reduces reoccurrence of the specific actions/reasons that resulted in the room confinement and include:

 • Focused sessions with a youth's advocate and/or clinician;

 • A parent or guardian in on-site sessions and/or visits;

 • Behavioral Contracts that are tailored to the youth (s) that identifies problematic behavior and tracks his/her progress over time.

 • Progress reviews with the youth daily and weekly.

Results:

According to the last three years of PbS data, DYS' use and duration of isolation is well below the field average of the other 159 PbS facilities. (PbS reports on all uses of isolation during the months of April and October and provides field averages of all like participants as a comparison point). DYS rarely uses isolation and since April 2011, all of the cases when a youth was placed in isolation were terminated in less than four hours.

DYS uses the PbS' continuous improvement technology to collect data, identify issues such as high use and/or duration of isolation that need to be addressed, to design and implement structured improvement plans setting targets for desired outcome measure changes and to monitor performance over time.

MAINE

> **Reducing the Use of Isolation**
> **Maine Division of Juvenile Services**

Background/Issues:

Several years ago, the Maine Division of Juvenile Services (DJS) relied excessively on the use of isolation to manage youths in its two facilities. Youths were routinely confined to a Special Management Unit (SMU) for a variety of acting out behaviors. Staff repeatedly resisted all efforts to limit the use of isolation. They responded to all attempts to limit use of the SMU with: "You can't take our 'tools' away from us and expect us to do our jobs."

Maine's campaign to reduce the use of isolation extends back to 2008 when it began to develop Facility Improvement Plans (FIP) as part of its participation in the Performance-based Standards (PbS) continuous improvement process. Two of the FIP Action Steps written in April 2008 were:

1. "To review and revise time-out forms while implementing a supervisory review of all time-outs designed to identify issues that will decrease the number of incidents of use, as well as the duration of time-outs."

2. "Define, review and track all incidents (time-outs & disciplinary board hearings) to determine needed areas for improvement and provide training in the use of less restrictive alternatives."

Standards:

PbS standards are clear: isolating or confining a youth to his/her room should be used only to protect the youth from harming himself or others and if used, should be brief and supervised. Any time a youth is alone for 15 minutes or more is a reportable PbS event and is documented. PbS reports isolation, room confinement and segregation/special management unit data together to draw attention to practices that are inappropriate, ineffective and can have deadly consequence, as cited in Hayes' study.

Process and Changes:

Below is the list of specific changes introduced by DJS to reduce isolation. Changes were made in four areas:
- Policy
- Training
- Practice
- Programming

Policy
- Behavior Management System revised – Phase System created opportunities for residents to demonstrate the capacity to function with increasing independence.

Training
- Staff receive training in Behavior Management System and Motivational Interviewing;
- Staff and youths receive training in Collaborative Problem Solving and Trauma Affect Regulation Guide to Education and Treatment (TARGET) –staff and youths receive training by teams in each facility; and
- Agency leadership participates in training in the "teamwork model."

Practice
- Prevailing philosophy in two youth development centers: "There are not many benefits to keeping a resident behind a closed door. As soon as all threats are believed to be gone, the resident is returned to programming;"
- Use of isolation operates in the context of the 'unit team' – cannot move the youth away from the staff he has a relationship with. If a resident must be isolated, his unit manager follows the youth to the isolation unit to understand the events that precipitated the isolation and work with the youth to solve the problem;
- Unit team works with resident to return him to program as soon as possible, collaborative problem solving and motivational interviewing techniques that staff and youth have been trained on are employed;
- Upon release from the isolation unit, a new program plan is developed by the team and the resident that is different from the previous plan;
- Facility administration is committed to keeping the high-risk offender in as normalized an environment as possible; and
- DJS uses PbS outcome measures to monitor change over time.

Programs
- Introduced Creative Problem Solving Curriculum developed by Ross Greene, Ph.D. in 2006.
- Introduced Trauma Affect Regulation Guide to Education and Treatment (TARGET) in 20011.
- Aggression Replacement Therapy
- Motivational Interviewing

Results:
According to three years of PbS data, DJS is well below the use and duration of isolation compared to other PbS facilities. (PbS reports on all uses of isolation during the months of April and October and provides field averages of all like participants as a comparison point). Maine uses isolation infrequently and only for short periods of time. DJS uses the PbS' continuous improvement technology to collect data, identify issues such as high use and/or duration of isolation that need to be addressed, to design and

implement structured improvement plans setting targets for desired outcome measure changes and to monitor performance over time.

