



STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE

INVESTIGATIVE FACILITY REPORT
CONNECTICUT JUVENILE TRAINING SCHOOL AND PUEBLO
UNIT

July 22, 2015

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GLOSSARY

American Correctional Association

ACA standards guide operations in correctional facilities, addressing standards related to safety, training, facility policy, procedure and practice. The ACA will accredit facilities that comply with all applicable mandatory standards and 90 % of non-mandatory standards.

Juvenile Correctional Program

A juvenile correctional facility is any residential facility with construction fixtures or staffing models designed to restrict the movements and activities of those placed in the facility. It is used for the placement of any juvenile adjudicated of having committed an offense, or, when applicable, of any other individual convicted of a criminal offense. See Office of Juvenile Justice and Delinquency Prevention, Model Programs Guide Glossary of Terms, *Correctional Facility*, found on the web at: <http://www.ojjdp.gov/mpg/Resource/Glossary>.

Juvenile Detention Alternatives Initiative

The Juvenile Detention Alternatives Initiative (JDAI), established by the Annie E. Casey Foundation, targets overall juvenile justice system improvement. JDAI strategies and standards are also used to improve conditions of confinement in juvenile detention centers without compromising public safety. JDAI strategies are being employed in over 30 states. Although JDAI addresses reforms for juvenile detention facilities and not specifically training schools, the standards are an important reflection of best practices in the juvenile justice system.

Major Sanction

“Major” sanctions are administered for conduct within the facilities such as assault, fighting, disturbance, and resisting movement.

Minor Sanction

“Minor” sanctions are administered for less significant offenses such as having unauthorized items, disorderly behavior, non-compliance with staff directives, sanitary or hygiene violations.

Out of Program

A sanction administered for misbehavior (e.g., fighting, resisting movement, engaging staff in a restraint, creating a disturbance). Duration of sanction may be for 1, 2 or 3 days. OOP sanction requires the youth, when not in school, to “sit in a chair” outside his cell for the duration of the OOP status. He may not interact with others. According to the CJTS Manual, if the boy refuses to sit in the chair, he may be “considered a danger” based on his “noncompliance” and will be placed in seclusion.

If the youth repeatedly tries to interact with others, he will be placed in seclusion until he can comply with OOP “norms.” If too many boys are on OOP status, facility policy states that a schedule be utilized to rotate boys from chairs to locked seclusion. Youth who

“violate” OOP norms may have to start their time all over again. At Pueblo (the girls’ program at CJTS), OOP is referred to as “Frozen.”

Performance Based Standards

A framework to monitor and improve conditions of confinement promulgated by the Department of Justice in the mid-1990s.

Periodic Room Confinement

Any period of time a resident is required to be in room confinement for safety and security. A group of residents may be placed on a brief period of PRC for the sake of safe and secure facility operations during times of transition. An individual resident may be placed on PRC as a result of the need for risk management for behavioral dyscontrol. When PRC is used in response to minor misbehavior, the child’s readiness to rejoin the group is assessed ongoing. **PRC is “seclusion” per Connecticut law.**

Unit Bound

A youth on Unit Bound status is restricted to the unit but may attend school and may interact with peers.

Restraint.

Per Connecticut law. “Any mechanical or personal restriction that immobilizes or reduces the free movement of a person’s arms, legs or head. The term does not include: (A) Briefly holding a person in order to calm or comfort the person; (B) restraint involving the minimum contact necessary to safely escort a person from one area to another; (C) medical devices, including, but not limited to, supports prescribed by a health care provider to achieve proper body position or balance; (D) helmets or other protective gear used to protect a person from injuries due to a fall; or (E) helmets, mitts and similar devices used to prevent self-injury when the device is part of a documented treatment plan or individualized education program pursuant to section 10-76d and is the least restrictive means available to prevent such self-injury.

Restraint may not be used except “as an emergency intervention to prevent immediate or imminent injury to the person at risk or to others, provided the restraint is not used for discipline or convenience and is not used as a substitute for a less restrictive alternative.” Anyone restrained shall be “continually monitored” for “indications of physical distress. Anyone secluded shall be “frequently monitored” for distress. The evaluation shall be entered into the persons’ record

Seclusion.

Per Connecticut law, “The confinement of a person in a room, whether alone or with staff supervision, in a manner that prevents the person from leaving, except ... the term does not include the placing of a single child or youth in a secure room for the purpose of sleeping.” Seclusion may be used only as an emergency intervention “to prevent immediate or imminent injury to the person or to others, provided the seclusion is not used for discipline or convenience and is not used as a substitute for a less restrictive alternative.”

Trauma-informed Programming

According to the federal government's Department of Health and Human Services:

"A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

EXECUTIVE SUMMARY

The Office of the Child Advocate (OCA) is charged with investigating, evaluating and publicly reporting regarding the efficacy of state-funded services to children. OCA is specifically charged with reviewing conditions for children and youth in state-funded facilities and in programs serving children with special needs.

The following investigation was undertaken in part because of concerns about conditions at the Connecticut Juvenile Training School and Pueblo brought to OCA by whistleblowers, some of whom work at the Department of Children and Families. CJTS and Pueblo are DCF-run juvenile correctional programs for boy and girls adjudicated as delinquent and committed to state custody due to juvenile offenses. Most of the children confined at CJTS have adjudications for non-violent offenses. The primary purpose (if not the sole purpose) of CJTS and Pueblo is to improve public safety through the rehabilitation/treatment of delinquent youth.

The vast majority of children and youth at CJTS and Pueblo have histories of trauma, abuse, neglect, complex psychiatric disorders and special education needs. To rehabilitate successfully, these youth require intensive, therapeutic supports, seven days a week, and discharge to rigorous and effective services and *supervision*.

OCA's months-long review of facility video tapes, incident reports, and treatment records revealed urgent safety problems for youth. Findings include inadequate suicide prevention, lack of appropriate support and training for staff, inadequate and harmful crisis management, and an opaque system that, despite significant public funding, reports scant information regarding quality, public safety outcomes and oversight.

There is a tension between the rehabilitative mission of the juvenile justice system and the operations of a maximum-security facility like CJTS. These tensions give rise to many of the risks and harms discovered by OCA during this investigation. In part due to similar findings around the country and research *demonstrating such programs are ineffective for improving public safety*, many states are moving away from prison-like facilities for high need youth and re-allocating dollars towards more effective interventions.

Connecticut has rightfully been lauded as a national leader in decreasing incarceration rates for juveniles and adults. However, reliance on the state's maximum security juvenile correctional complex continues, despite stakeholders and leaders' historic lack of confidence in this facility. OCA respectfully and strongly urges close attention to the urgent issues outlined in this report.

OCA's recommendations are also similar to those recently offered by DCF's consultant, Dr. Robert Kinscherff of the National Center for Mental Health and Juvenile Justice. DCF has pledged to act on several of Dr. Kinscherff's recommendations and has begun to take additional steps to do the following:

1. Eliminate unlawful restraint and seclusion of children in the facilities;
2. Improve suicide prevention protocols and training;
3. Improve risk assessment and response;
4. Strengthen trauma-informed supports for youth;
5. Improve quality assurance and reporting.

OCA applauds that commitment. Given the gravity of OCA's findings, the unique vulnerability of confined youth and the extraordinary state expenditure for CJTS and Pueblo, it will be critical to ensure that changes are implemented expertly, expeditiously and transparently.

Given the complexity of issues reviewed during this investigation, OCA consulted extensively with mental health and other professionals to support our review and recommendations. To that end, OCA also consulted with the State's Office of Protection and Advocacy—charged with protecting the rights of persons with disabilities. The Office of Protection and Advocacy (OPA) reviewed numerous primary source records, including treatment plans, progress notes and video tapes collected during our investigation. The Office of Protection and Advocacy has issued a responsive public statement, attached to this report.

OCA's Findings

Through videotapes, record reviews and interviews, OCA uncovered numerous safety risks within the facility. OCA, and the Office of Protection and Advocacy, are particularly concerned regarding the following:

- CJTS and Pueblo have not adequately prevented or responded to youth suicide attempts and self-injurious behavior. Between June, 2014 and February, 2015 OCA discerned over two dozen *documented* acts of youth trying to injure or kill themselves at CJTS and Pueblo.
- DCF did not complete a comprehensive suicide-prevention audit for Pueblo prior to opening the facility. Pueblo cells still have dangerous "blind spots," contrary to the advice of national experts on suicide prevention.
- Isolation of youth with psychiatric needs has at times been prolonged and used in lieu of treatment.
- Isolation and restraints were repeatedly used unlawfully, at times as behavior management strategies or for discipline when there was no documented *ongoing emergency*.
- OCA's review of facility incident reports over a 12 month period (July 1, 2014 through July 1, 2015) reveal *at least* 532 physical restraints and 134 uses of mechanical restraints (handcuffs or shackles).
- DCF has declined to investigate several allegations of abuse and neglect of children confined in the facility.
- There is a general lack of transparency, which includes inadequate auditing, poor data use, collection and reporting.
- Staff need significantly improved training to respond to youth behavior that emanates from trauma.

- Public safety will not be improved without rigorous attention to the *effectiveness* of rehabilitation and operations within this facility.

Recommendations

1. Immediately audit and rectify safety issues with the facilities' buildings, such as blind spots in rooms.
2. Solicit independent audits of suicide prevention protocols.
3. Provide access to mental health facilities as an alternative to confinement for youth with significant psychiatric disorders or suicidal tendencies.
4. Reduce isolation and end it as a form of punishment.
5. Ensure that youth are not kept out of school as a punishment.
6. Increase training, coaching and supervision to support staff's work with children who have mental health disorders and trauma histories. For example, one set of national standards recommends 160 hours of training for staff during the first year of employment and 40 hours in each following year.
7. Adhere to nationally recognized performance standards from the Juvenile Detention Alternatives Initiative and Performance Based Standards, and adopt more rigorous quality assurance protocols.
8. Ensure youth are discharged to an appropriate level of supervision and intensive therapeutic support services.
9. Increase transparency and collaborative review of investigations into abuse and neglect of children in the facilities.
10. Solicit *outside expertise* to support facility reforms and *ensure annual audits regarding improvements*. Create a timeline for implementation of recommendations contained in the Georgetown technical assistance report (2013), the Kinscherff Report (2015) and OCA's report.
11. Utilize the state's Juvenile Justice Policy and Oversight Committee to oversee and support reform efforts.
12. As part of the state's multi-agency work on criminal and juvenile justice reform, alternatives to the Connecticut Juvenile Training School and Pueblo should be considered an urgent juvenile justice priority.

FOREWARD

Over 18 months ago, the Office of the Child Advocate commenced an investigation into complaints regarding conditions of confinement at Connecticut Juvenile Training School. After the Pueblo girls' unit opened at CJTS, the investigation encompassed that facility as well. Core concerns and conditions identified by OCA, communicated to DCF and outlined in this report include:

1. Inadequate support for youth with significant mental health disorders.
2. Improper or unlawful restraint and seclusion.
3. Inadequate suicide prevention practices and protocols to respond to numerous youth who attempted suicide or self-injury.
4. Lack of accurate information to evaluate, report and respond to conditions *and outcomes* of confinement.

Although discussions between OCA and DCF over the past year have at times been difficult, marked with disagreement and dispute about the existence, scope or *urgency* of the issues identified above, ultimately some progress is being made. Over the last year, DCF has agreed to undertake the following:

- Improve provision of trauma—informed care.
- Improve pre-service and in-service training for staff.
- Improve suicide prevention training (new as of May, 2015).
- Ensure outside auditing of suicide prevention policies and practices, including the safety of buildings and cells (going forward).
- Incorporate evidence-based strategies to reduce unlawful and harmful reliance on restraint and seclusion, particularly for youth with disabilities.

In December, 2014 DCF also hired Dr. Robert Kinscherff, a national expert in juvenile justice reforms, to review programming at CJTS and Pueblo. Dr. Kinscherff's final report, dated July 1 and issued publicly on July 13, 2015, offers important observations for continued juvenile justice reforms. Dr. Kinscherff's report rightfully notes Connecticut's track record as a national leader of juvenile justice transformation and the resources available at CJTS.

But Dr. Kinscherff outlines at length the changes that must take place in these facilities to effectively rehabilitate youth and improve public safety: better identification of children's risks and needs, more trauma supports, greater suicide prevention, and more clinically-informed crisis management and planning for youth with significant mental health disorders. These are *challenging reforms that will require significant expertise and operational sophistication to implement*. Acknowledging the complexity of this work, Dr. Kinscherff wrote that DCF would benefit from an "*external review, training and consultation with an annual audit of progress over time.*" (Emphasis added.)

Underscoring his recommendations, Dr. Kinscherff nodded to the existential dilemma at the heart of the Training School and its female counterpart: is treatment the primary purpose of these maximum secure juvenile facilities? Dr. Kinscherff emphasized that

effective public safety reforms will *require* skillful provision of trauma-informed, individualized treatment across the continuum of care. Similar to the findings and recommendations of the Office of the Child Advocate (2015), and before it the Georgetown technical assistance report for DCF (2013), Dr. Kinscherff highlighted the state's need for a data-driven system that can assess programs and report on conditions and outcomes. Without this capacity, transformation is not possible.

While acknowledging Connecticut's legacy of reform and the promises cited above for improvements to these correctional programs, OCA must unequivocally state that *right now*, conditions at CJTS and Pueblo place many youth at risk of physical and emotional harm, and that the investigative findings outlined in this report are critical and require *urgent attention*. These findings are echoed by the state's Office of Protection and Advocacy, a consulting partner on this report and author of a joining statement attached herein.

Any reforms agreed to by the Department of Children and Families will necessarily require transparency and oversight of implementation efforts.

Ultimately, as OCA's report will outline, the state must decide whether CJTS and Pueblo—both launched inauspiciously--have adequate *or any* value for public safety so as to warrant the continued extraordinary investment of resources in a juvenile corrections model from which many states are now retreating.

Franklin¹

Franklin was admitted to the Connecticut Juvenile Training School—the only state-run juvenile correctional program for boys-- in January, 2014 on misdemeanor charges of Interfering with an Officer and Resisting Arrest². He was 16 years old and committed to DCF's custody both as a victim of child abuse or neglect and as a juvenile justice commitment. Franklin's family has a long history with DCF dating back to his infancy. Shortly before Franklin was confined at CJTS, his father died. Franklin is diagnosed with Depressive Disorder; Borderline Intellectual Functioning; Cannabis Abuse; and a History of Neglect.

Franklin's records indicate he was considered a regular education student, though he struggled in school as far back as Kindergarten, when he was first retained. Despite being identified as having low intellectual functioning, he was never evaluated for special education services during his 15 months of confinement at CJTS.³

Franklin missed excessive amounts of classroom time at CJTS, with the majority of absences indicating he was "unit bound." Attendance records reviewed by OCA document 3 occasions when Franklin received Unit Bound instruction.⁴ Franklin missed part or all of 36 days of school over a 100 school day period (Sept. 15 2014 through Jan. 30, 2015). At least 24 of those missed days included removals for discipline. One facility report observed that it was "unclear if he comprehended the [school] work."

Successive monthly reports from CJTS staff rated Franklin's progress and presentation as marginal or "poor." He accumulated dozens of sanctions each month, frequently resulting in restricted status such as Out of Program time and Unit-Bound time. Out of Program (OOP) time means that a youth, when not in school, has to sit in his chair outside his cell, and may not interact with peers and may not attend programming. If a boy violates the rules, he has to start all over again or go into seclusion. During his 15 1/2 months at CJTS, Franklin was sanctioned with over 200 days of OOP and Unit Bound time.⁵ Franklin was also put in over 160 waking hours of seclusion.

¹ All children's names have been changed for purposes of this public document.

² References to charges in this document are drawn from the DCF facility database (CONDOIT) "charges" and "adjudications" information.

³ It should be noted that Franklin's school district's failure to appropriately meet his individualized education needs is very concerning and potentially a very egregious violation of his civil rights. DCF records indicate that no PPTs were held for Franklin while at CJTS.

⁴ CJTS leadership indicates that this is a documentation error and that all youth who are Unit Bound receive educational work. OCA is requesting additional documentation on this data point.

⁵ Based on a review of incident reports in youth's file.

Multiple monthly reports stated that Franklin missed rehabilitative or other activities due to being on “status,” and that he participated in “no specialty groups.”

Franklin was frequently described by staff as “depressed and quiet.” When his clinician asked him why he couldn’t follow directions, Franklin “could not answer the question.”

Franklin was bonded with his mother—who he would greet with a hug and kiss—and repeatedly told staff that he wanted to be home for Christmas. Franklin also visited with his brother and called his sister regularly.

Franklin told staff often that he did not want to go to a group home or residential. He wanted to ‘go home’. However, facility reports repeatedly noted that there were no definite plans for discharge and that Franklin’s options were very limited. Through February, 2015 reports stated that Franklin could not go home and that it was not safe for him there.

Clinicians described Franklin as playful and helpful in a crisis, honest. But he was also noted by staff to be easily distracted, resistant to talking, and struggling with built up anger. Franklin was ultimately offered Benadryl to help him with his mood issues and avoid restraints. By his last few months at CJTS, Franklin relied on Benadryl on almost a daily basis, sometimes taking it multiple times a day.

While at CJTS, Franklin was subject to many restraints and seclusions, sometimes spending an entire day, or even lengthy periods of successive days, in isolation. Staff worried when Franklin started to talk to himself in streams, particularly at night, sometimes for hours in his cell.

In April, he was suspended from the CJTS school for another 10 days for fighting. By May, he was discharged to his mother’s house, though his last report noted that he accumulated 3 dozen sanctions during the final review period, did not attend groups, had no individual therapy session in the weeks before his discharge⁶ and was in seclusion the day before he left.⁷ DCF recently ended its foster care commitment of Franklin, reverting guardianship back to his mother. Parole notes show, despite attempts, there has been no parole contact with Franklin for over six weeks.⁸

⁶ According to CJTS final report, “No individual or family sessions were held this month as clinician was out 5/1/15 until 5/14/15.”

⁷ Despite the negative information in his last monthly report, the discharge summary states that “Franklin has made significant progress on his goals and is ready to apply his new skills in the community.”

⁸ As of July 16, 2015.

INTRODUCTION

The Office of the Child Advocate (OCA) is charged with investigating, evaluating and publicly reporting regarding the efficacy of state-funded services to children. OCA is specifically charged with reviewing conditions for children and youth in state-funded facilities and in programs serving children with special needs.

Investigation Begins of CJTS and Pueblo

Over a period of several months from 2013 through 2014, the Office of the Child Advocate received numerous citizen concerns—sometimes whistleblower complaints from state employees--regarding conditions for children and youth housed at Connecticut Juvenile Training School and, after March, 2014, the new girls' locked corrections program administered by CJTS, nicknamed "Pueblo." Concerns raised with OCA came from the following stakeholders:

- DCF employees;
- Advocates for children confined at CJTS and Pueblo, including lawyers and mental health professionals;
- Family members of youth confined at CJTS.

