



**STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE**

**INCARCERATED/DETAINED YOUTH - AN EXAMINATION
OF CONDITIONS OF CONFINEMENT**

**EXECUTIVE SUMMARY
WITH FINDINGS AND RECOMMENDATIONS**

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INTRODUCTION

The Office of the Child Advocate (OCA) is an independent state oversight agency directed by law to investigate and report on the efficacy of child-serving systems, investigate unexplained and unexpected child fatalities or critical incidents involving a child, review complaints of persons concerning the actions of any state or municipal agency providing services to children, and periodically review the facilities and procedures of any and all institutions or residences, public or private, where a juvenile has been placed by any agency or department.¹ The OCA was created in 1995 in response to the death of an infant involved with the Department of Children and Families (“DCF”).

In July, 2015, the OCA published an investigative report regarding conditions of confinement within two state-run juvenile correctional facilities, (i) the Connecticut Juvenile Training School for boys and the (ii) Pueblo Unit for girls – both facilities operated by DCF. The OCA’s investigation came in response to several complaints regarding the conditions for youth within those two programs. OCA’s report, published after an 18 month long investigation, included an extensive review of facility documents and video-tapes, and detailed findings regarding youths suicidal behavior, facilities’ restraint and seclusion practices, and deficient handling of allegations of abuse and neglect of youth within the facilities.

Subsequent to the publication of the OCA report, Governor Dannel Malloy announced his intention to permanently close the Connecticut Juvenile Training School by July, 2018. The state’s Juvenile Justice Policy and Oversight Committee (“JJPOC”), created pursuant to Public Act 14-217, continues its efforts to support youth rehabilitation and ongoing improvement of public safety outcomes, with attention to diversion of low-risk youth, and delivery of a continuum of services and interventions for children with more complex needs. A critical component of the JJPOC’s work is to ensure provision of appropriate rehabilitative services to the highest risk youth in need of treatment in secure programs.

Conn. Gen. Stat. § 46a-13/(12) requires the OCA to report to the legislature regarding conditions of confinement for youth detained or incarcerated in the juvenile and adult criminal justice systems.² Accordingly, this report provides information regarding key issues affecting such youth, including: (1) suicidal behavior and suicide prevention; (2) use of force (restraint) and physical isolation (seclusion) of youth; (3) availability and utilization of clinical and rehabilitative programming; (4) access to educational programming for youth; (5) access to family visits and family therapy/engagement; and (6) child abuse/neglect reporting and prevention, in the following state-run juvenile and adult correctional facilities:

- Juvenile Detention Facilities (Bridgeport/Hartford) — Operated by the Judicial Branch’s Court Support Services Division (“CSSD”);
- Department of Correction Adult Correctional Facilities that House Minors—Manson Youth Institution (MYI) (boys) and York Correctional Institution (YCI) (girls);

¹ Conn. Gen. Stat. § 46a-13k *et. seq.*

² Section 46a-13/(12) provides that the Child Advocate shall “[p]repare an in-depth report on conditions of confinement, including, but not limited to, compliance with section 46a-152, regarding children twenty years of age or younger who are held in secure detention or correctional confinement in any facility operated by a state agency. Such report shall be submitted, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to children not later than March 1, 2017, and every two years thereafter.”

- Connecticut Juvenile Training School (“CJTS”) — Operated by the Department of Children and Families State-Run Juvenile Correctional Facility (Locked) for Boys Through April 2018—Now Closed.³

The period under review (“PUR”) was July 1, 2016 through June 30, 2017, unless otherwise noted. Given the scope of review, this report addresses each of the six key issues, with relevant findings by agency. The report concludes with a series of issue specific recommendations for consideration by agency leadership and state policy makers.

EXECUTIVE SUMMARY

OCA’s review of conditions for youth incarcerated in state-run facilities confirms that children/youth of color remain disproportionately confined and incarcerated in Connecticut’s state-run facilities, and that the deeper youth go into the correctional system, the less likely they are to receive any developmentally appropriate programming—supports necessary to help youth change their behavior and successfully discharge back to their communities without committing new offenses.⁴

Children/youth, particularly boys with the most complex needs, who are incarcerated in the adult criminal justice system, are the most likely to lose meaningful access to education, rehabilitative services, visits with family, even the ability to purchase hygiene products or extra food, if they are deemed a risk to the general youth prison population. These boys, the children/youth who often need the most help--are counterintuitively the most likely to go without help in the adult prison system. They are the most likely to be placed in repeated or prolonged physical and social isolation while incarcerated, a practice that research consistently shows has devastating impact for youth, increasing their risk of mental health deterioration and suicide.