INDIANA

Reducing the Use of Isolation Indiana Division of Youth Services
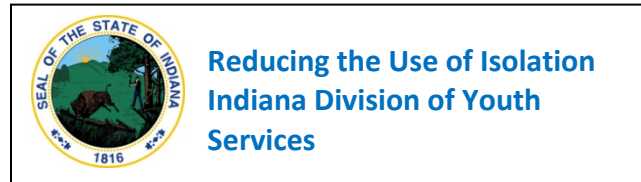
Background/Issues:

The Indiana Department of Correction, Division of Youth Services (DYS) had serious problems in its facilities. Crowded and dangerous, staff relied on overuse of isolation. The Executive Director of DYS decided to change the adult corrections culture staff had become accustomed to. The first facility selected for improvement through culture change was the Pendleton Juvenile Correctional Facility, a program that had come under Department of Justice oversight after a Civil Rights of Institutionalized Persons (CRIPA) lawsuit over conditions of confinement.

Standards:

DYS participates in the Performance-based Standards (PbS) initiative.

Process and Changes:

Below is the story of specific changes made in DYS to reduce the use of isolation by changing facility culture. Changes were made in four areas:
- Policy
- Training
- Practice
- Programming

Policy
- Use of Force Policy was revised;
- Use of Isolation Policy was revised to limit its use and to reduce its duration;
- Superintendent and staff conduct an "hourly assessment" and "daily review" of any youth held in isolation with a goal of returning him to the program as soon as he is ready to return;
- Student's Code of Conduct was revised; and
- Behavior Management System for residents was adopted- based on token economy (rewards outnumber the sanctions).

Training
- Trained and educated staff to treat youth in the facility as young offenders who needed help with their problems, not as adult inmates;

- Established and trained teams of staff to work together in each unit;
- All staff are trained in Trauma Informed Care (7.5 hour training);
- All staff are trained in Conflict Resolution/ staff mediation;
- Superintendent speaks with new staff members during orientation training.

Practice
- Population of the facility (Pendleton) was reduced from 370 youths to 200;
- Developed living units no larger than 12-14 youths;
- Assessed youths in order to place them in the appropriate treatment program;
- After going a full year without using its Special Management Unit (segregation), the unit was converted into a transitional living unit;
- Created a Crisis Awareness Response Efforts (CARE) Team made up of experienced staff who were not involved in an assaultive incident to intervene and try to use "conflict resolution" practices to resolve the issue without using isolation - 95 percent of the time, the CARE Team has successfully calmed the situation without resorting to a security response;
- Increased family involvement at the facility;
  - As a Performance-based Standards (PBS) participant, the facility volunteered to pilot implementation of new set of Family Engagement and Social Support Standards. One of the standards encourages family visitation. After receiving the PbS site report that showed low visitation rates, staff created a Facility Improvement Plan (PbS component) that opened visitation to just about any time a family member could get to the facility. The plan resulted in an increase in visits and improved behavior by youths.
  - Created a Family Council called PIES to improve communication between staff and parents;
  - If a youth is placed in isolation, the staff conducts a conference call with the parent (s) and youth to speak about the events that resulted in the youth's isolation. Staff noted that this involvement of the parent has been very helpful in ending the isolation event;
  - Held daily incident monitoring meetings at the beginning of each day to discuss the issues a youth in isolation might be experiencing, e.g., not taking medication. Staff are kept abreast of developments. This practice has increased communication among all staff so they can address current issues within the facility;
  - Introduced "Staff Shadowing Program". In lieu of using isolation, a single staff member is selected to "shadow" or follow the youth during his program activities during the day;
  - Reviewed film footage of use of isolation to determine if isolation was the appropriate response to the youth's behavior;
  - Established a Student Council in order to hear the 'youth voice' about life in the facility – youth involvement has been a factor in reducing use of isolation.

Programming
- Introduced trauma informed care perspective into the facility;
- Introduced use of motivational Interviewing that has facilitated the decrease the use of isolation;
- Introduced Conflict Resolution (mediation) – staff and youth use alternative approaches to address the active issue rather than resorting to isolation.