Concerns raised include the following:

1. Lack of suicide prevention protocols and concerns regarding suicidal youth;
2. Inappropriate and unlawful restraints of boys and girls;
3. Lack of access to adequate treatment for youth with significant mental health disorders;
4. Prolonged use of closed-door seclusion, in lieu of treatment, for children with disabilities;
5. Abuse or neglect of youth by certain staff members, and a culture that tolerates harassment and derogatory treatment, particularly of boys.

OCA initiated an investigation into conditions of confinement for youth at CJTS and Pueblo. Investigation activities included the following:

- Review of hundreds of incident reports and/or videotapes of conditions in the girls' and boys' facilities;
- Review of facility reports regarding suicidal/self-injurious behavior;
- Review of training curriculum materials;
- Review of educational attendance data;
- Review of treatment plans, progress reports and clinical notes for approximately 2 dozen youth served over a 100 day period;
- Visits to CJTS and Pueblo, meetings with youth and staff;
- Review of DCF investigations into allegations of abuse or neglect at CJTS and Pueblo.
- Multiple efforts to communicate and meet with DCF staff and leadership regarding systemic concerns and recommendations.

SUMMARY OF FINDINGS

Conditions at CJTS and Pueblo, observed by the OCA through site visits, video tapes and case files, have depicted urgent and significant risks of physical and emotional harm for certain children and youth. These conditions, including inadequate treatment for and response to self-injurious youth, unlawful restraint and prolonged seclusion, and multiple incidents of abuse and neglect of children in the facilities, stand in stark contrast to Connecticut's well-earned record as a leader in juvenile justice reform.

Over the last several years, Connecticut has steadily reduced its reliance on incarceration of young people. For this Connecticut has been recognized around the country for transformational juvenile justice practices. However, concurrent to this impressive record of reform, the state continues to rely on the large-scale juvenile correctional facility, created by former Governor Rowland's administration in 2001, to confine youth committed to the juvenile justice system. There have been many efforts over the last decade and a half to reduce the utilization of CJTS and infuse more supports into the facility to make it work for children. However, the facility remains an extraordinarily expensive maximum security setting confining youth of various risk and need levels, including youth with significant psychiatric disabilities.

While it is true that CJTS confines only a few hundred youth per year, its ripple effect across the juvenile system is significant. CJTS is expensive, with one of the highest per diem costs in the country.⁹ At a time of ongoing fiscal constraint, it is notable that CJTS has cost the taxpayers of Connecticut hundreds of millions of dollars since its inception, without *demonstrated* effectiveness.

This dramatic expenditure for CJTS, and now also Pueblo, continues despite a dearth of *any reporting on the facilities' effectiveness for children and impact for public safety*. A 2013 report by Georgetown University Center for Juvenile Justice Policy ("Georgetown Report") pointedly observed that DCF stakeholders *assumed the quality of CJTS "but could not articulate any evidence or study to support their contention--"*¹⁰ According to the same report, "Connecticut does not have a well-developed quality assurance system, either for parole supervision or for confinement."¹¹

⁹ Justice Policy Institute, *The Costs of Confinement*, (2009), found on the web at www.justicepolicy.org

¹⁰ Center for Juvenile Justice Policy, Georgetown University for the Department of Children and Families: Connecticut Parole Report, *Final Report for the State of Connecticut*, 43 (2013) (hereinafter "Georgetown Report").

¹¹ *Id.* at 44.

What are CJTS and Pueblo?

CJTS and Pueblo are state-run juvenile correctional programs¹² for youth committed to state custody for juvenile delinquency charges. They are considered maximum secure facilities, with razor-wire barriers, isolation cells, and, in the boys' facility, locked units with single, locked rooms. The Georgetown report described CJTS as a "secure facility built to [American Correctional Association] juvenile maximum standards."¹³ Youth are committed for a range of juvenile charges, with the majority of youth confined in 2014 for non-violent offenses.¹⁴ Youth at CJTS and Pueblo generally remain on-site, do programming and attend school inside the facility. Many youth at CJTS are also committed to DCF custody due to their history of being abused and neglected at home. There were approximately 250 youth admissions to CJTS and Pueblo during 2014. CJTS's utilization rate was approximately 90 to 150 per month; Pueblo's utilization was less than 6 per month.

The annual cost of maintaining CJTS and Pueblo is more than \$32 million dollars, with a projected cost of approximately \$750 per child per day.¹⁵ The only purpose of the facilities is to rehabilitate children through the provision of treatment and thereby improve public safety upon their discharge.

To support this effort, the facilities' menu of services includes education, mental health treatment and recreation. CJTS and Pueblo employ 18 clinical staff, including psychologists, clinical social workers, and psychiatrists. The units are staffed by Youth Service Officers-- paraprofessional positions that require a minimum of 1 year of experience working with children who have complex psychiatric or behavioral health needs.

¹² Training schools are widely considered an alternative name for "large style juvenile corrections institutions." See Annie E. Casey Foundation, *No Place for Kids: The Case for Reducing Juvenile Incarceration*, 2 (2011) (stating that "largest share of committed youth—about 40 percent of the total—are held in locked long-term youth correctional facilities operated primarily by state governments. These facilities are usually large... and feature correctional hardware such as razor-wire, isolation cells and locked cell blocks."); According to a literature review on the website of the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Programs, "A [juvenile] correctional facility is any residential facility with construction fixtures or staffing models designed to restrict the movements and activities of those placed in the facility. It is used for the placement of any juvenile adjudicated of having committed an offense, or, when applicable, of any other individual convicted of a criminal offense." Office of Juvenile Justice and Delinquency Prevention, Model Programs Guide Glossary of Terms, *Correctional Facility*, found on the web at: <http://www.ojjdp.gov/mpg/Resource/Glossary>.

¹³ Georgetown Report at 25.

¹⁴ Based on an examination of 221 charges from the 2014 admissions at CJTS. Non-violent charges include (but are not limited to): Possession of drugs, Larceny, Disorderly Conduct, Violation of Probation, and Breach of Peace. Remaining charges include, but are not limited to, assault, robbery, carrying a weapon (less than 10% of the 221 admission charges at CJTS during 2014 were for robbery or carrying a weapon).

¹⁵ From the 2015 CJTS Advisory Board Report.

OCA Investigation Leads to Urgent Concerns Regarding Conditions of Confinement

While OCA recognizes the positive efforts of many state employees working in these facilities, OCA found numerous urgent concerns that directly affect the safety of youth and the community: including unlawful restraint and seclusion, harmful crisis management, inadequate prevention of and response to youth who attempt suicide or self-injury, an ineffective system for responding to reports of abuse and neglect within the facility, and a pervasive lack of effective quality assurance. It does not appear that DCF Central Office has historically rigorously audited conditions and outcomes for confined youth.

As stated throughout this report, DCF has begun to take some steps to address concerns identified herein. However, concurrent to these recent steps, DCF has also generally rejected many of OCA's findings, and administrators asserted to OCA in May of this year that investigators were taking treatment reports, incident reports or video tapes out of context to support a particular "viewpoint."¹⁶ Specifically, DCF rejected findings regarding 1) a pattern of practice of inappropriate restraint and lengthy seclusions; 2) inadequate treatment support for youth in crisis; 3) inadequate systemic review for youth experiencing repeat difficulties in the program; 4) inadequate quality assurance.

Throughout, DCF facility administrators have maintained in meetings with OCA that most children do well at CJTS and Pueblo, and the agency's public reports or statements frequently reference programmatic resources and *census* information regarding how many children enter CJTS/Pueblo and how many discharge.

However, *without longitudinal data regarding recidivism and other indicators of stability and progress in the community, admission and discharge data, and even information regarding resources within the facilities, shed little if any light on the facilities' effectiveness at promoting rehabilitation or public safety.*

The reports submitted by DCF and its facility advisory board do not adequately address quality and outcomes of care. What data does exist shows that many youth are admitted to CJTS multiple times, whether for new offenses, parole violations, technical violations or even "respite."

OCA's findings regarding the dearth of data are echoed by the 2013 Georgetown Report, which emphatically concluded that DCF must develop a data-driven vision for improving juvenile justice and that it must transform its capacity for meaningful quality assurance. Despite the concerted efforts of various individual staff members and clinicians, the facilities remain unable to show whether youth are better off or how often they re-offend, the *primary purposes of the facilities.*

The agency is beginning to take steps to address these deficiencies, but to date, these material questions remain. ***OCA takes the position that it is critical to raise these questions about the quality and outcomes of state confinement of children.***

¹⁶ Email from DCF Facility Superintendent W. Rosenbeck, dated June 1, 2015, on file with author.

OCA finds that youth with significant mental health disorders are at *profound risk of physical and emotional harm* in these correctional programs. OCA has watched videos depicting youth who are not physically threatening anyone yet experience violent take-downs; mentally ill youth who are isolated in padded cells; self-injurious youth who are sanctioned and disciplined for trying to hurt themselves; youth who are subject to abuse and neglect inside the program.

While OCA does not assert that these incidents take place every day, they have, however, taken place *repeatedly*.

One 14 year old boy still confined at CJTS has been the identified victim in *multiple investigations of abuse and neglect* within the facility (the first when he was raised to shoulder height and slammed to the ground by a staff member and the second—very recently--when he was allegedly restrained in an illegal choke hold and then held prone to the ground despite a medical alert in his file prohibiting such an intervention. This boy was arrested for *his* behavior in both incidents.)

Research around the country echoes the concerns raised by OCA’s investigative report, and a leading foundation for child welfare and juvenile justice reform—the Annie E. Casey Foundation—recently sounded a nationwide call for states to put an end to juvenile incarceration due to its ineffectiveness and potential to harm children.¹⁷

Specific Investigative Findings of Concern Regarding Conditions of Confinement at CJTS and Pueblo: Summary

- 1. CJTS and Pueblo Do Not Adequately Prevent and Respond to Youth Suicide Attempts and Self-Injurious Behavior.** Between June, 2014 and February, 2015 OCA discerned over two dozen *documented* acts of youth trying to injure or kill themselves at CJTS and Pueblo. OCA concludes, however, that this is an *undercount* of self-harming incidents as not all incidents of self-injurious behavior are clearly documented.
- 2. DCF Did Not Complete a Suicide-Prevention Evaluation for Pueblo Prior to Opening the Facility.** OCA found that Pueblo was not “cleared” as having suicide resistant housing prior to opening in April, 2014. Pueblo cells still have “blind spots,” contrary to the advice of national experts on suicide prevention. OCA also found that CJTS has not had a comprehensive audit of suicide prevention protocols and facility infrastructure in almost a decade.
- 3. CJTS and Pueblo Do Not Meet the Needs of Youth With Significant Mental Health Disorders.** The majority of youth entering CJTS and Pueblo present with significant trauma histories, compounded by social stressors, a history of physical or sexual abuse, and educational or learning deficits. Many of these youth, diagnosed with a range of challenges and disabilities including Borderline

¹⁷ Annie E. Casey Foundation, *CEO Calls for States to Close Youth Prisons*, June 24, 2015 (press release found on the web at: <http://www.aecf.org/blog/annie-e-casey-foundation-ceo-calls-for-states-to-close-youth-prisons/>).

Intellectual Functioning, Post-Traumatic Stress Disorder, Depressive Disorder, Bi-Polar Disorder, substance abuse, and learning disorders-- are subjected to restraint and locked-door seclusion and restricted status that limits access to programming and treatment. It is not uncommon to read in the case file of a youth with significant disabilities that his or her access to rehabilitation activities was limited due to "being on [restricted] status." One boy, profiled in this report, was issued over 200 days of restricted status time during his 15 months in the facility. Most urgently, these youth are the most at-risk for hurting themselves in the facility and facing other poor outcomes.

4. CJTS and Pueblo Lack a Reliable and Transparent Framework for Measuring and Reporting Conditions and Outcomes of Confinement.

Internal reporting regarding conditions and outcomes of confinement is inadequate or missing. The 2013 Georgetown technical assistance report regarding juvenile justice services at DCF confirmed that the "lack of access to data is a significant limitation in Connecticut's DCF-[Juvenile Services Division]. ... [DCF] cannot advance significantly without objective data and performance outcomes."¹⁸

5. Excessive Absenteeism from the CJTS/Pueblo School

An examination of CJTS/Pueblo school attendance records, academic year to February, 2015, revealed many youth, including youth with mental health disabilities, learning deficits and intellectual challenges, who are missing excessive amounts of time in the classroom.¹⁹ Excessive absenteeism also raises concerns that students with disabilities are not receiving education services in accordance with state and federal law.

6. Failure to Adequately Address Allegations of Suspected Abuse or Neglect within the Facilities.

OCA found multiple allegations of physical abuse or neglect of youth in the facility that were not "accepted" by DCF for investigation and staff mistreatment of youth was not always deemed "neglect" unless a boy could state that he was specifically harmed by the mistreatment.

7. Unlawful Use of Restraint and Locked Seclusion.

OCA's review of facility incident reports over a 12 month period (July 1, 2014 through July 1, 2015) reveal *at least* 532 physical restraints and 134 uses of mechanical restraints (handcuffs or shackles).²⁰ OCA looked at a 100 day period

¹⁸ Georgetown Report at 3.

¹⁹ Reasons for missing school periods includes "period removal," "off grounds," "unit bound instruction," "clinical," "suspension," "awaiting hearing," "medical," "meeting," "refused." Investigators do not yet have clarity on what instruction youth have when they are suspended, Unit Bound, or Out of Program. It does not appear that youth who are in Seclusion receive instruction.

²⁰ To tally restraints, OCA reviewers hand-counted and reviewed incident reports involving aggressive or non-compliant behavior in the facilities, that regardless of incident coding (e.g., "failure to comply," "fighting," "other,") contained documentation of a physical or mechanical restraint.

during the course of the investigation²¹ which revealed that approximately 1/4 to 1/3 of youth each month were subject to a physical or mechanical restraint (this includes handcuffs and leg shackles);²² approximately 30 percent of youth were subjected to documented locked-door seclusion, sometimes in the units' padded isolation cells.²³ Certain youth are secluded or restrained with much greater frequency than other youth. Research consensus around the country confirms the potentially destructive impact of isolation for children and youth.

To review pattern and practice issues, OCA examined the use of seclusions at CJTS and Pueblo that were for durations of 4 hours or longer. A leading set of national standards for managing youth in a correctional setting **limits isolation to 4 hours or less, and never for purposes of punishment.**²⁴ However over a six month period of time OCA found **at least 225 documented incidents of seclusion for 4 hours²⁵ or longer, of which almost 100 were 8 hours or longer.**²⁶

Though Connecticut law requires that physical and mechanical restraint or seclusion be used only to “*prevent immediate or imminent injury to the person or to others,*”²⁷ restraints have repeatedly been depicted on video tapes and in incident reports at CJTS and Pueblo as a behavior management response. Some of these restraints have escalated situations to the use of the handcuffs, shackles and even the arrest of youth who physically respond to the restraint itself.

8. Frequent Arrests of Girls and Boys at CJTS and Pueblo

During 2014 there were at least 44 arrests of boys and girls at the DCF-run facilities for their behavior *in the program*. As DCF moves to reduce the rate of arrest for its youth in community programs, it must address the same issues at CJTS and Pueblo.²⁸

²¹ January through end of March, 2015.

²² Restraint numbers include any physical hold, inclusive of physical escorts, standing restraint, supine restraint, prone restraint and mechanical restraint (handcuffs). The census numbers for January through March, 2015 were 96, 88 and 98 respectively. Actual children served may be slightly higher. Individual youth subject to restraint: January (27) February (27) March (26).

²³ Seclusion, per Conn. Gen. Stat § 46a-150 *et seq.* requires seclusion and restraint to be used only in response to *an emergency*. Allegations made to OCA by staff from CJTS indicate that not all seclusion is documented, including group seclusion and “reflection time.”

²⁴ JDAI Standards, cited herein.

²⁵ Aug., 35 seclusions were longer than 4 hours (of which 20 were 8 hours or longer); Sept., 32 seclusions were longer than 4 hours (13 were 8 hours or longer); Oct., 44 seclusions longer than 4 hours²⁵, (18 were 8 hours or longer); Nov., 45 seclusions longer than 4 hours (19 were 8 hours or longer); Dec., 25 seclusions longer than 4 hours (only 4 were 8 hours or longer); Jan. 44 seclusions longer than 4 hours (19 were longer than 8 hours).

²⁶ OCA has continuing concerns about the reliability of this data and believe that these numbers month to month still represent an *undercount* of actual isolation. For example, one December report indicates that a youth *was not* in seclusion, however incident reports document that the youth was in his cell *banging on the door*.

²⁷ Conn. Gen. Stat. § 46a-152

²⁸ Kinscherff Report, at 14.

Note from the Child Advocate

OCA emphasizes that the issues outlined above are not due to a lack of effort by individual line staff or clinicians, some of whom go to great lengths to offer support for youth in need, and several of whom brought concerns about conditions and treatment of youth to the attention of the OCA. However, CJTS and Pueblo are extremely costly and, to-date, not demonstrably effective in promoting the facilities' *sole goals* of rehabilitation and public safety. Most urgently, as reported on *multiple times since CJTS was built*²⁹, the effort to address youths' complex behavioral and mental health needs in a juvenile correctional environment creates ongoing risk for poor outcomes for youth with disabilities and the communities they rejoin. *Sarah Healy Egan*

RECOMMENDATIONS

Connecticut can build on its legacy of reform by transforming its system of support and supervision for delinquent youth. The continuum of services may well include secure care for some youth, but these services must be evidence-based and individualized to the needs and risk presented. Confined youth are often children with the most significant needs—children with limited education, histories of abuse, and complex mental health disorders. Their goals and the public's overlap—increased functioning (rehabilitation) and decreased recidivism.

Missouri Model

Connecticut stakeholders have long advocated for this state to follow the lead of Missouri in the creation of regionalized, therapeutic programs in lieu of a traditional juvenile corrections training school.³⁰ The “Missouri Model” is heralded nationwide by juvenile justice experts as a more therapeutic, rehabilitative and effective way to improve outcomes for delinquent youth and promote safety. According to a 2010 report by the Annie E. Casey Foundation regarding the Missouri Model, Missouri's safety record is favorable even compared with facilities utilizing

²⁹ Report of the Child Advocate and Attorney General regarding Connecticut Juvenile Training School, (2002) (describing widespread problems with quality, safety, suicide prevention); Supplemental Report by OCA and the Attorney General Regarding the Connecticut Juvenile Training School, (2003); Follow up report of the Child Advocate and the Attorney General Regarding the Connecticut Juvenile Justice Training School (CJTS) (2004) (key findings from prior reports include lack of prior protocols to protect children at risk of attempting or committing suicide; unlawful restraint and seclusion; inadequate training regarding mandatory reporting of suspected abuse or neglect within the facility; administration of sanctions that restrict access of youth to rehabilitative programming.)

³⁰ Justice Policy Institute, *Juvenile Justice Reform in Connecticut: How Collaboration and Commitment Have Improved Public Safety and Outcomes For Youth* (2012) (In 2001, “Connecticut's Governor, John Rowland, rejected recommendations to build a therapeutic facility or a regionalized network of smaller facilities following the successful model employed in Missouri. Instead, Rowland fast-tracked a plan to build a new facility modeled after a maximum security adult prison in Ohio...”).