OCA also found that while some policies regarding provision of care and treatment to incarcerated youth in the juvenile justice system are developmentally appropriate and progressive, attention to facility operations and compliance with agency policies remains an urgent priority for further review by stakeholders and agency leaders. OCA recognizes the comprehensive reform work that state agencies are engaged in to support better outcomes for juveniles and their communities, with continued success in diverting lower-risk youth to community-based services and away from detrimental engagement with the criminal justice system. The OCA is encouraged by the DOC’s recent discussions with the Vera Institute of Justice to review its policies, procedures and practices for detained youth.

³ Despite its closure in May 2018, the analysis of CJTS remains in this Report as it offers relevant comparative information regarding the management and treatment of incarcerated youth.

⁴ Connecticut correctional facility admission data continues to show that incarcerated youth are disproportionately African American/Black and Hispanic. Research shows the disproportionate minority contact in the justice system is both a national and a local problem: Racial and ethnic minorities are often disproportionately represented in the juvenile justice system. The observed disproportionality cannot be fully explained by differences in delinquent behavior across racial and ethnic groups. Disparities were found in system processing of minority youth, even when controlling for social and legal background variables at various points of juvenile justice systems across the country. A 2017 report by, commissioned by, found that disparities in system process of minority youth in Connecticut continues to affect rates of detention and incarceration for children of color. Addressing racial inequities in the juvenile and criminal justice system must be an urgent and core priority for all stakeholders. Source: Spectrum Associates Market Research, “An Assessment of Disproportionate Minority Contact in Connecticut’s Juvenile Justice System,” (Nov. 17, 2017), submitted to the Office of Policy and Management, available on the web at: https://www.ct.gov/opm/lib/opm/cjppd/cjjyd/jjydpublishations/ct_2017_dmc_assessment_study_final_report.pdf

However, OCA also found that throughout the child-serving juvenile and adult correctional system, substantial work remains to support better outcomes for the highest-risk youth. A determination must be made by policy makers and agency leaders as to the supports that incarcerated youth require, the work that needs to be done with them and their loved ones, and how such work can be most effectively accomplished in the context of the facilities that confine youth and the communities they come from and will return to. The state's reform work must also include development of a transparent framework for ensuring the provision of effective rehabilitative programming for incarcerated youth. Finally, the state needs to consider whether conditions can even be created for youth in adult facilities that will promote effective rehabilitation and public safety goals.

OCA found that, with regard to incarcerated youth, there are few, and in some cases, no universal standards in Connecticut law or agency practices regarding a) the provision of mental health services; b) the use of isolation or force; c) strategies to prevent or respond to youth suicidal/self-harming behavior; d) provision of educational services; e) family engagement and relationship building; or even f) prevention and reporting of child abuse and neglect.

OCA finds that the lack of a standard, developmentally informed approach for incarcerated youth and the lack of a transparent framework for publishing information regarding the efficacy of secure care is highly problematic for the state's twin goals for youth incarceration-- promoting youth rehabilitation and improving public safety, in part due to the lack of information regarding what help youth actually receive while incarcerated and whether that help is adequate or effective. The lack of uniform standards can also place youth and facility staff at risk of harm, and may result, in some cases, in violations of state and federal law and deeply concerning conditions of confinement, particularly for minors in the adult prison system.

“Adult-style prisons that emphasize confinement and control are devoid of the essentials required for healthy adolescent development---engaged adults focused on their development, a peer group that models prosocial behavior, opportunities for academic success, and activities that contribute to developing decision-making and critical thinking skills.

At the same time, these facilities provide too many of the elements that exacerbate the trauma that most confined youth already experienced and reinforce poor choices and impulsive behavior. Maltreatment is endemic and widespread.”

McCarthy, Patrick, Vincent Schiraldi, and Miriam Shark. *The Future of Youth Justice: A Community-Based Alternative to the Youth Prison Model. New Thinking in Community Corrections Bulletin*. Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2016. NCJ 250142, available at

<https://www.ncjrs.gov/pdffiles1/nij/250142.pdf>.

CASE STUDY - NATHAN⁵

Nathan, an African-American teenager from one of Connecticut's urban communities, was 16 when he was incarcerated at MYI on multiple felony charges.⁶ A review of Nathan's story shows time after time that when he needed or asked for help, he didn't get it or didn't get enough. Throughout his young life, Nathan's family was the subject of more than 16 reports to DCF alleging abuse and neglect of Nathan and other children in the family home.⁷ Nathan first became involved with Juvenile Probation when he was 8 years old and he was the subject of a Family with Service Needs Petition for "truancy." By age 10, Nathan was placed on juvenile probation after a charge for Breach of Peace for fighting.