Results:

According to three years of PbS data, Indiana DYS' use of isolation has trended downward in its facilities and is lower than other PbS facilities around the country. The average duration of isolation has dropped significantly. For example, the Logansport facility reported 42 incidents of isolation with an average duration of 37 hours in the October 2010 data collection. In the April data collection, Logansport had only one isolation event, which lasted 17 minutes.

Indiana DYS uses the "continuous cycle of improvement" (i.e., data collection, facility site report analysis and Facility Improvement Plan) to improve the conditions of confinement.

ALASKA

Reducing the Use of Isolation
Alaska's Juvenile Justice Facilities – DJJ Trauma Informed Care Initiative
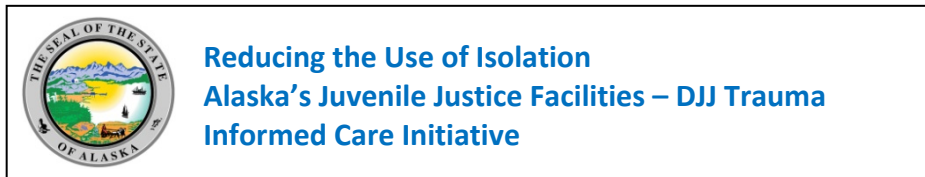
Background/Issues:
- Initiative launched in 2009 as a pilot project at the state's largest facility.
- Now expanded to all DJJ facilities and probation offices.

Standards:
- Performance-based Standards (PbS):
  - Data for 8 facilities;
  - Trend analysis and progress reported by facility and by state and compared to national average; and,
  - Track data in room confinement, isolation, and segregation.
- Alaska Incident Tracker:
  - Database used to report incidents in all DJJ facilities and probation offices. Trends are analyzed to inform practice, policy, and training.

Process and Changes:
- Training staff in the following areas:
  - How traumatic childhood experiences impact the youth's developing brain;
  - How trauma impacts youths' behavior and response to stress;
  - How to enhance youths' ability to regulate their own emotions and improve coping skills; and
  - The importance of healthy relationships with healthy adults in healthy environments.

Results:
- Results include a reduction in resident restraint, assault incidents and reduced room confinement.

APPENDIX C – STATEMENT FROM THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY (AACAP)

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis[1]. Due to their development vulnerability, juvenile offenders are at particular risk of such adverse reactions[2]. Furthermore, the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.

Solitary confinement should be distinguished from brief interventions such as "time out," which may be used as a component of a behavioral treatment program in facilities serving children and/or adolescents, or seclusion, which is a short term emergency procedure, the use of which is governed by federal, state and local laws and subject to regulations developed by the Joint Commission, CARF and supported by the National Commission of Correctional Healthcare (NCHHC), the American Correctional Association (ACA) and other accrediting entities.

The Joint Commission states that seclusion should only be used for the least amount of time possible for the immediate physical protection of an individual, in situations where less restrictive interventions have proven ineffective. The Joint Commission specifically prohibits the use of seclusion "as a means of coercion, discipline, convenience or staff retaliation." A lack of resources should never be a rationale for solitary confinement.

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty establish minimum standards for the protection of juveniles in correctional facilities.

The UN resolution was approved by the General Assembly in December 1990, and supported by the US. They specifically prohibit the solitary confinement of juvenile offenders. Section 67 of the Rules states:

"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." In this situation, cruel and unusual punishment would be considered an 8th Amendment violation of our constitution[3].

Measurements to avoid confinement, including appropriate behavioral plans and other interventions should be implemented[4].

The American Academy of Child and Adolescent Psychiatry concurs with the UN position and opposes the use of solitary confinement in correctional facilities for juveniles. In addition, any youth that is confined for more than 24 hours must be evaluated by a mental health professional, such as a child and adolescent psychiatrist when one is available.

References:
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2. Mitchell, Jeff, M.D. & Variety, Christopher, M.D. "Isolation and Restraint in Juvenile Correctional Facilities." J.Am. Acad. Child Adolesc. Psychiatry, 29:2, March 1990.
3. Vasiliades, Elizabeth. "Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards." American University International Law Review 21, no.1 (2005): 71-99.
4. Sedlak, Andrea, McPherson, Carla, Conditions of Confinement, OJJDP, May 2010.

Source: American Academy of Child & Adolescent Psychiatry Policy Statements:
Solitary Confinement of Juvenile Offenders (April 2012).