Performance Based Standards (PBS)—a framework to improve conditions of confinement promulgated by the Department of Justice in the mid-1990s.³¹

For example, on average PBS facilities used mechanical restraints 17 times as often as Missouri Division of Youth Services and isolation was used 245 times more frequently. In Missouri any time a restraint or any isolation is used, a critical incident report is generated.³²

Perhaps most significantly, Missouri has generated the lowest juvenile justice recidivism rates in the country and saved tax dollars through its approach.³³

With regard to improving conditions at CJTS and Pueblo, OCA is recommending immediate steps the state can take:

1. Adhere to national juvenile justice performance standards such as those promulgated by the Juvenile Detentions Alternative Initiative—a project of the Annie E. Casey Foundation—and Performance Based Standards—promulgated by the Department of Justice.
2. DCF must develop and implement rigorous quality assurance protocols to audit conditions and outcomes of confinement, as recommended by the 2013 Georgetown Report and the 2015 report developed by Dr. Robert Kinscherff. This work may need to be assisted by outside experts in continuous quality improvement.
3. DCF should ensure use of “electronically-based dashboards of facility operations with progress and outcome measures to guide facility policy and practice that is updated at least monthly.”³⁴
4. DCF should submit a public plan regarding implementation of operations recommendations contained in the 2013 Georgetown report, the 2015 Kinscherff Report, and this report.
5. DCF should work with outside experts (as identified in the Kinscherff Report) to assist with establishing and sustaining trauma-informed care in facilities and invite a follow-up review in 12 months to thoroughly assess progress and assist with continued implementation of reforms.³⁵

³¹ Annie E. Casey Foundation, *The Missouri Model: Reinventing the Practice of Rehabilitating Youthful Offenders*, 5 (2010).

³² May, 2015 telephone meeting between OCA and MO Interim Director of Youth Services, Phyllis Becker.

³³ *The Missouri Model* at 12 (\$3 - \$6 million can be saved by keeping just 1 high-risk kid away from a life of crime).

³⁴ Kinscherff, R. *Strategic Review of CJTS/Pueblo Girls Program Policies and Practice* (July 1, 2015) (hereinafter “Kinscherff Report”) at 28.

³⁵ Kinscherff Report at 35 (It is a very challenging process to establish and sustain trauma-informed care in residential and correctional facilities until it is firmly embedded into ongoing

6. Increase training and coaching for front-line staff and supervisors to support a trauma-responsive facility.
7. Create a clear protocol or Memorandum of Understanding to support timely and effective transfer of youth with acute mental health needs to appropriate treatment facilities. Utilize the Office of the Health Care Advocate where needed, to address access issues.³⁶
8. Treatment plans must be ACES and trauma-informed and realistically conform to the capabilities and individual needs of children and youth diagnosed with significant learning, emotional and psychiatric disorders.
9. Reduce isolation and *end* physical and social isolation (including “out of program time”) as a punitive response or as a response to mental health crisis. Incorporate the recent toolkit developed by the Council of Juvenile Correctional Administrators to reduce the use of isolation.³⁷
10. Incorporate annual and independent audits of suicide prevention protocols, with attention to the safety of the buildings and units and the use of isolation.
11. Require expert, multi-disciplinary review of individual treatment plans for youth who have been repeatedly restrained or secluded or who have self-harmed while in the facility/s or prior to entering the facility/s.
12. Improve access for youth to the CJTS/Pueblo school, reduce or eliminate unit-bound instruction and school suspensions. Ensure all children’s individual or special education learning needs are appropriately identified and addressed. Ensure data dashboards can electronically manage and report relevant outcome measures related to attendance, special education status, treatment planning and outcomes.
13. Ensure regular trainings for youth and staff regarding the law on seclusion, restraint and youths’ right to access mental health and educational programming within the facilities.

practice. This process often benefits from an external review, training and consultation with annual audit of progress for a time. CJTS/Pueblo leadership should consider retaining a consultant to conduct a “state of progress” review of facility operations with follow-up as may be recommended. Resources to consider include: Dr. Robert D. Macy (Center for Trauma Psychology) in Massachusetts, Dr. Ross Greene (Center for Collaborative Problem-Solving) in Maine, and Dr. Julian Ford in Connecticut (University of Connecticut Health Center). Each of them has demonstrated success in implementing trauma-informed care in juvenile justice and other settings.”)

³⁶ *Id.* at 21.

³⁷ CJCA toolkit found on the web: http://www.sprc.org/library_resources/items/cjca-toolkit-reducing-use-isolation

14. Immediate consideration should be given to re-purposing Pueblo (given its limited utilization) or reallocating resources to craft individualized supports for girls with particularly complex needs.³⁸

15. Abuse/neglect investigations conducted by DCF should include multi-disciplinary review and include outside consult with OCA and, where appropriate, the Office of Protection and Advocacy. Data related to abuse/neglect claims should be reviewed with the Juvenile Justice Policy and Oversight Committee and the CJTS Advisory Board. All records related to abuse/neglect allegations should be maintained by DCF.

INVESTIGATIVE REPORT

I. MANY YOUTH WITH TRAUMA HISTORIES AND DISABILITIES HAVE UNMET NEEDS IN THIS JUVENILE CORRECTIONAL FACILITY.

The population of CJTS and Pueblo is made up of approximately 250 girls and boys—age 12 to 19--over the course of a year. The overwhelming majority of these youth have significant emotional, psychiatric and cognitive disorders. Diagnoses for youth in these facilities range from cognitive limitations and learning disorders to significant psychiatric disorders such Bi-Polar Disorder or even Psychosis. A high number of these children have been exposed to significant trauma, including violence in the home or community, physical and sexual abuse and neglect. If the goals for state intervention are to “rehabilitate” these children and reduce their likelihood of committing delinquent acts, then all of the children at CJTS will need intensive, trauma-informed treatment supports, individualized to their various learning needs and intellectual capabilities. They will need access to positive and effective supports and interventions seven days a week with a clear method for assessing skills acquisition and progress in treatment. They will need to discharge to families that are capably supported; and they will need access to intensive community support and supervision. All of this service delivery will need to be rigorously evaluated for effectiveness if we want these youth to be able to re-enter their communities and succeed. For too many youth, and their communities, we are simply not meeting this need.

As one reads the profiles below and stories throughout the report there are recurring themes: youth with significant trauma and psychiatric disorders; a lack of appropriate crisis management; a lack of individualized treatment plans despite obvious failures; the inappropriate use of restrictions leading to the loss of the very rehabilitative or educational programming that these youth require.

³⁸ Id. at 20. “Given the significant deployment of resources required to keep Pueblo Unit operational at its current potential capacity, it is reasonable to ask whether those resources might be more effectively deployed to craft and fund highly individualized supports for the very few girls having the kinds of difficulty stabilizing in lower levels of care that would otherwise prompt admission to Pueblo Unit.”)

Roberto

Roberto is a Hispanic 16 year old boy at CJTS, who is diagnosed with Post Traumatic Stress Disorder, Depressive Disorder, Attention-Deficit-Hyperactivity-Disorder (ADHD) and Conduct Disorder. He was confined at CJTS for the 4th time in April, 2015. Roberto's original commitment to CJTS was due to charges of Assault in the 3rd Degree. Roberto accumulated additional charges, mostly for Breach of Peace.

Roberto has been described by CJTS staff as likeable, engaging, invested in his future and eager to make better choices. He is also frequently described as mentally ill, and he suffered a possible psychotic break during an episode at CJTS last summer. He has been discharged from CJTS on multiple occasions to the care of his mother, who also has chronic mental health issues.

Roberto has been subjected to many restraints and lengthy seclusions at CJTS, sometimes face down restraints that are banned in licensed treatment facilities and which are now banned in schools, and several restraints involving the use of handcuffs and shackles, as well as isolation in one of the facility's padded cells.

Facility administrators recently told OCA that Roberto has done well "overall" at CJTS,³⁹ often "settling down" into being a model client.⁴⁰ However, though Roberto's progress reports varied, multiple monthly reports during his recent admission⁴¹ *authored by CJTS staff* documented Roberto's progress as "poor" or as "needing improvement." He missed significant days at the CJTS School over a 100 day period—a total of 34 days where he missed all or part of school, with 10 days of "refusals" and 15 days where he lost time for punitive reasons (including a lengthy suspension in December, 2014).

Roberto engaged in multiple incidents of suicidal behavior while at CJTS. At one point in November, 2014 he was found elaborately tying a sheet around his neck and attempting to attach it to a vent in the ceiling of his cell. He had more incidents in April and in June, 2015.

During Roberto's time at CJTS, documentation shows he was secluded for almost 100 *waking hours*.

Note Authors note that seclusion is counted in terms of awake hours though hours of isolation are much longer. State law provides that once "sleeping hours" begin (at CJTS this is 8:30 p.m.) confinement is no longer considered "Seclusion." So a youth that goes into seclusion at 3:00 p.m. on Day one, and remains in seclusion through second shift on day two (ending at 3:00 p.m.), will have experienced approximately 24 hours of *isolation* (save for hygiene and meals), while *seclusion* will be documented as 13.5 hours.

³⁹ Meeting between OCA and DCF, July 7, 2015 to discuss OCA's concerns about abuse and neglect of Roberto at CJTS.

⁴⁰ Id.

⁴¹ 2014-February 2015.

Roberto was discharged in February, 2015 despite marginal reports. But he quickly lost control, leading to an emergency room visit and a return to CJTS in the middle of the night less than two months later. Roberto was distraught upon his return to CJTS and threatened to kill himself within a week. The day after he was brought back Roberto was found face down on his bed, under a blanket with a shirt tied around his neck, unwilling to speak, and crying. He was handcuffed, shackled and brought to the isolation cell.⁴²

Since Roberto's return to CJTS in April, 2014, monthly reports from April and May of 2015 included identical language regarding clinical progress. Individual notes and "status" descriptions were also virtually identical to the language from Roberto's last report prior to February discharge. It is unclear what will change the outcome for Roberto this time around.

Note: Prior to release of this report, OCA learned that Roberto exhibited suicidal behavior again at the end of June when he was found tying a sheet around his neck, distraught over a delayed discharge. He was placed on safety watch for six days. Roberto was discharged shortly thereafter, back to his mother's house. His discharge summary notes that despite Roberto's participation and "engagement" in CJTS programming during this most recent admission, he was unwilling to participate in individual substance abuse prevention activities and he refused referrals for substance abuse treatment in the community, believing he could stay sober on his own. No family therapy sessions were held during this most recent confinement.

Samuel

Samuel is a bi-racial youth who has been in many DCF placements since the age of 4.⁴³ He has been in group homes, residential treatment facilities, juvenile detention, and psychiatric hospitals. Samuel has stated that "his anger and aggression stems from feeling like he is being left in various placements with no plan ... He feels that DCF has 'kept him from his family,'" and that he acts out when he "feels he is being denied visits or does not have a plan."⁴⁴

His father is dead and he has little contact with his mother. He has been at CJTS multiple times. Samuel's juvenile delinquency adjudication was for Breach of Peace.⁴⁵ Samuel has been diagnosed with significant mental health disorders, including Bi-Polar Disorder. At the time he first discharged from CJTS in 2014, Samuel's clinician described him as struggling with a return to the community and his lack of relationship with a family. Samuel felt he had "nothing to lose." He didn't want to go the city and he didn't want to stay at CJTS. Samuel was in a precarious state, with his clinician observing that due to

⁴² OCA discussed these interventions at length with DCF leadership through correspondence and a meeting in July, 2015. The use of shackles and handcuffs was defended by facility leadership as due to the boy's tendency to kick or trip staff during a physical intervention. OCA contended, *strongly*, that there is was no need for physical and mechanical restraint of this suicidal boy and that the interventions used were contraindicated and harmful.

⁴³ Samuel's case record from CJTS.

⁴⁴ *Id.*, Clinical note, CJTS.

⁴⁵ Per Adjudication History, CONDOIT records.

ongoing emotional challenges he could not even attend group therapy in the facility. He spent much of the time isolated from others.

Due to smoking marijuana and running away, Samuel was re-admitted to CJTS for approximately 7 weeks, from early December, 2014 through the end of January, 2015. Again, he remained isolated from peers, often in seclusion or on safety watches. He tried to hurt himself on multiple occasions. He told his clinician that he wanted to die if could not learn to be successful in the community. Samuel was described as struggling and unable to cope. His treatment plan continued to state that he was too dysregulated to be able to go to group programming. Samuel's January progress report stated that he had no family sessions and no group therapy. Sometimes Samuel stayed on 1:1 on his own request, with adults surmising that he needed this to address anxiety and access comfort. Samuel worried to his clinician that no one cared about him or liked him.

During his very brief admission to CJTS (Dec. to January) Samuel was placed in seclusion for over 70 waking hours. These hours do not include days of being on 1:1 or other watch statuses.

While Samuel's treatment plan noted what he could not do, reviewers did not see an attempt to introduce alternative forms of therapy and support. He was frequently dysregulated and often subject to physical and mechanical restraints and seclusion. He was described by his clinician at one point as "hopeless and helpless." Samuel did not participate in group therapy and he did not receive individual therapy on a daily basis despite his protracted isolation. At times, he spent hours in the padded cell with no treatment. At the end of January, Samuel was discharged from CJTS to the Department of Corrections.⁴⁶

Nathan

Nathan is a Caucasian youth who is committed to DCF custody as an abused/neglected child and as a juvenile justice commitment. He has an extensive history of abuse and neglect from birth, numerous out-of-home placements and multiple psychiatric hospitalizations beginning at the age of 10. Nathan has had many diagnoses through the years and has a history of hallucinations. Nathan was confined to CJTS for a charge of Burglary in the 3rd Degree.

⁴⁶ See Kinscherff Report at 30 ("From a broader systems perspective, jeopardy of criminal justice involvement for misconduct while being served by DCF in the community or in out-of-home placements warrants careful individual case review. Similarly, this kind of case review is warranted in all cases where a youth transitions into the criminal justice system for misconduct while at CJTS/Pueblo. Whenever possible, youth whose misconduct is significantly driven by a behavioral health need (such as assaults occurring during episodes of extreme emotional dysregulation related to a trauma history) and is reactive rather than instrumental/predatory should be diverted from adult criminal justice involvement... movement of a youth previously involved with the juvenile justice system into the adult criminal justice system or an incarceration setting operated by DOC should be presumptively viewed as a "**catastrophic**" systems failure prompting detailed case review.")

In response to OCA's concerns about Nathan, CJTS administrators responded in May, 2015 that Nathan was well-supported during his confinement and that he was "discharged successfully" to the community.⁴⁷ Notably, administrators wrote that Nathan "completed" multiple programs at CJTS, though it is critical to state that compliance with facility expectations does not confirm *progress*.

In contrast, CJTS documents reveal that Nathan's overall progress was described as "poor" in **all** of his monthly reports prior to discharge in 2015.

Nathan told staff that there was no one in his life that he trusted. In the fall, he was on suicide watch after deliberately cutting his arm. Several episodes of self-injurious and mental health crisis behavior led to restraints, isolation and administrative sanctions for everything from contraband (when he cut himself with wood), bodily waste (when he urinated in the padded cell), engaging staff in restraint (when he resisted movement or tried to hurt himself) and creating a disturbance.⁴⁸

Between August, 2014 and March, 2015 he was given 92 days of Out of Program and Unit Bound time. These restrictions do not include Nathan's 70+ hours of seclusion. Nathan told his clinician that the restrictions made him stir-crazy, but that at some point, he stopped caring. Nathan saw a clinician while at CJTS to address aspects of his psychiatric issues, but monthly planning reports still reflected *minimal progress in his presentation*.

Despite DCF's assertions that Nathan did well at CJTS and that his discharge was "successful," a review of Nathan's records indicate that he was discharged in March despite a final report stating that his "pattern of poor behavior in general population is well established" and describing his behavior as unstable and unpredictable. **He was discharged despite accrued sanction time.**

As of June, 2015, Nathan was back at CJTS on charges of Disorderly Conduct and Interfering, where upon admission he was assessed as paranoid and possibly delusional. Nathan's medications were adjusted and he was recently re-released to a community placement.

Eleanor

Eleanor has a long history of abuse, neglect and trauma. She was removed from her parent's home when she was a baby and she was moved through multiple foster homes before returning to her parent's care at age 3. She was removed again when she was 7 after allegations of significant physical and sexual abuse. Over the next several years she experienced numerous placements including 9 foster homes; 7 hospitalizations and residential placement. Her parents' rights to her were eventually terminated. Prior to the age of 12 Eleanor experienced over 30 placements and disruptions. Since returning from

⁴⁷ Email from CJTS Superintendent W. Rosenbeck, dated May 21, 2015, on file with author.

⁴⁸ DCF reported to OCA that youth are "seen" each day during crisis periods by a licensed clinician. However, records show that often times, youth are not receiving "treatment" during crisis periods, rather they receive "status assessments," brief "check-ins" to determine whether the youth presents a risk to himself or others, or requires medication. These "check-ins" are not equivalent to adequate therapeutic support services.

residential treatment in 2012, Eleanor has been in multiple institutional settings, including the state’s children’s hospital and Pueblo.

Eleanor is diagnosed with Post-Traumatic Stress Disorder and Reactive Attachment Disorder. In 2013, Eleanor was arrested for the first time for purposefully breaking a car window in the parking lot at DCF’s Psychiatric Hospital (Solnit South). Later that year Eleanor was hospitalized twice at CCMC for suicide attempts. Eleanor later ran away from a treatment program and was missing for months. After she was found, Eleanor was brought to the Pueblo Unit. Within only a couple of weeks of admission, Eleanor tried to commit suicide. She presented afterwards as distraught that her attempt to kill herself was interrupted.

On multiple occasions in the following months, Eleanor’s records showed uneven participation in rehabilitative activities, with frequent lack of attendance due to “off grounds,” “refusal” or “frozen.” Eleanor continued to struggle with self-injury. She scratched her hands and sides. She cut her forearm. She cut herself in the shower. She cut her thigh.

Eleanor’s clinical engagement and presentation at Pueblo varied over time. Her clinician’s notes are thoughtful and well-observed and reflect the gravity and complexity of Eleanor’s needs and the deleterious impact of being arrested.

Eleanor’s engagement in services at Pueblo increased and by her 4th month she was preparing for discharge to a group home. However, she quickly ran away from the group home. Within a day she was found and brought back to the Pueblo Unit. Several weeks later Eleanor was subject to a protracted physical and mechanical restraint after she “threatened” staff with a bowl of peanut butter and bananas and would not go to her room.⁴⁹ She was arrested for assaulting a staff member during the restraint. She was subsequently remanded to the Department of Correction, returned to Pueblo, was arrested again for Assault in the program, and was sent again to the Department of Correction.

From Eleanor’s File. March, 2015: As the month began, Eleanor’s improved motivation from last month began a rapid decline. Her engagement in therapy sessions reflected this. At times she was irritable and disengaged, while at other times she was on-track and focused on moving forward in her life with optimism (making plans for college, etc.). Her frustrations with the program and the discharge process increased, and she expressed hopelessness and pessimism in different ways. Early in the month she had two significant episodes of aggressive and destructive behavior, and as a result accrued additional legal charges. Once this happened, Eleanor’s engagement and functioning became more inconsistent, as she anticipated re-incarceration in [adult corrections].