By the time Nathan was 14 years old, he had been incarcerated in juvenile detention five times, with the 5th admission lasting for more than 100 days—90 days more than the average length of confinement for youth detention. While in detention Nathan presented with signs of Post-Traumatic Stress Disorder and he reported being afraid of his peers. Nathan is a special education student with multiple clinical diagnoses, including Borderline Intellectual Functioning, Conduct Disorder, ADHD, and enuresis (involuntary urination, especially by children at night). In juvenile detention, Nathan struggled with behavioral control, suicidal ideation, peer and staff relationships and frequent refusal to engage in school. He was placed in room confinement or physically restrained on multiple occasions.

Detention management attempted a variety of interventions for Nathan, including advising staff about necessary precautions in addressing his behavior, instructing staff on how best to talk to Nathan, and learning how to verbally prompt Nathan so he could understand facility expectations. Various safety measures were taken for Nathan, and he was placed on multiple mental health precautions due to his statements about wanting to harm himself, his repeated behavior of tying items around his neck, and his hoarding a sharp object to self-injure. After more than 3 months in detention, Nathan was discharged to the Connecticut Juvenile Training School (CJTS)-a secure juvenile correctional program for boys run by DCF. Nathan was adjudicated a Serious Juvenile Offender and committed as a delinquent to DCF custody.

The CJTS admission notes for Nathan documented his difficulties in detention, and that he had been placed on suicide watch several times for threatening to hurt himself or others. Nathan initially struggled at CJTS as well, and he experienced restraint and seclusion and sanctions on multiple occasions. Nathan did have a period of time at CJTS where clinical notes indicated that he began to settle in and engage more in counseling. However, he struggled again towards the end of his stay when there was no clear discharge plan.

After 11 months at CJTS, Nathan was discharged to his father's home. Nathan's father, like his mother, had previously been placed by DCF on the state's Central Registry of child abusers due to DCF's finding of a "pattern of substantiated [maltreatment]." While Nathan was incarcerated at CJTS, his father participated in only three family therapy sessions and he did not show up for the final two.

⁵ Pseudonyms are used for all youth referenced in this Report.

⁶ Robbery in the First Degree, Larceny in the Sixth Degree, Home Invasion and carrying a Dangerous Weapon (a BB gun).

⁷ Reports were made to DCF in 2002 (2); 2006; 2007; 2009; 2010 (3); 2011; 2012; 2013; 2014; 2016; 2017; 2018 (2). When Nathan was a baby, DCF substantiated neglect given concerns about how the children were being cared for. When Nathan was 6, DCF received a report that the children's living conditions were poor and they were not attending school, but the allegations were unsubstantiated and the case closed because DCF could not locate the family. When he was 8, Nathan told an adult at school that his mother ties up his 6 year old sibling and puts tape over the 6 year old's and a baby sibling's mouth as punishment and to keep the baby from crying. The children's mother denied what Nathan was trying to tell adults at school, and authorities did not substantiate the case. Reports of suspected abuse and neglect continued for the next several years about Nathan and his siblings, including reports of physical abuse, substance abuse, lack of housing, medical and education neglect, all without sustained intervention and help for Nathan. There were significant untreated mental health issues with Nathan's family.

During this time Nathan had a hard time at CJTS as his anxiety around discharge and his fears that he would not be successful in the community grew. Nathan heard through peer connections at CJTS that he might be targeted by peers in the community, and on several occasions he asked staff if he could remain incarcerated and not go home.

Nathan was ultimately discharged to his father's custody with DCF Parole Supervision and referrals for two community-based services.⁸ Nathan did not participate actively in either service. Nathan quickly struggled in the community, left his father's home, and lived briefly with other relatives. His records show he gravitated towards neighborhoods where he smoked marijuana, was at risk of escalating criminal behavior and of being targeted and harmed by peers and adults. He did not initially attend school upon discharge, due to what his record characterized as "issues with enrollment."

Within 3 months of discharge from CJTS, Nathan was arrested again and this time he was transferred to the adult prison system, incarcerated at the Department of Corrections' Manson Youth Institution (MYI). Since being incarcerated, Nathan has continued to struggle with behavioral control, suicidal ideation, and aggression, and he has experienced multiple sanctions, including physical isolation for days at a time.