⁴⁹ Multiple explanations for this incident were offered to OCA: 1) that Eleanor “threatened” staff with the snack; 2) that she was “blocking” the entrance for 3rd shift staff and therefore presented a danger to the unit. However, the take down took place long before third shift staff would enter, the substance was a snack, and video shows Eleanor standing in the corner of the hallway and not blocking anything.

She showed glimmers of taking responsibility for herself and acknowledgement that she needed to manage her anger better (mixed with a hopelessness that she would never be able to), but at her court date, she was again remanded to Adult Corrections where she remained at the month's end.

Eleanor was returned to Pueblo several weeks later, reportedly with some relief and hope for discharge. However, her progress with group therapy was poor, and though she was motivated for discharge her clinician wrote that she still struggled with peer interaction and negative influences.

In May Eleanor was found in her room having cut her forearm and leg. Two weeks later Eleanor was out with a community-provider and she ran away. Eleanor was gone for several weeks though she stayed in contact with Pueblo and her Parole officer, telling them that she would find a place to stay with a family member. Eleanor eventually turned herself back in to Pueblo staff, and a note in her case record indicated that DCF would “seek to expedite her placement to [family member] as keeping her in a locked setting leads to more criminal charges.” Eleanor was released in June. Notes state that a parole supervisor met with Eleanor in the community and Eleanor was “in her usual nasty disposition... she had numerous new tattoos and a bandage around her left leg which she said was from a cat scratch.”

Jackson

Jackson is an African-American boy who was 13 years old when first confined at CJTS in September, 2013. He is the oldest of 3 children. His father was shot and killed when Jackson was 2 years old. The family has been involved with DCF since 2007 with regular reports of physical neglect. Jackson has been the victim of gun violence and has witnessed violent crime.

According to Jackson’s records from CJTS, Jackson’s significant trauma history causes him to have “multiple night awakenings, intrusive thoughts, anger, self-blame and distress.” Jackson was unwilling to engage in trauma treatment while at CJTS. Jackson is diagnosed with ADHD; Conduct Disorder, Post-Traumatic Stress Disorder, and Borderline Intellectual functioning. Jackson is a special education student.

After a year at CJTS, in September, 2014 Jackson was still “continuing to struggle” on the unit; he was described as getting easily angered and unable to interact well with peers. Clinically, Jackson presented as “hopeless.” Therapy was to focus on helping Jackson “cope with his stress around being at CJTS.” Jackson accumulated numerous sanctions and was restrained and secluded on multiple occasions.

His clinical records at CJTS show a gradual increase in engagement, but Jackson worried aloud that he shouldn’t be discharged from CJTS or else he might hurt someone or get hurt himself. He asked for his discharge to be delayed.

Jackson's **January, 2015 report indicated he earned zero incentive days.** Like other youth, Jackson lost access to rehabilitative programming due to being on restricted "Status" and serving sanction time— noted repeatedly in his records from November, December and January, 2015. In the months prior to his discharge he requested Benadryl *on a regular basis* to help him get through the night.

Jackson, like other youth at CJTS, is plagued by restlessness and fear.

In March, Jackson was discharged to his mother's house. His discharge summary stated that he made minimal progress and "Struggled tremendously" with reducing aggression. Notably his discharge report also stated that he made "some" progress in developing coping skills, but had difficulty *utilizing the skills*. Frustrated at having lost two discharge dates, Jackson reportedly tried harder to remain in control. He earned levels 1 and 2 for the first time in the two months prior to his discharge (levels go up to 5 at CJTS).

By June, Jackson was back at CJTS with numerous new juvenile delinquency charges. He was recently transferred to the Department of Corrections. Jackson is 15 years old.

Discussion

Children and youth like those profiled above who have experienced abuse and neglect, or have significant mental illness require intensive, individualized clinical and behavior interventions. In many cases, it is unclear how CJTS' (and Pueblo) Plan of Service, program policies, and treatment provisions *align* with the complex trauma history and emotional dysregulation with which these youth present.

As Dr. Robert Kinscherff's recent expert report noted:

"In practice, the operations of CJTS and Pueblo Unit currently reflect deep ambiguities and, at least at times, tensions regarding their functions and goals. Some reflect the transitions of organizational change and others reflect tensions among goals."⁵⁰

Many of the youth whose files were reviewed appear to under-report their trauma exposure, and their initial assessments and screenings do not always match up with what we know about them from prior records or assessments, or with what we would expect regarding a child with a history of abuse or neglect. Many youth enter CJTS and Pueblo with a history of multiple hospitalizations or have been involved with intensive out-patient and partial hospitalization programs. Many youth exhibit trauma-induced, dysregulated behavior.

⁵⁰ Kinscherff Report at 16 (describing tensions "between developing operations intended to support relatively short-term stabilization return for most youth to community-based services and developing operations for longer term rehabilitative efforts to address trauma, significant behavioral health needs, educational and/or vocational needs, and life-skill preparation.")

Records in the CJTS database appear to catalogue contact with youth but do not clearly describe the clinical work that is being completed in sessions. Records do not appear to reflect a milieu that is based on trauma-informed care. Records may discuss an approach with a youth (e.g., youth is going to a particular therapeutic group) but there is little discussion of how the youth is integrating the material they are learning, how they are able to practice the material, and how these skills are being enforced on the floor by staff. This work may be very hard to do in a maximum secure juvenile correctional facility. **For example, one 15 year old's recent discharge summary from CJTS stated that, after more than 18 months of confinement, he had learned new coping skills yet struggled to *utilize* them in the unit.**⁵¹

The facilities offer evidence-based treatment modules such as Anger Replacement Therapy and Dialectical Behavioral Therapy, but it appears that these models are implemented in isolation, as opposed to within the context of the facility as a whole, so that the treatment modules are not informing a therapeutic milieu. As Dr. Kinscherff's report stated:

“While there are considerable clinical resources, there is not an overall integrated treatment model or definition of role. All youth are offered individual treatment sessions once a week but what is provided in individual sessions is a reportedly matter of each clinician's training and preferences. Clinical staff are not directly involved in unit behavior management incidents but the nature and level of clinician engagement following a restraint or during a room-placement or seclusion varies by clinician and by unit. Some staff have received DBT training but there has not been success in bringing it to scale on units and the initiative to do so has reportedly significantly faltered.”

These gaps described in Dr. Kinscherff's report raise the concern that a youth is only able to acquire skills or support when he or she is attending group or other rehabilitative sessions. For example, the use of Out of Program Time as a sanction⁵² is not informed by therapeutic or trauma-informed principles. OOP as stated above requires a youth, when not in school, to sit in a chair outside of his cell (in Pueblo, girls sit in “frozen stations”) and not interact with others. OOP status may be issued for 1, 2 or 3 days in a row. OCA reviewers read countless incident reports where a youth “on status” escalated to needing physical interventions or even mechanical restraint and seclusion.

⁵¹ This youth has since been re-arrested and is now incarcerated in the Department of Correction.

⁵² CJTS and Pueblo rely on a point-driven system that leads to sanctions (restricted status, school removal) or incentives (longer more frequent phone calls, radio in the room, later bed time). Sanctions include “minors” for a non-compliant behavior ranging from not walking properly in line, not completing rules of for hygiene, not maintain a cell in proper order or having too many items in the cell, or engaging in rude behavior or offensive language. “Major” sanctions are given for behaviors ranging from “resisting movement,” “creating a disturbance,” “engaging staff in a restraint,” “contraband” or fighting.

To expect struggling youth who have cognitive challenges, mental illness and other difficulties to sit in a chair, socially or physically isolated from others for lengthy periods of time or even days, is a futile, un-therapeutic and potentially harmful practice.

The CJTS/Pueblo behavior management manual describes a traditional juvenile-correctional approach to behavior modification. Certain concepts are not addressed at all in the more than 30 page manual provided to OCA: trauma, disability, psychiatric disorder, or special education status. For example, the Manual discusses the disciplinary response for youth who “refuse” to attend school. However, the same section does not identify unmet learning or mental health needs as a possible or even likely indicator for school refusal.

One of the youth profiled above missed at least 80 periods of school due to “refusal.”

American Correctional Association Standards Guide Operations at CJTS and Pueblo

When questioned about the sources for the girls’ and boys’ behavioral plans at CJTS and Pueblo, DCF replied that the plans derive from and are consistent with guidance from the American Correctional Association. However, given that the facilities’ purpose is described as rehabilitative and therapeutic, OCA questions the reliance on the ACA *exclusively* as the source of best practices for these programs, particularly given the need for gender-responsive programming at Pueblo.

Of urgent concern and seen in many profiles above, if a youth is dysregulated or if he or she is put on restricted status as a sanction for negative behaviors he or she may not have access to adequate levels of supportive programming. This leads to a counter-intuitive frame where the facility has identified that a youth has certain needs, but the youth is not provided the supports to address those needs because of the youth’s ongoing difficulties.

The facility is not consistently engaging with youth *when youth are struggling*. Youth on [safety] “watch” status may receive “check-ins” but are not necessarily receiving *treatment*, or receiving treatment at the level required, and youth on restricted status do not have adequate access to regular and sustained therapeutic programming.

Case records reviewed for this report reveal that youth with disabilities may repeatedly miss group interventions or rehabilitative activities due to being on “status”, and some youth have no current plan to address complex, developmental trauma. Plans are hyper-focused on compliance and behavior as opposed to a service plan that extends throughout the facility and that is focused on the meaningful acquisition of skills and mental health rehabilitation.

The profiles above show youth who frequently feel, according to staff, “helpless” or “hopeless.” They want to do better, but may have little to anchor or encourage them. Clinicians and staff working with youth with complex disabilities may feel at a loss to help them progress at CJTS, and records show that certain youth are discharged back to the community having made little, if any progress. Such situations place both children and communities at risk.

The Georgetown Report found a lack of meaningful quality assurance for program delivery in the DCF juvenile services division, including CJTS. Existing reporting focuses on aspects of performance, but no provides no “macro assessment of the quality of services or an indication of those areas in need of improvement.”⁵³ Indeed, Georgetown Report authors indicated that “CJTS would be a good place to start” with an improved quality assurance framework in order to evaluate the relationship between services delivered and recidivism.⁵⁴

Remedies to Improve Trauma Informed Care for Youth

Guidance commissioned by the Department of Justice in 2014 cautions against a “correctional” approach to behavior management—where sanctions are often issued without exploring whether there are potential vulnerabilities or alternative explanations for a youth’s behavior.⁵⁵ The “correctional” approach *erroneously* assumes that the “discomfort and distress of incarceration and sanctions is what motivates youth to engage in prosocial behavior in the future. *However no data exist to support that assumption,*” and evidence shows that these responses may *actually escalate* youth with mental health and trauma-related disorders.⁵⁶

Instead, experts recommend a “trauma-responsive” approach, recognizing that many youth cannot immediately control what triggers their negative behavior and such youth often perceive every day occurrences as threatening. The trauma-responsive approach still embraces accountability and treatment, but the approach changes the frame for and responses to youths’ behavior. For example, symptoms or behavior are understood as attempts to “cope and survive.”⁵⁷ The trauma-responsive approach emphasizes relationships between staff and youth as the key to improving youth behavior. Support provided by adults in a trauma-responsive facility is designed to help youth do the following:

- 1. Recognize how they have been impacted by trauma**
- 2. Identify what specifically triggers their trauma related reactions (e.g., angry outbursts, shutting down, aggression, overreacting, self-injury)**
- 3. Learn more appropriate ways to respond.**⁵⁸

The trauma-informed approach requires “significant training, coaching and changes to existing policies and procedures. Management strategies such as isolation and restraint are discouraged due to potentially re-traumatizing youth.”⁵⁹ For example, the Missouri Model, touted by many national experts on juvenile justice reform and recently highlighted in a

⁵³ Georgetown Report, at 45.

⁵⁴ Id.

⁵⁵ Office of Juvenile Justice and Delinquency Prevention, Department of Justice-commissioned technical assistance guide: *Desktop Guide for Working with Youth in Confinement (2014)* at 422 (hereinafter “OJJDP Guide”), found on the web at <http://www.desktopguide.info/>.

⁵⁶ Id.

⁵⁷ Id.

⁵⁸ Id.

⁵⁹ Id.

2015 article on Trauma-informed Care in Juvenile Justice facilities, ensures that new staff are provided at least 200 hours of training in the first two years of work.⁶⁰ Training focuses on everything from group dynamics to trauma-informed care and conflict resolution.

Missouri emphasizes that trauma-informed supports must be provided to youth in *small groups* and in *small settings*.

They emphasize trauma-informed principles as an “underlying theme in training... [Agency] Treatment Beliefs align with trauma-informed principles. Staff are trained in Treatment Beliefs from day one and throughout their employment.”⁶¹ New York juvenile justice administrators partnered with the Sanctuary Network to create trauma-informed care in facilities. According to leadership, this means “not labeling a youth as ‘an aggressive kid’... this puts them in a box and doesn’t open the door to changing behavior.” To engage youth successfully, staff must be supported with intensive and *ongoing training*.⁶²

In North Carolina, administrators worked with the MacArthur Foundation to train staff in correctional centers on trauma-informed care, using curriculum developed by the National Child Traumatic Stress Network. Each youth now has a crisis assessment and response plan that identifies their trauma triggers and which is used to help staff de-escalate them. According to the deputy commissioner for juvenile justice, “I tell people all the time, I want that form wrinkled and with coffee stains on it. I want you to use it all the time.”

Dr. Kinscherff’s report recommends all youth have individual assessments that should “routinely include descriptions of youth triggers, how they look and behave when they are distressed, what works to help them regulate, and the individual elements of a crisis response safety planning” to allow for a more “proactive response to youth before they go into crisis.”⁶³ Dr. Kinscherff also recommends that DCF should “consider developing an integrated treatment model with corresponding clinical skill sets, processes for effective individualized treatment-matching to specific modalities, and specific attention to risk-need-responsivity factors most relevant to each youth’s recidivism risk.”⁶⁴

Leaders across states acknowledge moving from training into daily practice is the most significant challenge in the system, emphasizing the need for quality assurance to ensure fidelity and good implementation. “When it’s the heat of the moment, do you remember [your training?].”⁶⁵ Research confirms that *training* is often the most important indicator of positive outcomes for youth.

DCF should *dramatically* expand and strengthen its pre-service and ongoing training curriculum to ensure robust attention to treatment and trauma-informed principles, with attention also paid to the impact of youths’ learning disorders on efforts to teach and change

⁶⁰ Finkel, Ed. “Juvenile Jails Adopting ACE and Trauma-informed Practices,” Mar. 29, 2015, found on the web at: <http://acestoohigh.com/2015/03/29/juvenile-jails-adopting-ace-and-trauma-informed-practices/>

⁶¹ Id.

⁶² Id.

⁶³ Kinscherff’s Report, at 41.

⁶⁴ Kinscherff Report at 42.

⁶⁵ Id.

behaviors. Training hours should be increased, and trauma-informed curricula utilized from nationally-recognized sources such as the National Child Traumatic Stress Network. (www.nctsn.org). DCF should work with local experts in trauma-informed system reform to assist staff and administrators in skillfully supporting positive outcomes for youth.

II. FINDING: NUMEROUS ALLEGATIONS OF ABUSE AND NEGLECT AT CJTS AND PUEBLO HAVE BEEN MISHANDLED BY DCF

Of significant concern to OCA are the allegations of abuse and neglect by those entrusted with the care and treatment of youth at CJTS and Pueblo.

When there is a concern or an allegation that a youth is physically or emotionally abused or neglected at CJTS or Pueblo, this must be called into the DCF hotline. The hotline will then either “accept” or “not accept” the report for further investigation. If the call is “accepted” then the DCF Special Investigations Unit will review the matter and determine whether a child was or was not abused or neglected. There is no outside entity that is required to weigh in on the acceptance of the allegation, the investigation, or the disposition of the case.

The OCA reviewers looked at how these calls were handled over a period of several months from 2014 to 2015. Many allegations of abuse or neglect are, in fact, called in by agency employees. However, OCA reviewers found numerous issues including the failure to accept and respond to allegations of physical and emotional abuse of youth.

Multiple facility staff spoke with OCA confidentially and raised concerns that certain adults are permitted to verbally abuse or threaten youth: “I’ll knock your jaw out.” “I’ll beat your ass.” “You are a piece of shit.”⁶⁶

A Parole Officer called in an allegation that his adolescent client was being bullied by certain facility staff, that he was called “retard,” and “Forrest Gump.” The allegation was accepted by DCF for investigation but was not substantiated.

OCA’s first concern is that OCA could find no written agency guidance regarding how the DCF hotline-workers should respond to calls alleging abuse or neglect *in a facility or program*. Given that these youth are confined within a locked, DCF-run program, it would seem prudent to err on the side of *ruling-in* allegations for investigation rather than ruling them out.

- In January, 2015, a CJTS clinician reported to the hotline that a staff member got upset with a youth and told the youth that staff was going to have oral sex with the youth’s female family members. The youth was upset and then the same staff member wrote him up, gave him an incident report and placed him in seclusion. The clinician reported that the staff member later apologized to the

⁶⁶ OCA interview with a whistleblower knowledgeable about conditions at CJTS and Pueblo.

youth and promised not to repeat the behavior. The clinician called this incident into the hotline and reported an additional concern regarding the “misuse of authority”. The hotline did not accept the case for further investigation.

- In September, 2015, a report of alleged sexual harassment of boys by a female staff member was called into the Hotline and accepted for investigation. Allegations of sexual misconduct were found in 7 unsigned grievance letters written by multiple youth. Three residents told the DCF investigator that a female staff member made sexualized comments and “deep-throated” bananas in a youth’s presence. Examples of allegations uncovered by the investigator: “While eating a banana, [female staff member] said “it was small for her, she needs something bigger.” “While wrestling with a resident, [female staff member] said “this is the closest she is going to get to him, so you better take advantage of the opportunity, while he has the chance.” A youth “reported that he has come out of the shower and [staff member] has said she wanted to kiss him.” The staff member admitted that she “puts pressure on the pressure points of youths’ neck until [they] yell ‘Auntie.’”

However, investigators did not substantiate neglect or sexual abuse/exploitation as *the investigator found “there is no evidence the comments made or perceived by the residents had any impact on them.”*

Note: OCA does not have information regarding what Human Resources-related responses may have taken place for individuals identified in these allegations.

- In September, 2014, an allegation was called in by a facility unit leader regarding physical abuse of a teenager during a restraint. The youth had a cut or bruise on his left cheek. The Careline did not “accept the case for investigation,” due to “insufficient information.”
- In January, 2015, a CJTS school teacher reported to the DCF Careline an allegation that a staff member slapped a youth in the face while in the gym. DCF declined to accept the case for investigation as there was no allegation that the youth had marks or bruises.
- In April, 2015, a facility manager called the DCF hotline and reported an allegation that a staff member, during an intervention with a youth, grabbed the youth “picked him up and slammed him to the ground.” The report was initially **not accepted** by the hotline for investigation. [OCA learned of this allegation close in time to DCF’s refusal to investigate. OCA challenged this decision and DCF reversed the Careline determination and accepted the allegation for investigation.]

The investigation found the following: Jason, a 14 year old 8th grader, has a medical alert in his file stating that he cannot be restrained on his stomach with any pressure on his abdomen. He has congenital kidney abnormalities and a history of asthma.

The DCF investigator looked at a video tape which showed staff, during the course of a physical intervention, picking up Jason, raising him to shoulder height and slamming him to the floor. Staff placed his knee onto the boy's stomach and chest and put his arm around the boy's throat area. The boy was criminally charged as a result of the incident. The man was not.

Unfortunately, although investigators substantiated the staff member for physical neglect, they decided not to substantiate physical abuse, apparently due to the boy's "lack of injury." However, the boy reported to investigators that his hips and shoulder were sore for days; and given his medical issues, he was at much greater risk of physical harm from the staff member's deliberate actions.

- In October, 2014, a facility staff member called the hotline after finding a grievance from a youth alleging a staff member was sexually harassing him. The Careline did not accept the report for further investigation because the youth had already been discharged and had not specifically expressed being harmed by staff's behavior.

OCA is concerned by multiple allegations that youth are mistreated or even physically abused in the facility. Beyond the incidents reviewed above, OCA learned of the following:

- In June, 2015, an anonymous caller alleged that a staff member allegedly struck a youth at CJTS during a physical intervention. This call was initially "not accepted" for investigation due to insufficient information. The decision not to investigate was reversed when another supervisor at CJTS called the matter in again, stating that the videotape confirmed the youth had been struck in the face during the course of the physical intervention.
- In April 2015, a youth alleged that a staff member bribed him and other youth to hurt another boy in the facility. A second youth corroborated this allegation, stating that a boy was re-entering CJTS (for the 3rd time) and that the day the boy came onto the unit from intake, the staff member said "this asshole's back and whoever beats his ass gets Chinese." The boy learned of the threat and confronted the staff member, who denied it and instead sanctioned the victim.

Multiple youth also alleged that this staff member sexually harasses them, reportedly stating "I'll give a nickel to tickle your pickle. I'll give you a dime to do it another time." The staff member was also reported as telling kids "Do you want to suck my dick?" and "Does your mother have a good mouth?" The investigation found that the victim went to a supervisor and reported his concern that a staff was bribing kids to hurt him. The supervisor did not report this allegation to the Careline. Multiple staff members also reported to investigators that the victim had come to them or that they had heard about this concern, but none of the staff members followed up, one stating that he didn't ask anyone about it because "it was not his business." A supervisor reported that she spoke with the staff member about his lack of boundaries, but that after she would speak with him, he would go "overboard" disciplining and sanctioning youth. DCF investigated all of these

allegations and substantiated the staff member for emotional and moral neglect; DCF also determined that his actions led one youth to attack another. Though the investigation in this case was thorough in many ways, there was no mention of a concern about the lack of follow up by other staff—all of whom are mandated reporters.

- In April, 2015, OCA reviewed incident reports and videotapes of a boy being handcuffed and transported to the padded cell. The boy had just re-entered CJTS for the 4th time and was in the midst of a mental health crisis. He reported that he wanted to kill himself but he would not engage with staff. A clinician met with the boy in his cell, where he was crying and trying to hide under his blankets. The clinician pulled the blanket back and told the boy he had to cooperate. At this point the boy became angry, jumped up and eventually tried to get out of the cell. He was physically and mechanically restrained. En route to the padded isolation cell, the boy struggled and kicked his legs, resulting in all of the adults and the boy falling to the ground. The boy banged his head and shoulder on the unit floor, but was picked up and brought into the isolation cell. Video depicts the boy propped up against the wall of the cell, his head bobbing in circles, while staff remove his handcuffs. As the cuffs are removed, staff pushed him up against the wall and then turned and ran out, closing and locking the door. The boy immediately fell to the ground and lay there, without getting up, for 50 minutes before a nurse (who had previously entered the cell for a total of six seconds) returned and provided him psychotropic medication. Staff and nursing, in response to OCA’s stated concerns of medical and emotional neglect, claimed that the boy was fine, that leaving him in the cell alone was protocol, that he was monitored by the nurse “the whole time,” and that video could not confirm whether he was unconscious or not. DCF’s Special Investigations Unit investigated OCA’s allegation and decided that the incident revealed no abuse or neglect and no program concerns regarding the facility’s handling of this mentally ill and suicidal boy.⁶⁷

The incidents outlined above not only raise significant concerns about the systemic response to allegations of abuse and neglect within the facility, but also about the safety of youth and the culture of the program. Each allegation raised with DCF by OCA is treated as anomalous, an outlier in an otherwise well-functioning program. But to OCA investigators, the pattern of abuse/neglect complaints and findings of investigations reveal critical concerns about an opaque system and the boys (and girls) confined within.

** It is important to note that multiple DCF employees raised concerns about facility culture or the handling of abuse and neglect complaints with the OCA. Multiple DCF employees acknowledged the lack of transparency for operations at CJTS and Pueblo and the inadequate or “superficial” nature of quality assurance and accountability. Several employees asked for assurances about anonymity while others did not. These

⁶⁷ In a July 7 meeting regarding this incident, the DCF legal director informed OCA that the Special Investigations Unit was not required to document program concerns. OCA questioned whose job it is to audit the quality of the program.

whistleblower efforts are critical to shining a spotlight on the need for reforms that benefit youth and the adults trying to serve them.

OCA asserts the following additional concerns related to the above referenced incidents:

1. A lack of transparency regarding complaints and investigations related to abuse and neglect at CJTS and Pueblo.
2. The lack of function for the CJTS Advisory Board in addressing or responding to the type of complaints outlined above.
3. A lack of adequate *record keeping* regarding complaints of abuse and neglect—e.g., complaints that are not accepted for investigation are not maintained in the DCF database.
4. The lack of legislative oversight for abuse/neglect concerns identified at CJTS and Pueblo.
5. The lack of independent process for investigating and responding to allegations of abuse and neglect within the agency. Having a system where concerns of abuse or neglect by DCF employees are handled entirely internally, with all investigative dispositions assisted with advice from the DCF legal department, creates an unsustainable appearance of institutional conflict of interest.⁶⁸

Remedies to Improve Handling of Abuse/Neglect Allegations

1. DCF should develop specific guidance and quality assurance protocols for the DCF Careline regarding handling of abuse/neglect claims regarding facilities and programs.
2. Maintain all records regarding allegations of abuse and neglect regarding facilities and programs.
3. Regularly train all staff members regarding mandatory reporting obligations and protections for reporters.

⁶⁸ *** OCA met with various DCF administrators regarding concerns about Careline processes. Meetings about this issue between DCF and OCA are ongoing and recent discussions with operational managers of the Careline point to the possibility of positive changes forthcoming. Additionally, OCA meets regularly with the DCF Ombudsman, sharing information and concerns about the facility. The Ombudsman's office, with the support of DCF leadership, recently created a new system for the prompt dissemination of information to relevant stakeholders, including OCA, regarding youth grievances and reports to the Careline. In June, 2015, the Ombudsman's office developed a new report regarding youth grievances and this report was shared with the CJTS advisory committee and the OCA.

4. Include the Office of the Child Advocate and, where appropriate, the Office of Protection and Advocacy, in review of findings and program concerns related to abuse and neglect claims.
5. Create a multi-disciplinary team of clinical, and medical experts to consult on facility investigations.
6. Report on expectations and outcomes to reduce allegations and improve response to concerns of abuse or neglect in the facility.

III. FINDING: CJTS AND PUEBLO HAVE INADEQUATE RESPONSE FOR YOUTH AT-RISK OF SUICIDE OR SELF-INJURY.

Eleanor has lived in DCF care for many years. She was hospitalized at a community children’s hospital on two separate occasions in 2013 after attempting suicide. Eleanor eventually ran away from her program in 2014 and was picked up by police and brought to the Pueblo unit in August (Eleanor had a previous charge of assault that she picked up from her stay in the state’s children’s hospital).

After being committed to Pueblo, Eleanor engaged in multiple attempts to hurt herself. One night, Eleanor was found in her room with something tied around her neck. She was observed “not breathing, turning purple.” Staff had to use a rescue hook to get the ligature off. “She showed some signs that she was breathing,” according to the incident report.

Eleanor was very upset that she did not die. “I was so close, I did not feel any pain or hurt, it felt so good just the way I wanted it to be.” Eleanor was not taken to the hospital because she did not want to go, though staff also assessed her as having a persistent cough, a sore throat and strangulation abrasions on her neck. The next day, after review of Eleanor’s lethality, she was taken to a hospital for evaluation.

On another occasion, Eleanor attempted to “cheek” her medications and had to be hospitalized as a suicide precaution. Eleanor has also been arrested multiple times within the Pueblo facility, and as a result she was moved to the Department of Corrections for a month in 2015. Eleanor has never been arrested outside of a DCF-run program.

On May 15, 2015, Eleanor again attempted to hurt herself. She approached staff and told them that she felt depressed and unsafe. She was permitted to return to her room/cell, and after a few minutes a staff member closed the door, leaving Eleanor in her room by herself. Ten minutes later, staff came to check on her and Eleanor was found in her room, bleeding, having cut her arm and leg with an object.⁶⁹ She was transported to the hospital, where her arm was stitched and she was kept overnight for evaluation.

⁶⁹ While Eleanor was in her room, staff conferred and determined that Eleanor would be put on a watch status given her depressed presentation. By the time staff returned to Eleanor she had already hurt herself.

According to a technical assistance guide commissioned by the United States Department of Justice's Office of Juvenile Justice and Delinquency Programming (OJJDP) and published in 2014:

"[b]ecause most incarcerated youth often have three, four, or even all of the listed suicide risk factors, plus the stress of being detained or incarcerated, and restricted access to their typical coping skills (cigarettes, alcohol, other drugs, fighting, sex, running away)—all youth in custody should be viewed as at-risk for killing themselves."⁷⁰

OCA reviewers identified approximately 2 dozen incidents⁷¹ of suicidal behaviors over a 6 month period between 2014 and 2015, with some youth repeatedly engaging in such efforts. Gestures and behavior most frequently entailed a youth tying items of clothing around his or her neck, sometimes necessitating the use of a J-hook (also known as a "rescue hook" to remove the item.⁷²

However, ongoing review of incident reports reveals *additional* episodes of self-harming or even suicidal behavior by youth that are not *coded* as suicidal behavior in the facilities' database. This means that when OCA reviewers run a report from the data-base looking for "suicidal behavior," these additional incidents do not emerge.

Example: 2.15.2015. Code: FAILURE TO COMPLY

Resident was observed covering his window while he was on no access [seclusion] and was over-heard threatening that he was going to "hang it up." He had a radio cord around his neck when staff entered his room to transport him to the padded isolation cell. The boy was physically restrained, moved to the bed and handcuffed. He was then transported to the padded cell as a result of his self-harming behavior.

Accordingly, OCA cannot accurately determine the true number of incidents of self-harm or suicidality during this period of time.⁷³

⁷⁰ OJJDP Guide at 412.

⁷¹ OCA concludes that there may be more than 20 incidents that occurred as not all incidents of self-harm are clearly recorded in a way that can be later measured.

⁷² For comparison, OCA interviews with Court Support Services Division of the CT Judicial Branch in January, 2015 (the Branch administers Juvenile Detention) reveals no record during the last year of suicidal gestures necessitating the use of a J-hook to remove item from a youth's neck. OCA also reviewed CSSD suicide prevention protocols and met with CSSD's outside-contractor regarding the content of results of quarterly audits.

⁷³ Reviewers noted differences in how self-harming or suicidal behaviors were coded and memorialized. Some incidents were coded as "failure to comply" incidents, others as "other." Many were correctly coded as "suicidal behavior" "with" or "without" injury. It is unclear whether a clinical expert familiar with the youth and his record determine how incidents should be coded. It is not clear that *all incidents* of self-harming or suicidal behavior are recorded as significant events and transmitted to DCF Central Office.

Finding: OCA finds inadequate protocols to prevent youth suicide

There has been no defined process at CJTS and Pueblo for auditing, on an *ongoing basis*, the adequacy of suicide prevention protocols or the safety of the buildings and cells.⁷⁴ Expert guidance commissioned by the Department of Justice recommends that facilities should have a “quality assurance process in place to monitor the components of a facility’s suicide prevention program with *immediate modification* made when indicated.”⁷⁵

During a 6 month review by OCA of suicidal behavior, at least 2, and possibly 3, at-risk youth were documented to be behind closed-doors (or in closed door seclusion) and sitting in *blind spots* where they could not be fully visualized by staff.

- *One girl was found by staff, with her back to the wall next to the door and with a cloth tied around her neck so tightly that a rescue hook was used to free her.*
- *Another girl in the Pueblo Unit was in her room at night and staff noted that she was “not in clear view.” The staff member “knocked” on the door and the girl did not respond. Another staff member came over and looked in the window and “could only see [the youth’s] arm.” Only when staff opened the door could they then “see the [girl] laying on the floor alongside the wall with a white rope material tied tightly around her neck. Her face was red and blue.” She had used a cord from her pants to tie around her neck. She had written a six page suicide letter to explain why she wanted to die.⁷⁶*
- *Another boy was documented to be in his cell with the door closed on “safety watch,” when he went into a “blind spot,” and staff could no longer see him.*

OCA was told by DCF in April, 2015 that the facilities were “cleared” by a national expert, however no documentation was produced regarding the purported audits. This issue was addressed during an April 10 meeting between OCA and DCF leadership then again in a May 8, 2015 letter from OCA to DCF, and subsequent correspondence between OCA and DCF. Concerns about the safety of the facility were also raised by *facility staff* who contacted the Hartford Courant—resulting in an August, 2014

⁷⁴ For comparison purposes, the Connecticut Judicial Branch Court Support Services Division, which runs juvenile *detention facilities* (pre-adjudication facilities), contracts for an annual audit of detention facilities’ physical plant and a quarterly audit of its prevention practices as part of a continuous quality improvement effort to address suicidality in the detention centers.

⁷⁵ OJJDP Guide, at 419. (Emphasis added).

⁷⁶ DCF disputes that this youth was in a blind spot during her suicide attempt, but incident reports entered by staff at the time of incident clearly state that only the youth’s arm could be seen, and only when the door was opened could staff see her lying against the wall. OCA reviewers also visited the Pueblo unit and stood in the rooms with doors closed, noting continued blind spots.

article—wherein DCF stated that it had “secured the endorsements of national security consultants who toured the space and deemed it safe.”⁷⁷

However, upon request, facility administration could not produce an expert report for OCA documenting such conclusions. On April 29 and 30th OCA spoke with and exchanged correspondence with the national expert that DCF said “cleared” both facilities. This expert indicated that *he did not* conduct a comprehensive suicide prevention assessment for Pueblo, which would ordinarily consist of an audit of the following: training, intake screening assessment, communication, safe housing, levels of observation management, intervention, reporting, and follow-up/review.

The expert also advised OCA that all facility cells must be made as “suicide resistant” as possible and that “each room or cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to *allow staff a full and unobstructed view of the cell interior.*”

The expert emphasized that with regard to his work for Connecticut DCF that while he toured the now-named Pueblo facility prior to its opening, he gave brief recommendations for DCF’s process and that “it would be inappropriate for anyone to suggest that [he] ‘cleared’ the Pueblo facility and CJTS as having suicide-resistant housing for its youth.”⁷⁸ He further stated that the last time he conducted a comprehensive assessment of CJTS was *9 years ago*.

OCA brought these concerns to the attention of DCF leadership in a letter dated May 8, 2015. Subsequently, facility leadership agreed to commission an annual building audit and a quarterly suicide prevention audit similar to that already employed by the state’s juvenile detention facilities. OCA acknowledges the importance of this agreement for youth served by the facilities. However, OCA is concerned that a new multi-million dollar program was opened for high risk girls without adequate attention to the safety of the physical plant. Recent visits to the facility continue to reveal physical infrastructure issues, including exposed beams and pipes, blind spots and portions of ceilings that are rotted.

Finding: OCA finds inappropriate use of isolation contributes to suicidal and self-injurious behaviors.

The majority of suicidal or self-harming incidents reviewed by OCA occur when a youth is ***already in seclusion***. The response to a self-injury attempt may be to place the youth in further isolation in a padded cell, sometimes transported by a combination of physical

⁷⁷ Kovner, Josh. “Injuries, Restraints Raise Concerns Over Locked Juvenile Unit,” Aug. 06, 2014, found on the web at: http://articles.courant.com/2014-08-06/news/hc-youth-confinement-dcf-0730-20140801_1_transgender-girl-pueblo-unit-solnit-center (“Officers say that Pueblo is not as suicide proof as it should be. There are blind spots in the bedrooms—small areas where a girl cannot be seen from the hallway. In July, one of the girls went into a blind spot and was able to tie a shirt around her neck.”)

⁷⁸ Email from Mr. Lindsey Hayes on file with OCA.

restraint, handcuffs *and even leg shackles*.⁷⁹ **Youth in juvenile justice facilities are considered at risk for suicide simply by being there;**⁸⁰ isolation heightens this risk, *and predictable monitoring (e.g., 5 minute or 10 minute watch) and use of closed-door seclusion (both relied upon at CJTS and Pueblo) is contra-indicated.*

4.13.15.

“Staff entered unit to do an administrative hearing for Roberto. When staff went to Roberto’s room staff looked through the window and the door and saw that Roberto was lying on his bed with the blankets about chest high over him, he appeared to be asleep. Staff knocked on his door to get his attention but he didn’t respond. Staff then informed others to open the door. ... As staff walked to the resident he could see that Roberto’s eyes were open and a thermal top tied tight around his neck. Staff also noticed that it was tied in a slip knot just under his chin. Staff then began to untie the knot and called out to staff for assistance. Others entered the room and assisted in removing the item from Roberto’s neck.

Assistance call was made to remove the item... youth would not respond to medical or clinical staff that responded. Roberto just stayed face down on his bed frame. After a while it was decided that he needed to be placed in the padded cell for his own safety. Due to his out of control behaviors yesterday that led to restraint. He was going to be placed in hand cuffs and shackles for the purpose of transport. As staff attempted to lift him up he began to struggle and started to bang his head. Staff quickly moved in to stop him and applied cuffs and shackles. He was transported to the padded cell and all hardware was removed, staff exited without further incident. Resident placed on 1:1 safety watch.”⁸¹

Roberto can be seen on the videotape brought into the padded cell in handcuffs and leg shackles, surrounded by 4 staff members. He stands in the corner, with his face to the wall, then drops to his knees to allow staff to remove his leg irons. All four staff members exit the padded cell. Roberto then curls in the corner of the cell, face to the floor, and sobs. The video ends. Documentation related to this incident notes that Roberto was later assessed by a nurse through the door of the padded cell. She did not enter. Roberto was medically assessed two hours later but was not seen by a therapist while in the padded cell or during the rest of the day.

⁷⁹ For comparison, Court Support Services Division does not permit the use of mechanical restraints within its detention facilities. When asked about the reason for this policy, Deputy Director Karl Alston reported that cuffs and shackles are considered to be a traumatizing response to crisis behavior.

⁸⁰ OJJDP Guide at 413.

⁸¹ Youth had just been readmitted to CJTS for the 4th time. He would not participate in intake screening, refusing to answer questions. He was placed on a 10 minute watch at that time, per clinical recommendation. Youth has significant mental health disorders and a history of suicidality and suicidal ideation.

Finding: Self-harming behaviors are sometimes dismissed as a youth being “manipulative” or “acting out.”

Following a self-injury by a girl on May 15 where she hoarded a metal pin and cut her arm and leg, leadership at the facility cautioned OCA that the girl’s “attempt” was not serious, that her cutting was “not a big deal,” and that she barely needed a stitch. These types of comments echo what juvenile justice experts warn is the dangerous minimization of suicidal or self-harming behavior.

According to juvenile justice experts, “there is no way to tell if youth are manipulating or truly want to die; ‘Manipulative’ individuals have died by their own hands. Although frustrating and difficult to manage, youth who engage in suicidal behavior solely to solicit attention, facilitate a transfer, or obtain coveted resources can accidentally kill themselves.”⁸²

Finding: Youth Who Engage in Suicidal or Self-Injurious Behaviors May be sanctioned as a Result of Their Behavior

Samuel

Samuel began second shift in locked seclusion (continuing from first shift). He was moved to the padded cell as he continued to try to hurt himself. He attempted on multiple occasions, while in the padded cell, to tie his clothing around his neck. At one point he had a thermal shirt tied around his neck and staff entered the padded cell to remove it. Samuel then held onto staff’s leg and wouldn’t let go. He was calm for a little while but then began to tie clothing around his neck again. At this point staff had to re-enter the padded cell where Samuel had been left alone. Samuel struggled with staff and tried to keep the shirt tight on his neck, forcing staff to cut it free with a rescue hook. Samuel was then alone again in the padded cell. Several hours later, Samuel was again attempting to self-strangulate; staff entered the padded cell and again tried to remove the shirt from Samuel’s neck, placing him into a 2-person restraint while Samuel struggled and grasped their clothing. Staff tried, but were unable to get Samuel in the prone position. Samuel was given a “Major” Administrative Sanction for “Engaging staff in a restraint.” He was kept in the padded cell for approximately 6 hours.

Nathan

In September, 2014, Nathan broke a clock and took the pieces and cut his arm in several places. Later when asked why he hurt himself, he answered “I don’t know,” but said that he was “stir-crazy” in his cell. Two days later Nathan went to the bathroom and wouldn’t come out. He was physically restrained, handcuffed and moved to the padded isolation cell. While in the cell, he attempted on multiple occasions to tie clothing around his neck. He found or had hoarded wooden sticks into the cell and picked at his skin and wounds, bleeding on his leg. As a result, staff repeatedly entered the cell, restrained Nathan and then left, locking the door. Nathan continued to escalate, taking his clothes off, spitting

⁸² OJJDP doc. pg. 415.

and urinating in the cell. In response to this crisis behavior, Nathan received multiple Major Sanctions for “Engaging Staff in a Restraint,” “Assault,” “Contraband,” and “Bodily Waste.” Nathan remained on sanction status for the next two days, “out-of-program” and “unit bound.”

Jenny

Jenny is a 16 year old girl who is committed to DCF as an abused and neglected child and as a juvenile delinquent. She has been confined at Pueblo for a year. Jenny has experienced repeated traumas and struggles with unpredictable and dysregulated behavior. She presents with significant mental health needs. Jenny wants to live with a family. During periods of low utilization in 2015, Jenny was at times the only girl at Pueblo

On May 30, 2015, Jenny was very upset after a phone call with her mother. She refused to return to her room. Staff were not sure how best to respond to Jenny and repeatedly urged her to return to her room. There were no clinicians there and no one called the on-call clinical staff.⁸³ Staff “touch prompted” Jenny to encourage her to move. Jenny flailed back in response, using her arms and legs to fight the physical restraint—a predictable response for a youth with chronic PTSD. Jenny was eventually handcuffed and brought to the padded isolation cell. While in the cell, she tied her shirt around her neck and attempted to self-strangulate. Staff entered the cell and had to use a rescue hook to cut the garment off her neck. She was then left alone in the cell again. She attempted again to tie clothing around her neck but began having an asthma attack. Jenny later stated that the call with her mother made her very sad and that she didn’t know what to do with that feeling so she became angry instead. She said that she didn’t really want to kill herself, but that she didn’t want to be left alone in the cell. Jenny was arrested for felony assault for this incident.

Reggie

Reggie was in his cell and “blocking the window of his room.” He did not respond to staff knocking on his door. The door was opened and the boy was lying on his stomach with a shirt over his head. He told staff “I am going to be dead in 4 minutes.” The staff member physically removed the shirt but then found that the boy had a shoe string “tightly tied” around his neck. He had already “turned purple” but was still breathing. Staff yelled out for a rescue tool and the ligature was cut off. Medical was called and in the interim the boy was told to walk to the padded cell. En route he was “combative” and therefore was physically restrained. The boy was taken into the cell and the door was closed. He then became “angry and combative to himself.” A nurse and staff member then went in and talked to the boy and he was able to calm down. “Resident will be getting charged with creating a disturbance, engaging staff in a restraint and bodily waste.” He was sanctioned with 3 days of Out of Program and 3 Days of Unit Bound Time, seclusion to be used “as needed.” Reggie later told staff that he tried to hurt himself because he was not able to contact his family and he feels more comfortable in the hospital.

OCA sought and reviewed over a dozen facility debriefings of suicidal behavior and other significant events during an 18 month period at CJTS and Pueblo. Typically, the debriefing

⁸³ See also Kinscherff, R. *Strategic Review of CJTS/Pueblo Girls Program Policies and Practice* (July 1, 2015) at 39 (noting the absence of clinical staffing during 2nd and 3rd shifts).

documents contain a summary of events surrounding the suicide or self-injury attempt and an outline of individual staff members' responses. These reports often note whether an incident report was timely or properly filed; whether the handheld video recorder was used; whether appropriate restraint techniques were used. Only one debriefing reviewed by OCA documented how the youth's escalation or self-harm could have been avoided. Documents do not clearly contain a clinical analysis of circumstances leading to the crisis or the appropriateness of staff response.

Finding: Suicide Prevention Training for Staff is Not Adequate

OCA found through documentation and interviews with CJTS staff that training for staff regarding suicide prevention has been deficient. The "Shield of Care" suicide prevention training was *just added* in May 2015 to the mandatory pre-service training for staff, but only with an abbreviated version.⁸⁴ The Shield of Care is an 8 hour training, and the pre-service training for CJTS and Pueblo includes less than ½ of it. While the addition of Shield of Care is an improvement in the training curriculum, the hours offered will still fall short of what is recommended in guidance commissioned for facilities by the DOJ which sets a standard of mandatory, "up to date and interactive training on suicide prevention" of 8 to 16 hours for "Every facility staff who comes into contact with or makes decisions about youth."⁸⁵

REMEDIES

1. All state-run or state-contracted juvenile justice facilities should undergo an annual audit of physical plant (units, rooms, isolation cells) for suicide resistance; and a quarterly independent audit of suicide prevention practices and protocols;
2. Consistent with the juvenile justice standards promulgated by the Annie E Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI), training supports should be increased for all staff members. JDAI standards, revised in 2014, recommend 160 hours of training for staff during the first year of employment and 40 hours in each following year. Missouri, nationally recognized as a leader in juvenile justice reform, adheres to this recommendation offering 200 hours of training to staff in the first two years of employment.
3. All suicidal incidents should trigger a comprehensive case review and a mortality/morbidity review with participation from clinical and facility operations experts.

⁸⁴ Interview with CJTS Operations Management, Ron Brone, Ph.D., July, 2015.

⁸⁵ OJJDP Guide at 415.

IV. OCA finds that Isolation is Unlawfully Used in Response to Mental Health Crisis and as a Punitive Sanction.

12/19/14. Clinical Case Management Note by youth's primary clinician.

“This clinician met with Samuel in the padded cell along with [State Police Officer stationed at CJTS]. Samuel vented frustrations about abandonment from his mother and his conflictual relationship with other family members, he talked about his inability to do well in the community and the fact that he believes he will remain here for a long time because ‘no one likes him or cares about him.’ Samuel appears to feel helpless and hopeless as he stated that if he doesn’t reach his goals to do well in the community he will ‘end it.’—referring to killing himself because he’d ‘rather die without a record than with one.’ Samuel’s facial expressions were intentful as he did not smile while he stated that he will end it. This clinician encouraged Samuel to take care of himself by way of seeking out medical attention in efforts to keep himself in emotional control however he continues to dismiss use of medical intervention. Youth also reported that he felt overwhelmed with his schedule and service providers while living in Hartford. He spoke with this clinician and [State Police Officer] at length until he was calm enough to return to his room. He was escorted back to his room without incident.”

Over a three day period from December 17 to December 20, Samuel spent 16 hours in the unit’s padded cell. The note above is from December 19 and reflects the only time he was seen by his clinician. Samuel spent a significant portion of his time at CJTS over the next 7 weeks in seclusion or on 1:1 (sometimes at his own request). On some of these days he received no treatment, and he had limited contact with clinical support staff other than for a “status assessment,” (assessing his risk of harm to self and others and determining level of staff supervision.)

On December 17th Samuel was handcuffed and placed in the padded cell for over 5 hours. He had no clinical support while in the padded cell⁸⁶ and on at least 4 occasions, staff had to enter the isolation cell to restrain him from hurting himself. On December 18th, he was again secluded for over 5 hours and did not see a clinician. On December 20th, Samuel was seen by the on-call clinician who “touched base” with him to determine his “watch status” and to see if he was willing to take Benadryl to reduce his anxiety.

This pattern continued for Samuel, who would go days in between treatment sessions, isolated from peers and removed from programming.

⁸⁶ According to CJTS clinical notes contained in the database.

Dr. Kinscherff’s recent report noted that records suggest “clinicians have a relatively limited role when a youth is on room restriction or in seclusion. This role reportedly is often limited to conducting brief mental status and suicide assessments during periods of restricted movement or seclusions.”⁸⁷ Best practices, Dr. Kinscherff recommended, “call for more clinical engagement during episodes rather than less engagement, active use of de-escalation strategies, and access to ‘sensory rooms’ to facilitate self-soothing rather than traditional seclusion or room restriction.”

Samuel’s Seclusion Chart over 4 days in December. The “check” symbol indicates when seclusion included time in the padded cell.

Seclusion	12/20/2014 08:15 PM	12/20/2014 10:50 PM	✓
Seclusion	12/19/2014 10:00 AM	12/19/2014 11:12 AM	✓
Seclusion	12/18/2014 03:00 PM	12/18/2014 08:30 PM	✓
Seclusion	12/18/2014 01:42 PM	12/18/2014 03:00 PM	
Seclusion	12/18/2014 07:00 AM	12/18/2014 08:34 AM	
⁸⁸ periodic room confinement	12/18/2014 12:00 AM	12/18/2014 12:00 AM	
Seclusion	12/17/2014 11:00 PM	12/17/2014 11:20 PM	✓
Seclusion	12/17/2014 09:16 PM	12/17/2014 11:00 PM	✓
Seclusion	12/17/2014 09:12 PM	12/17/2014 11:00 PM	✓
Seclusion	12/17/2014 05:45 PM	12/17/2014 08:50 PM	✓
Seclusion	12/17/2014 05:40 PM	12/17/2014 06:00 PM	
Seclusion	12/17/2014 03:20 PM	12/17/2014 04:20 PM	

National Standards Regarding Isolation (aka “seclusion” “room confinement” “solitary confinement”)

The Juvenile Detention Alternatives Initiative, established by the Annie E. Casey Foundation, promulgated standards to support improved conditions of confinement in juvenile detention centers across the country.⁸⁹ These standards, revised in 2014, provide the following regarding the use of isolation/seclusion:

⁸⁷ Though DCF collaterals informed Dr. Kinscherff that there is more clinical support during crisis periods than is readily apparent, Dr. Kinscherff noted that if this is the case, then “clinicians should more consistently document their engagement with youth.” Kinscherff Report at 44, N. 92.

⁸⁸ Periodic Room Confinement, despite the use of the term “periodic” means that a youth is confined to his cell and the door is closed, but *unlocked*. The youth may not “pop out” without permission and if the youth does “pop out” then the youth will be placed in *seclusion*. Periodic Room Confinement as used at CJTS constitutes seclusion as a matter of law.

⁸⁹ The Juvenile Detention Alternatives Initiative, established by the Annie E. Casey Foundation, targets overall juvenile justice system improvement. JDAI strategies and standards are also used to improve conditions of confinement in juvenile detention centers without compromising public

1. Isolation should never be used other than for brief periods to prevent immediate risk of physical harm;
2. Isolation can never be used for longer than 4 hours;
3. Isolation can only be used if staff provide continuous one-on-one crisis intervention and observation;
4. Any youth who cannot be calmed within 4 hours must be transferred for mental health evaluation and intervention.

National juvenile justice experts caution that while youth with trauma histories must be held accountable, facilities must also be aware that such youth are vulnerable to re-traumatization when youth are:

1. Confined and locked in small rooms.
2. Physically restrained, especially by multiple staff members at once.⁹⁰

Isolation can be harmful for the youth the facility is serving. OCA has reviewed many incidents where youth *escalate* while in the padded cell.⁹¹ Nationally, experts agree that isolation is particularly harmful for adolescents.

FINDING: Youth with Significant Disabilities Experience Inappropriate Restraint, Seclusion and Removal from Programming and Education

Throughout the last 10 months OCA has reviewed concerns with DCF about its reliance on restraint, seclusion, and restrictive measures and sanctions in the facility to address behavior that may arise from youths' documented psychiatric disorders.⁹² Information regarding the use of isolation, restraint and restricted status is inaccurate or, at times, absent.⁹³

safety. JDAI strategies are being employed in over 30 states. Although JDAI addresses reforms for juvenile detention facilities and not specifically training schools, the standards are an important reflection of best practices in the juvenile justice system.

⁹⁰ OJJDP Guide at 404.

⁹¹ OCA recently reviewed a video tape where youth was in the padded cell and a staff member came in, spoke soothingly, offered comfort, but within a minute or two left and closed the door. It is clear that the protocol is to leave the youth alone and close the door, when perhaps it should be to sit with them for as long as necessary to engage and return to a less restrictive environment.

⁹² Data reveals a facility where, between January and March, based on the monthly census data, approximately 1/4 to 1/3 of youth were subject to a physical or mechanical restraint and approximately 30 percent of youth were subjected to *documented* locked-door seclusion. *However, certain youth* are secluded or restrained with *much greater frequency* than other youth; some youth may be restrained or secluded seldom.

⁹³ OCA asked DCF Central Office for monthly Emergency Intervention reports (seclusion and restraint) from CJTS and Pueblo, beginning with September, 2014 and OCA informed DCF that the previous official reports provided to OCA from Central Office were *discrepant* with facility documentation. DCF did not produce subsequent ESI reports. An email from DCF to OCA dated January 12, 2015 responding to OCA's ongoing request for this information indicated that "discrepancies" remained and the reports *may be forthcoming*. (Emails on file with authors.)

School Removals

School attendance data obtained from DCF from September 2014 through February 2015 reveals over 30 youth who missed a substantial portion of at least 2 weeks of the facility's school. Several missed substantial portions of more than 4 weeks of school.

Reasons for absences are variable and include "refusal," "clinical," "off-grounds," among other documented reasons, but OCA is most concerned about youth who miss school due to restricted status, suspension or refusal. According to the CJTS Manual, youth may be removed from school for any of the following behaviors:

1. Foul language;
2. Horseplay (touching);
3. Disruptive behavior;
4. Refusal to give point card.

Youth may also be suspended from school for lengthier periods for more disruptive or combative behavior.

Federal law and Education in Juvenile Correctional Programs

The law provides that any youth suspected of having a disability who needs special education services must be evaluated in a timely manner. Students with individualized special education plans (IEPs) must be provided appropriate services.

A recent guidance letter from the United States Department of Education, dated 2014, specifically provides that "any exclusion from the classroom is particularly harmful for students with disabilities in correctional facilities."⁹⁴ Students in correctional programs are also entitled to protection regarding disciplinary removal from school. A suspension for more than 10 days or a *series of suspensions* that total more than 10 school days is considered a change in educational placement necessitating due process protections under federal education law.

OCA's finding that more than 30 students missed a substantial portion or all of 10 days of school within a less-than six month period of time raises significant concern about practices that lead to removal or absence from the educational setting at CJTS and Pueblo.

At least 100 youth missed some school due to restricted status, with a range of 1 missed day to more than 30 missed days. Multiple attendance records reviewed by OCA reveal youth who missed more than 10 days of school for *punitive* reasons with some youth losing significantly more than 10 days. Note that these absences are only over a 5 month period and do not reflect cumulative absences over an entire school year.

⁹⁴ United States Department of Education, Office of Special Education and Rehabilitative Services, "Dear Colleague Letter on the Individuals with Disabilities Education Act for Students with Disabilities in Correctional Facilities" (2014).

FINDING: OCA Found Repeated Examples of Seclusion Being Used For Discipline and for Administrative Convenience

Consistent with numerous studies that confirm the harmful and non-therapeutic impact of seclusion, Connecticut law states that seclusion can only be used in facilities (including CJTS and Pueblo) as “an emergency intervention to prevent immediate or imminent injury to the person or to others, provided the seclusion is not used for *discipline or convenience and is not used as a substitute for a less restrictive alternative.*”⁹⁵

Moreover, as Dr. Kinscherff’s recent report observed, “in a trauma-informed model, the need to use a restraint or seclusion is viewed as a clear intervention failure and so considerable effort is given following the episode to assess the process leading to restraint and seclusion with the individual and the staff involved...”⁹⁶

Based on OCA’s investigation and review of practices, OCA finds that CJTS frequently used both physical and social isolation in response to both mental health crisis behavior as well as for discipline and convenience. It is critical to note that facility administration strongly disputed OCA’s findings, claiming “CJTS and Pueblo do not use seclusion as a disciplinary measure, yet it appears from your report [a previous outline of findings and recommendations provided by OCA to DCF in April, 2015] that is what we do.”⁹⁷

However, volumes of records reviewed by OCA give rise to these determinations. For example, there have been at least 175 of instances over the last 12 months where a youth was placed in seclusion during second shift on day one, and then kept in seclusion *for part or all of the following day*, despite the lack of imminent risk of injury or any assessment of risk. Often the use of such prolonged seclusion is described as *due to previous behavior*.

“Roberto was secluded due to *an incident the previous evening (emphasis added)*. Given breakfast, allowed to complete hygiene, and use the bathroom. At 10:20 a.m. he came out to use the bathroom and refused to return to his room because he was upset about being secluded. As a result youth had to be restrained, handcuffed and placed in padded cell.... Youth was majored [an administrative sanction] for resisting movement, creating a disturbance and engaging staff in a restraint.”

Here, Roberto was secluded *as a routine matter* then restrained and placed in the padded cell because he did not want to be secluded. His escalation given prolonged seclusion is predictable and consistent with the overwhelming research about the harmful effects of isolation on children.

⁹⁵ Conn. Gen. Stat. § 46a-150

⁹⁶ Kinscherff Report, at 17-18.

⁹⁷ Email from W. Rosenbeck, DCF Facility Superintendent, to OCA, dated May 21, 2015, on file with OCA.

Samuel. Code: Failure to Comply.

“Samuel was off task needing repeated redirects by this writer. He continued to be off task and became disrespectful. Once at the café for lunch. Samuel was placed in his room for Reflection Time [authors’ note: undocumented seclusion].⁹⁸ His time was *extended* until he displayed appropriate behavior.” (Emphasis added.)

National standards for juvenile justice facilities, including JDAI and Performance Based Standards (PBS), as well as guidance from the Department of Justice, acknowledge the utility of brief room confinement or separation to address imminent risk, sometimes created by a very dysregulated youth or two youth who are fighting.

However, while the use of seclusion as a brief response at CJTS may be warranted, OCA found that seclusion in multiple cases was prolonged, often for several hours, and sometimes for an entire day or *successive days*.

Data

Much has been discussed by stakeholders regarding how big a problem restraint and seclusion is or is not at CJTS and Pueblo. DCF has asserted on multiple occasions that only a small percentage of youth account for many restraints. While it is true that a cohort of youth with significant behavioral health issues are the recipients of a disproportionate number of physical and mechanical restraints or lengthy seclusions, OCA asserts that this *helps to characterize* but does not *minimize* the urgency of the issue.

Moreover, OCA looked at a 100 day period during the course of the investigation⁹⁹ during which time approximately 30 percent of youth were subjected to documented locked-door seclusion, sometimes in the units’ padded isolation cells.¹⁰⁰ While certain youth are secluded with much greater frequency than other youth, research consensus around the country confirms the destructive impact of repeated or prolonged isolation for *all* children and youth.

⁹⁸ Note: This use of cell confinement was not documented in CONDOIT reports as seclusion.

⁹⁹ January through end of March, 2015.

¹⁰⁰ Seclusion, per Conn. Gen. Stat § 46a-150 *et seq.* requires seclusion and restraint to be used only in response to *an emergency*. Allegations made to OCA by staff from CJTS indicate that not all seclusion is documented, including group seclusion and “reflection time.”

Prolonged Seclusion

To review pattern and practice issues, OCA examined the use of seclusions at CJTS and Pueblo that were for durations of 4 hours or longer. A leading set of national standards for managing youth in a correctional setting **limits isolation to 4 hours or less, and never for purposes of punishment.**¹⁰¹ However over a six month period of time during the pendency of OCA's investigation CJTS *frequently used seclusion for periods of 4 hours or longer*, with at least 225 documented incidents of seclusion for 4 hours¹⁰² or longer, of which almost 100 were at least 8 hours or longer.¹⁰³

OCA found numerous incident reports documenting lengthy seclusions where youth are described as “cooperative” or “compliant.” Such youth may be allowed out of their cells for hygiene and meals, but will stay on locked seclusion status for hours at a time, or even an entire day.

First shift, two youth are both “in chairs” outside their cells, on “out of program” status. They verbally provoke each other. Each are put into their cells and placed on seclusion status for several hours. During the second shift, one of the boys stays in seclusion “due to the previous incident.” Staff document that the boy is “cooperative” and “compliant.” He remains on seclusion status for another additional 5 hours.¹⁰⁴

In April, several youth began fighting. After the fight was broken up, the boys were placed in seclusion. The next day, one boy remained in locked seclusion status for the entire first shift (8 hours), during which time staff documented that he “followed all directives.” By second shift however (and nearing the 24 hour mark in his cell), the boy was becoming agitated--and staff documented that *because of his agitation* he would have to stay in seclusion, not only for

¹⁰¹ JDAI Standards, cited herein.

¹⁰² Aug., 35 seclusions were longer than 4 hours (of which 20 were 8 hours or longer); Sept., 32 seclusions were longer than 4 hours (13 were 8 hours or longer); Oct., 44 seclusions longer than 4 hours¹⁰², (18 were 8 hours or longer); Nov., 45 seclusions longer than 4 hours (19 were 8 hours or longer); Dec., 25 seclusions longer than 4 hours (only 4 were 8 hours or longer); Jan. 44 seclusions longer than 4 hours (19 were longer than 8 hours).

¹⁰³ OCA has continuing concerns about the reliability of this data and believe that these numbers month to month still represent an *undercount* of actual isolation. For example, one December report indicates that a youth *was not* in seclusion, however incident reports document that the youth was in his cell *banging on the door*.

¹⁰⁴ Jason.

the rest of the day, but also for first shift the following day. Indeed, the next day, the boy was kept in seclusion though staff documented that he had “no issues.” He stayed on seclusion status (with some rotation out his cell) for the entire day. This period of isolation lasted for almost 60 hours with no documentation of an ongoing emergency as required by law.

Again, the use of seclusion in this manner is not only harmful to youth, isolating them and removing them from positive or therapeutic programming, it also *violates Connecticut law*. Multiple reports document similar trends: the use of prolonged isolation into a second day for something that happens the day before; and increased agitation on the part of the boy (or girl) in seclusion. One youth, on April 3, was secluded into a second day. He did okay for the first 8 hours, with staff documenting that he had “no major issues,” but as seclusion continued for another 5 hours into the evening, records indicate that he became agitated and anxious, threatening to harm himself or others if he was kept in isolation.¹⁰⁵

Youth may return to seclusion for failure to follow basic directions. One boy was kept in seclusion for almost 2 full days. When staff first rotated him out of his cell on day two, records indicate that he would not do his “hygiene routine.” As a result he was placed back in locked seclusion for the rest of the day.¹⁰⁶

FINDING: Seclusion and Out of Program/Unit Bound Time Harm Youth and Block Access to Rehabilitative Programming

OCA finds that often boys and girls are “stepped down” from locked seclusion to a sanction status called “out of program” (OOP). OOP status may go on for multiple days. It requires the child, when not in school, to “sit in a chair” outside his cell for the duration of the OOP status. He or she may not interact with others. According to the CJTS Manual, if the boy refuses to sit in the chair, he is “considered a danger” based on his “noncompliance” and will be placed in seclusion. If the youth repeatedly tries to interact with others, he will be placed in seclusion until he can comply with OOP “norms.” If too many boys are on OOP status, facility policy states that a schedule be utilized to rotate boys from chairs to locked seclusion. Youth who “violate” OOP norms may have to start their time all over again.

OOP status is routinely used as a response to noncompliant or misbehavior in the facility. It may also be used as a sanction for behavior arising out of a mental health crisis: OOP sanction was used when one youth tried to hurt himself with sticks; OOP sanction used when one youth tried to strangle himself and had to be restrained; OOP sanction used after a youth who was locked in the padded cell stripped naked, urinated and smeared feces on the walls after attempting self-injury.

OOP status concerns reviewers due to the lack of utility and rehabilitative benefit; the reliance on social isolation and removal from prosocial programming for youth who

¹⁰⁵ K,R

¹⁰⁶ D., Apr. 2015

depend on such programming to build skills and rehabilitate; and the over-use of this restricted status for youth with documented disabilities.

One youth talked to facility staff about his behavior challenges and his struggle with being on "Status." He said he felt some relief when he was moved from the chair (OOP) to only being "unit bound." He said that when he is "unit bound" he can still participate in games and activities, and that this helps him cope with his anger and frustration.

Sanctions for misbehavior specifically include seclusion and out-of-program time.

Elliot started the day in seclusion. He remained in seclusion for the next 8 hours, with documentation that he "followed all staff directives." After 8 hours of seclusion, Elliot asked if he could sit in a chair outside of his cell as an alternative to staying completely isolated. Staff told him he couldn't do this, because *despite his compliant behavior*, he was *still on seclusion status*. Elliot wouldn't go back in, and staff had to physically put him back in seclusion where he stayed for the rest of the day. Staff documented that Elliot "worked hard at maintaining control." The next day, Elliot was moved to OOP status. However, as he sat in the chair, he talked and rapped. As a result Elliot was "violated" and had to start OOP status all over again.

On May 3 Carlos was placed in seclusion at 2:30 p.m. after fighting with another boy. He stayed in seclusion for *the rest of the day*, though reports described him as compliant. Despite the lack of ongoing emergency, Carlos stayed in his cell overnight and began seclusion *again* on first shift the next day, where he stayed for another 2 1/2 hours before being let out.

On May 9, Franklin was placed in seclusion during second shift for getting into a fight. He remained in seclusion into the next day, and stayed in seclusion for another 7 hours on May 10. While in seclusion, Franklin was described as compliant.

FINDING: OCA finds that youth with disabilities have been placed in prolonged seclusion for multiple days at a time

DCF asserted to OCA that it did not seclude youth for multiple days and that OCA’s findings were erroneous or misleading.¹⁰⁷ However OCA’s findings arise of out a review of the data above and incident reports from DCF’s database.

The following is the seclusion chart for one youth who entered the facility in early January, 2015. Note that the term “periodic room confinement” is used to distinguish room confinement from locked seclusion. This is a distinction not recognized by Connecticut law. Per the facility manual, Periodic Room Confinement means that a boy or girl is confined to their cell and may not come out. The only distinction is that the door is not locked. All “PRCs” should be considered seclusion as a matter of law.

Seclusion Chart for one youth (13 years old) over a 2 week period in January, 2015

Seclusion	01/23/2015 07:00 AM	01/23/2015 03:00 PM
Seclusion	01/22/2015 03:00 PM	01/22/2015 08:30 PM
Seclusion	01/22/2015 03:00 PM	01/22/2015 08:30 PM
Seclusion	01/22/2015 07:00 AM	01/22/2015 03:00 PM
Seclusion	01/21/2015 03:00 PM	01/21/2015 08:30 PM
Seclusion	01/21/2015 02:35 PM	01/21/2015 03:00 PM
periodic room confinement	01/20/2015 03:00 PM	01/20/2015 08:30 PM
Seclusion	01/20/2015 07:00 AM	01/20/2015 03:00 PM
Seclusion	01/19/2015 03:00 PM	01/19/2015 08:30 PM
Seclusion	01/19/2015 07:00 AM	01/19/2015 03:00 PM
Seclusion	01/18/2015 05:55 PM	01/18/2015 08:30 PM
Seclusion	01/18/2015 05:50 PM	01/18/2015 08:30 PM
periodic room confinement	01/18/2015 07:00 AM	01/18/2015 01:24 PM
periodic room confinement	01/17/2015 03:00 PM	01/17/2015 08:30 PM
periodic room confinement	01/17/2015 12:00 PM	01/17/2015 03:00 PM
Seclusion	01/17/2015 07:00 AM	01/17/2015 12:00 PM
Seclusion	01/16/2015 03:00 PM	01/16/2015 08:30 PM
Seclusion	01/16/2015 11:15 AM	01/16/2015 03:00 PM
Seclusion	01/16/2015 07:00 AM	01/16/2015 08:00 AM
Seclusion	01/15/2015 03:00 PM	01/15/2015 08:30 PM
Seclusion	01/15/2015 02:36 PM	01/15/2015 03:00 PM

¹⁰⁷ Multiple conversations with DCF staff; call from DCF Legal Director in January, 2015 asking for more information regarding allegations that youth are secluded for multiple days.

Seclusion	01/12/2015 07:00 AM	01/12/2015 07:50 AM
Seclusion	01/11/2015 05:20 PM	01/11/2015 08:30 PM

**During this prolonged period of seclusion,
there is no school and no access to programming.**

OCA found many instances during the course of our investigation where youth were placed in seclusion over a period of several days, with one boy placed in locked seclusion for 9 days in a row.¹⁰⁸ Many of these youth are diagnosed with significant psychiatric or developmental disorders, including Post Traumatic Stress Disorder, histories of physical and sexual abuse, Depression and Expressive Language Disorder. When OCA brought these concerns to facility leadership, administrators responded that such youth are violent, necessitating a restrictive response.

However, prolonged isolation and over-reliance on physical restraint violate state law. Experts around the country, including the Department of Justice, the Council of Juvenile Correctional Administrators, and the American Academy of Child and Adolescent Psychiatry,¹⁰⁹ all agree that prolonged isolation not only fails to address problematic behavior, but can harm youth physically and emotionally, worsening their chances for rehabilitation. According to a recent Annie E. Casey Publication, Robert Listenbee, administrator of the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP), “wrote a letter to the American Civil Liberties Union confirming OJJDP’s official position that “isolation of children is dangerous and inconsistent with best practices and that excessive isolation can constitute cruel and inhumane punishment.”¹¹⁰

¹⁰⁸ J. M. [diagnosed with Mood Disorder, Post-Traumatic Stress Disorder, Conduct Disorder, as well as a victim of physical and sexual abuse] Secluded for *9 days in a row due to aggressive behavior*.¹⁰⁸ 10.7, 10.8, 10.9, 10.10, 10.11, 10.12, 10.13, 10.14, 10.15.

¹⁰⁹ Sedlak, Andrea & McPherson, Karla. United States Department of Justice, Juvenile Justice Bulletin "Conditions of Confinement: Findings from the Survey of Youth in Residential Placement," 2010. (describing the issues between youth and the staff when placed in solitary rooms that are locked during the day); PBS Learning Inst., “PBS Goals, Standards, Outcome Measures, Expected Practices And Processes,” 2007, found on the web at: <http://sccounty01.co.santa-cruz.ca.us/prb/media%5CGoalsStandardsOutcome%20Measures.pdf>. (stating that “The adolescent development portion of staff training presents the negative repercussions and ineffectiveness of long-term isolation and the rationale for shorter brief isolation periods . . . Isolation . . . should not be used as punishment.”); American Academy of Child and Adolescent Psychiatry, "Solitary Confinement of Juvenile Offenders," 2012, found on the web at: http://www.aacap.org/aacap/policy_statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx ("The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis. Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse reactions").

¹¹⁰ Listenbee, Robert. United States Department of Justice, "Letter to Senior Legal Counsel of ACLU" July 5, 2013

Extensive research and guidance commissioned and promulgated by the federal government states that rather than protecting staff, the reliance on seclusion and restraint *increases* the risk of harm to youth and adults.

Finding. OCA discovered one youth who has been placed in locked seclusion for over 400 hours while at CJTS.

One youth, who has a long history of suffering physical and emotional abuse, is diagnosed with Post Traumatic Stress Disorder, Depression and Conduct Disorder. He is alternately characterized by DCF as aggressive, angry, small, vengeful, traumatized, likeable and engaging. He does, without question, display the most aggressive behavior of any youth that OCA has encountered at CJTS. When asked about the prolonged and repeated use of seclusion for this youth, OCA was given by DCF a list of the youth’s aggressive behaviors. Indeed, this boy has been repeatedly assaultive to both youth and staff. And yet authors submit that this boy exemplifies the futility and harm of relying on seclusion to change the boy’s behavior and promote rehabilitation and safety.

Placing him repeatedly in isolation only gives rise to a harmful cycle of deterioration for the youth and others around him. ***All youth who enter CJTS will exit CJTS and return to his or her community. If they are not rehabilitated, there is no gain for public safety.***

Type	Start Time	End Time	Padded Cell
Periodic room confinement	10/14/2014 07:00 AM	10/14/2014 03:00 PM	
Seclusion	10/13/2014 03:00 PM	10/13/2014 08:30 PM	
Seclusion	10/13/2014 07:00 AM	10/13/2014 03:00 PM	
Seclusion	10/12/2014 03:00 PM	10/12/2014 08:30 PM	
periodic room confinement	10/12/2014 07:00 AM	10/12/2014 03:00 PM	
periodic room confinement	10/11/2014 03:55 PM	10/11/2014 08:30 PM	
Seclusion	10/11/2014 03:00 PM	10/11/2014 03:55 PM	
Seclusion	10/11/2014 07:00 AM	10/11/2014 03:00 PM	
Seclusion	10/10/2014 03:00 PM	10/10/2014 08:30 PM	
Seclusion	10/10/2014 07:00 AM	10/10/2014 03:00 PM	
Seclusion	10/09/2014 03:00 PM	10/09/2014 08:30 PM	
Seclusion	10/09/2014 07:00 AM	10/09/2014 03:00 PM	
Seclusion	10/08/2014 03:00 PM	10/08/2014 08:30 PM	
Seclusion	10/08/2014 07:00 AM	10/08/2014 03:00 PM	
Seclusion	10/07/2014 05:20 PM	10/07/2014 09:00 PM	✓
Seclusion	10/07/2014 07:00 AM	10/07/2014 12:00 PM	
Seclusion	10/07/2014 12:00 AM	10/07/2014 12:01 AM	

OCA is aware that some will point to this boy's assaultive behavior as *justification* for the use of harsh sanctions. However, the use of seclusion above exemplifies the tensions

investigated by OCA between a treatment-based, trauma-informed approach to youth and a correctional milieu. This boy is diagnosed with multiple mental health disorders, has lived for years in the custody of DCF due to his history of abuse and neglect, and he is only 16 years old. During the 8 day period of isolation charted above, *a total of 170 hours in locked confinement*, without peer interaction, without school, this boy saw a clinician only once, and then not again for a week, even after he was found in his cell on day 7, non-communicative, lying on his belly with blood on the floor which “appeared to be coming out of his nose.”¹¹¹ Staff called for a nurse, but then after the boy was assessed, the room was cleared and the boy locked in again. “Resident violated status and will resume on ‘no access.’”

Remedies to reduce physical and social isolation

1. It is important to acknowledge that DCF is already taking recent steps to reduce lengthy isolation at CJTS and Pueblo. Updated guidance has been issued by facility administrators, and recent policies are examining and reducing the practice of secluding youth for misbehavior from a previous day. OCA notes that a review of recent data confirms that isolation practices are changing in recent months in the facility.
2. DCF should adhere to juvenile justice standards for isolation/solitary confinement, as promulgated by the Juvenile Detentions Alternatives Initiative (JDAI) and Performance Based Standards (PBS). Currently, nearly 200 jurisdictions in 39 states and the District of Columbia have relied on the JDAI standards to re-shape their juvenile justice systems.¹¹² To date, however, CJTS and Pueblo have declined to use PBS and JDAI and instead rely exclusively on standards promulgated by the American Correctional Association.
3. OCA spoke to Missouri’s Director of Youth Services in June, 2015 who stated that the state has been phasing out the use of isolation rooms across the continuum of juvenile justice placements. The Director noted that isolation can be traumatizing and counter-productive for children and staff.
4. Connecticut should follow the Toolkit for Reducing Isolation in Juvenile Facilities, recently developed by the Connecticut Juvenile Correctional Administrators (CJCA) in March 2015.
5. Consistent with the guidance from the CJCA, isolation means “any time a youth is physically and/or socially isolated for punishment or for administrative purposes.” Accordingly, CJTS and Pueblo should examine and revise its practice of sanctioning youth with “out of program” days.

¹¹¹ CJTS incident report, 10/14/14.

¹¹² JDAI Helpdesk, found on the web at: <http://www.jdaihelpdesk.org/default.aspx>

6. Many states are moving to ban isolation as a punitive measure (note, however that Connecticut's law already does this). A recent proposed bill in California proposed a statewide limit on isolation and would prevent the use of isolation for youth whose behavior arises out of a mental illness. The bill emphasizes the need for increased staff training and utilization of mental health treatment facilities.¹¹³
7. One California County looking to limit the use of isolation in the wake of legal challenges, agreed to cap the use of confinement to four hours, consistent with the recommendations from JDAI.¹¹⁴

OCA FINDS INAPPROPRIATE USE OF PHYSICAL AND MECHANICAL RESTRAINT.

Pursuant to state law, restraint may only be used to respond to a risk of *imminent harm*. OCA has reviewed numerous incident reports and videotapes depicting unreasonable, dangerous and unlawful restraints. Indeed, it was the depiction of unlawful restraint on girls at the Pueblo Unit in July 2014 that raised significant alarm for OCA reviewers and accelerated an investigation into conditions of confinement.¹¹⁵¹¹⁶

OCA's review of facility incident reports over a 12 month period (July 1, 2014 through July 1, 2015) reveal *at least* 532 physical restraints and 134 uses of mechanical restraints (handcuffs or shackles).¹¹⁷ Additionally OCA looked at a 100 day period during the course of the investigation¹¹⁸ which revealed that approximately 1/4 to 1/3 of youth each of the 3 months were subject to a physical or mechanical restraint (this includes handcuffs and leg shackles).¹¹⁹

¹¹³ Therolf, Garret, "Advocates Seek to End Solitary Confinement Options for Young Offenders," Los Angeles Times, May 28, 2015, found on the web at: <http://www.latimes.com/local/crime/la-me-solitary-juvenile-20150528-story.html#page=1>

¹¹⁴ Bundy, Trey, "Bay Area County will End Youth Solitary Confinement per Settlement," Reveal News, May 21, 2015, found on the web at: <https://www.revealnews.org/article/bay-area-county-will-end-youth-solitary-confinement-per-settlement/>

¹¹⁵ OJJDP guidance clarifies that restraint should not be used to address non-compliant behaviors and that facility policies must clarify this. OJJDP Doc. pg. 565.

¹¹⁶ Staff must be continually supported in efforts to provide trauma-responsive care, which permits consequences for negative behavior but allows staff and youth to work together to "1) identify and understand what triggers his reactions and negative behavior and 2) practice new and more appropriate responses when triggered." OJJDP Doc. pg. 423.

¹¹⁷ To tally restraints, OCA reviewers hand-counted and reviewed incident reports involving aggressive or non-compliant behavior in the facilities, that regardless of incident coding (e.g., "failure to comply," "fighting," "other,") contained documentation of a physical or mechanical restraint.

¹¹⁸ January through end of March, 2015.

¹¹⁹ Restraint numbers include any physical hold, inclusive of physical escorts, standing restraint, supine restraint, prone restraint and mechanical restraint (handcuffs). The census numbers for January through March, 2015 were 96, 88 and 98 respectively. Actual children served may be slightly higher. Individual youth subject to restraint: January (27) February (27) March (26).

Though Connecticut law requires that physical and mechanical restraint or seclusion be used only to “*prevent immediate or imminent injury to the person or to others,*”¹²⁰ restraints have repeatedly been depicted on video tapes and in incident reports at CJTS and Pueblo as a routine behavior management response. Some of these restraints have escalated situations to the use of the handcuffs, shackles and even the arrest of youth who physically respond to the restraint itself.

Juvenile justice experts caution against sanctions that are issued without “exploring whether there are potential vulnerabilities or alternative explanations for a youth’s behavior. *For example, aggression [should not receive] the same penalty whether it is exhibited by a sophisticated gang member carrying out a hit, a traumatized youth trying to protect himself or herself from a perceived attack, or an intellectually disabled youth responding out of intense frustration.*”¹²¹

Standards from the Juvenile Detention Alternatives Initiative also provide that physical force may only be used when a “youth’s behavior threatens imminent harm to the youth or others or serious property destruction.”

January 21, 2:35pm. Staff tried to process incident with Youth and his peer. Youth had a difficult time with the discussion and process session and refused to process or go back to his room. He was restrained and handcuffed.

February 19, 8:28 p.m. J¹²² was sitting in a chair outside his cell throughout second shift due to being on “Out of Program status.” Staff warned him several times that he was not allowed to talk to other youth while he was on status. After he took a shower, he asked staff if he was “violated” because he talked. He got upset and kept insisting he should not be “violated.” He was told to go into his cell at 8:30 p.m., but he refused and instead sat down at his door again. Staff called for assistance and then physically restrained him to bring him into his cell. He was restrained on the bed in a face-down position. He was handcuffed and transported to the padded cell. J received multiple Major sanctions for Creating a Disturbance, Resisting Movement and Engaging Staff in a Restraint. The sanctions resulted in more “out of program” and unit bound time.

¹²⁰ Conn. Gen. Stat. § 46a-152

¹²¹ OJJDP Guide at 422.

¹²² J

On November, 26, E was in seclusion on first shift because of a problem the day before. He completed hygiene routine and used the bathroom. However, after using the bathroom he insisted that he could not return to seclusion. He was very upset. According to the incident report, E “had to be restrained, handcuffed and placed in the padded cell.” E received multiple Major sanctions for Resisting Movement, Creating a Disturbance and Engaging Staff in a Restraint. These Sanctions came with more restricted status time.

Jenny was talking on the phone while her clinician stood nearby. At some point during the call the clinician told Jenny that time was up, but she insisted on continuing to talk. A video tape of this incident, which led to felony assault charges for Jenny, depicts the clinician leaving the room and returning with 4 youth service officers. They begin moving furniture and preparing to restrain her. Jenny sees them approaching and throws the phone away as a staff member takes her arm. A very violent restraint ensues with staff grabbing Jenny’s side and her head. Two others grab her feet and she falls to the ground. Jenny flails and tries to hit as staff lean on her arms and legs. The clinician returns to the room with a video camera to record the incident. Jenny can be seen on the video screaming. She is handcuffed and brought to the padded cell. Once there, Jenny cries and begs staff to leave the handcuffs on because once the cuffs are removed, she knows she will be left alone in the cell. She keeps saying that she doesn’t want to be alone. The agency police officer who arrived on the scene sits down next to Jenny and puts his arm around her. He tells her they won’t close the door. She is eventually brought to the hospital. Jenny is criminally charged for this incident.

Eleanor was standing in the corner of the hallway of the girls’ unit, holding a bowl of peanut butter, milk and bananas. She was told to go to her room, but she continued standing in the corner. According to the incident report she “threatened staff” with her snack. A video tape of this incident shows Eleanor standing in the corner as staff fill up the hallway, one with a video camera and another with an impact cushion, preparing for a restraint. Eleanor stares at them but doesn’t move. In less than 3 minutes staff move in for a physical take-down. Eleanor is taken to the floor. Multiple adults lay on her arms and legs. She was on the floor for about 45 minutes while she kicked and flailed and

yelled. Eventually Eleanor was handcuffed and shackled and taken to the padded cell. She continued to yell and scream. In the padded cell, Eleanor tried to choke herself with clothing. Staff had to enter the cell and cut off the material with a rescue hook. Eleanor was charged with felony assault for threatening and hitting staff.¹²³

Restraint is also traumatizing for other youth and staff who only witness it. A clinician at CJTS was called to the school one day to see a boy who reported being upset after seeing another youth being restrained in the in-school suspension room. The clinician met with the boy who told him that another youth was taken down for refusing to leave the room. The boy told the clinician that he was “particularly upset” because he felt that the other youth was “tiny” and was “man-handled” by a large group of staff. The clinician validated the boy’s feelings and then congratulated him for almost completing his own 10 day suspension from school.

Remedies to Prevent and Reduce Restraint and Seclusion

Guidance commissioned by the Department of Justice provides that “decreasing and eventually eliminating, the isolation and restraint of youth housed in juvenile and adult facilities typically requires:

- 1) A major cultural shift involving everyone from administration to line staff;
- 2) Significant staff training;
- 3) Practical coaching on the units;
- 4) Accountability for staff behavior (e.g., rewarding effective use of less restrictive management strategies, and disciplining inappropriate use of isolation or restraint).¹²⁴

Additionally, experts caution that “disruptive behavior should not be viewed as a violation and disciplinary event; instead, it should be seen as acting out and be dealt with as part of a *treatment or behavior management protocol*.”¹²⁵

DCF has taken recent steps to address the concern of unlawful restraint at CJTS and Pueblo. DCF sent some staff to a training on the Six Core Strategies—an evidence based framework for

¹²³ See Kinscherff Report, FN 41 (“... youth can incur additional charges for misconduct while at CJTS or Pueblo Unit which can or will result in their transfer for adult criminal justice adjudication or incarceration in adult facilities. This is a developmentally, legally and socially a severe outcome for an adolescent. Since the stakes are so high, what process is or should be in place to reliably distinguish between those youth whose incident(s) of serious institutional misconduct—most commonly physical assaults on peers or staff—reflects predatory/instrumental violence from those whose misconduct reflects extreme demoralization or desperation, emotional dysregulation, deficits in social regulation or judgment, cognitive distortions, or other need subject to rehabilitative intervention in the juvenile justice system?”).

¹²⁴ OJJDP Guide at 442.

¹²⁵ *Id.*

reducing and eliminating reliance on restraint and seclusion, in use in mental health facilities throughout the country.

DCF has also created a committee at CJTS to review how to implement the teachings into practice. Adding training curriculum to support staff's ability to engage youth in a trauma-responsive manner will help reduce reliance on restraint and seclusion.

Restraint and seclusion must be seen, as demonstrated by ample evidence around the country, as *increasing* rather than decreasing the risk of staff and youth injury. Additionally, both OCA and Dr. Kinscherff recommend that specific protocols be established to "identify youth at CJTS and Pueblo who are failing to stabilize with routine facility structure and services... a specific duration of a single episode of seclusion or a specific number of restraint/seclusion episodes within a specified time frame should trigger a report to senior leadership," and a multi-disciplinary review of treatment planning.¹²⁶

V. OCA FINDS INACCURATE OR ABSENT MEASURES REGARDING CONDITIONS AND OUTCOMES OF CONFINEMENT

OCA's report regarding conditions at CJTS comes in the wake of a two substantial technical assistance reports crafted for DCF by national experts in the field. The Georgetown report, completed in 2013, leads off by stating that DCF's "Division of Juvenile Services (DCF-JSD) was able to provide only the most elementary data for the system analysis in [the experts' report]. ... It took substantial time and effort to assemble even the most basic information. ... It is impossible to establish and manage a modern data-driven system without valid and reliable data."¹²⁷ In the wake of the Georgetown report, DCF Central Office has been taking positive steps to increase the agency's capacity to collect and respond to data, though these reforms have not yet meaningfully improved quality assurance at CJTS. Throughout the duration of OCA's investigation, OCA continually struggled to obtain meaningful, reliable information about facility functioning, conditions and outcomes for youth.

Significantly, OCA conversations with several members of the DCF Executive Leadership Team revealed few individuals who had thorough knowledge of operations or conditions at CJTS.

Dr. Kinscherff's recent technical assistance report states that "it is critical that DCF continue to develop the electronic infrastructure to support key aspects of policy and practice development for juvenile justice operations," and that will allow for review and reporting regarding "program practices and outcomes" including recidivism, education and employment.¹²⁸

¹²⁶ Kinscherff Report, at 36. ("Youth identified by this protocol should be promptly reviewed and an individualized management plan updated to reflect these crisis incidents and a response plan consistent with the Six Core Strategies approach.")

¹²⁷ Georgetown Report at 3.

¹²⁸ Kinscherff Report at 27-28.

The current DCF database for CJTS and Pueblo has been characterized as a “mess’ in terms of its operational utility for CJTS and Pueblo.”¹²⁹

Finding: Reports Regarding Seclusion are Unreliable

Facility database reports do not consistently match up with narratives of incidents or videotape depictions. Administrators say that this is because staff enter something wrong in the heat of the moment and that this is later corrected by leadership. However, OCA found multiple occasions where an aggregate report indicated that no seclusion was used on a particular shift, while the *case narrative* states that a youth was largely or entirely confined to his cell for the same period of time. These discrepancies cannot be explained.

Finding: DCF Unable to Produce Reliable Data Regarding Restraints

The facilities are required to report data regarding the monthly use of restraint and seclusion to DCF Central Office. This requirement mirrors the expectation for all private providers licensed by DCF. However, OCA reviewers found significant discrepancies between the DCF Central Office reports and CJTS/Pueblo documentation (including video tapes) regarding restraint and seclusion of youth.

OCA asked for and received from DCF Central Office documentation of ESI (restraint and seclusion) incidents for the months of April through August, 2014. OCA compared the August ESI report to *all* facility reports available for the same time period and found *significant variances* with the DCF Central Office report. OCA was told that this was likely due to in-correct inputting or double-inputting at the facility level. OCA requested and received a sampling of videotapes for the same time period which confirmed restraints as recorded in narratives, but that *did not appear* in DCF’s Central Office report. OCA found discrepancies to be significant. For the month of August, OCA found at least 30 incidents observable in facility reports and/or video tapes that were not documented in DCF’s Central Office report.¹³⁰

OCA subsequently asked for continuing ESI reports from DCF Central Office, beginning with September, 2014 and OCA informed DCF that the recent official reports were discrepant. DCF did not produce subsequent ESI reports. OCA sent multiple requests for this information over a period of months. An email from DCF to OCA dated January 12, 2015 indicated that “discrepancies” remained and the reports may be forthcoming.

¹²⁹ *Id.* at 28 quoting collateral sources. Dr. Kinscherff’s report states “A variety of factors contribute to this situation, reportedly ranging from having only one person who as administrative rights to run and “clean up” data, to a pervasive lack of accountability for timely entering of accurate data, to some information not being available because individuals keep records separately from the CONDOIT system.”

¹³⁰ In verbal conversations with DCF over several months in 2014, leadership indicated that OCA may be “over-counting” or “double counting” incidents because of how line staff enter or document such incidents in CJTS’s case management system (CONDOIT). OCA carefully sought to avoid duplicate counting, and when in doubt, *did not* count uncertain events as ESI incidents. For the month of August, OCA read each individual incident report that indicated possible use of restraint or seclusion.

However, OCA is concerned that DCF continues to make public assertions about the duration or frequency of these interventions while having failed to produce the data for OCA. Multiple CJTS staff confidentially told OCA that not all incidents of seclusion are documented, that on certain units, seclusion is used without following protocols for reporting, that the duration of seclusion may be under-reported and that certain types of seclusion such as “reflection time,” or “group seclusion” are not documented at all.¹³¹

Finding: CJTS and Pueblo do not Track Out of Program or Unit Bound Time

The frequency of facility reliance on OOP status for youth is *not measured* in the facility database. When questioned, administrators stated that they are not legally required to track the usage of such restrictions.¹³² However, authors conclude that the facility should track the use of restrictive status as an important condition of confinement. Authors also conclude that DCF is required to track the use of restrictions to the extent that such restrictions act as a barrier to services, particularly for youth with disabilities.

Finding: Education Attendance and Instruction is not Adequately Measured at CJTS and Pueblo.

OCA cannot obtain up-to-date educational attendance data from the CJTS database. In February, 2015 OCA requested from DCF Central Office educational attendance data for youth at CJTS and Pueblo, academic year-to the present. Data produced by DCF in response to this request revealed more than 30 youth (out of a total 160 who attended some school during this 5 month period of time) who missed a significant portion of at least 2 weeks of school. Several youth missed more than 4 weeks of school. The school is housed within the facility. The boy who was secluded for more than 400 hours missed more than 7 weeks of school. Absences are coded by period, with a documented reason for lack of attendance, including “awaiting hearing,” “unit bound,” “refusal” or “suspension.” Data produced by DCF rarely noted that a youth was receiving Unit Bound Instruction.

OCA presented DCF with the information regarding the frequency with which boys and girls miss school in the program, and the inappropriate reliance on exclusionary discipline within a rehabilitative/treatment setting. Administrators replied, in part, that the data was incorrect and that any youth who is Unit Bound receives Unit Bound Instruction.¹³³ Yet OCA concludes that accurate data collection and structured review of attendance trends is required to ensure adequate, individualized instruction for confined youth.

Finding: Monthly Progress Reports Contain Duplicative, Inaccurate Information or Do Not Document Critical Information

OCA reviewed over 150 monthly progress reports for youth at CJTS. Reports varied considerably in attention to detail, accuracy and relevance. While some reports contained up-to-date, carefully considered information regarding a youth’s presentation, many did

¹³¹ OCA review of records confirms some of these allegations; e.g. use of “reflection time” without documentation as seclusion; use of group confinement without documentation as seclusion.

¹³² Statement of the DCF Legal Director to OCA, meeting on April 10, 2015.

¹³³ At this point in time OCA is requesting additional documentation regarding this data point.

not. Reports repeatedly did not identify or address any educational considerations, progress in school, suspensions or loss of instruction. Reports frequently did not accurately identify the rate of seclusion or restraint for a youth during the review period. Reports did not document the frequency with which youth were restricted to a unit or a chair losing access to rehabilitative programming. Reports at times contained identical language regarding a youth's progress (or lack thereof) from month to month. Reports did not always accurately reflect the participation of youth in therapeutic programming or the number of visits or family sessions. Errors and omissions were found by OCA to be significant.

Finding: DCF does not Adequately Track Abuse/Neglect Allegations for Quality Assurance Purposes

OCA found numerous instances of allegations of abuse and neglect of youth at CJTS or Pueblo that were called in to the DCF Careline and not-accepted for further investigation (See Section I of this report). Per DCF practice, however, reports that are not accepted for investigation are *not maintained* and disappear from the system within 60 days. Accordingly, a detailed analysis or audit of abuse/neglect allegations for CJTS and Pueblo over the last 24 months was not possible. OCA concludes that this is a serious deficiency in the quality assurance framework for the facility.

CONCLUSION

The critical issues outlined in this investigative report regarding CJTS and Pueblo—publicly funded juvenile correctional programs--require collective and urgent attention. Youth housed in juvenile justice programs have many treatment needs and are at heightened risk for poor and harmful outcomes, up to and including suicide. Girls and boys at CJTS and Pueblo require intensive, trauma-informed supports in the least restrictive environment appropriate to their risk and need levels.

This report also raises significant systemic questions. How well do publicly-funded facilities function? How do we know? What is their purpose? Who should be involved in decision-making regarding their future use? These are material questions raised by this report and echoed in ongoing stakeholder discussions regarding juvenile justice reform and mental health system transformation. Change is about people as much as it is about systems. OCA credits the efforts of many individuals working within and without the juvenile justice system, including the many professionals at DCF, families, policy makers, service providers and advocates. Change and system transformation will require continued collaboration and leadership, and OCA appreciates the public statements of DCF regarding this effort.

Ultimately, CJTS and Pueblo do not just belong to the Department of Children and Families, they belong to the public, and the facilities' performance and the condition of youth within these programs is an urgent matter for public attention. This report is OCA's sober attempt to respond to citizen concerns raised with this office and to fulfil our legal function for system oversight and advocacy for children.