Due to fights with peers and other violations of facility directives, Nathan has been placed multiple times in restrictive housing at MYI, on a sanction status called "Confined to Quarters (CTQ):" consisting of 23.5 hours per day of isolated cell confinement and no access to school or rehabilitative programming.⁹ Nathan accumulated over 70 days in CTQ isolation over 9 months. Despite Nathan's history of substantial mental health issues and current needs, a review of his record over a two month period where he was placed in isolation on multiple occasions indicates that Nathan was primarily seen only for brief mental status checks and not for individual therapy sessions or other clinical programming. Nathan remains incarcerated. He is 17 years old.

OCA FINDINGS: CSSD DETENTION FACILITIES

SUICIDAL BEHAVIOR AND SUICIDE PREVENTION

1. CSSD policy and practice recognizes the potential risk of self-harm for all youth admitted to detention.
2. During the PUR, CSSD reported 688 incidents of youth placed on suicide watch status, and 41 occurrences where constant observation was needed to support actively suicidal youth.
3. OCA's record review revealed multiple occurrences of youth being placed on Constant Observation, on different occasions throughout their stay in Detention, for self-injury, suicidal ideation and restricted statuses.

⁸Multidimensional Family Therapy-Re-entry/Family Treatment (MDFT-RAFT) and Fostering Responsibility, Education & Employment (FREE). The MDFT-RAFT program assists high-risk youth, ages 9-18, transitioning back to their communities following a period of incarceration or placement. The program includes targeted approaches for adolescents with a history of substance abuse and other behavioral issues. FREE programming includes an array of services to support the adolescent's growth in all areas of functioning: life skills and well-being, social, educational, vocational preparation and employment.

⁹A youth may receive and complete worksheets on his own while in CTQ, but youth are not provided educational services.

USE OF FORCE AND ISOLATION-RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

4. CSSD facilities reported that, on average, 11.5 percent of incarcerated youth were physically restrained during the PUR. CSSD protocols direct the mechanical restraint of **all** youth during transport.
5. While CSSD policy directs sparing use of cell/room confinement, in the small sample record review done by OCA, several examples of physical isolation for behavior management were found.
6. OCA's review of a sampling of youth-specific records revealed instances where CSSD utilized detention's most restrictive levels where youth can be isolated from the population for multiple days at a time, with no access to group programming or school.
7. CSSD was unable to provide data regarding how many youth were placed on restricted status during the PUR.

ACCESS TO MENTAL HEALTH TREATMENT

8. OCA's review of youth-specific records found that CSSD is challenged in meeting the treatment/support requirements for youth who present with profound mental health treatment needs while in custody and whose length of stay significantly exceeds the average stay of a youth in pre-trial custody.
9. CSSD was not able to provide OCA with utilization data regarding rehabilitative/group programming. The absence of this data made it difficult to determine what type of pro-social and rehabilitative programming is occurring outside of school time. CSSD has since added this to their data management system and has shared that the agency will be able to report on this in the future.
10. Record review did show that youth receive check-ins from clinical staff while placed on either a restricted status or some level of mental health monitoring, however, regular individualized therapy is not a component of ongoing service delivery in detention.

ACCESS TO EDUCATIONAL PROGRAMMING

11. Connecticut law provides that education in the detention centers is the responsibility of the local school district. Bridgeport Public Schools provides educational services to the Bridgeport detention center, and Hartford Public Schools contracts with a community-based provider to deliver education services in the Hartford detention center.
12. OCA examined attendance and discipline information from CSSD and the two responsible local school districts and found that neither school district was able to provide reliable data regarding incarcerated youth's attendance or instances of school removal. CSSD, however, did keep data on school removals which data showed that just under 10 % of confined youth were subject to a school suspension while in detention.
13. OCA's record review identified youth who were placed on restricted status who were not allowed to attend school programming. CSSD reported that youth may be provided school work to complete on the unit, but individualized instruction was not provided.

ABUSE/NEGLECT AND MANDATED REPORTING

14. Over a 36 month period, there were 12 reports to DCF of suspected abuse or neglect of children in juvenile detention facilities. DCF substantiated 1 of these reports and made a finding of sexual abuse. Over a 3 month period in late 2017, DCF identified numerous program concerns that it concluded contributed to unsafe conditions for youth in detention, including staff failure to follow agency policies, and staff failure to timely report suspected abuse or neglect of children.¹⁰
15. The Judicial Branch invited consultant Leo Arnone, a former executive administrator for DOC, DCF and CSSD, to conduct a review of agency policies and conditions in the detention centers. Mr. Arnone's report, published in November, 2017, concluded that agency policies are progressive and comprehensive, but he recommended action steps to improve quality assurance in the facilities and ensure facility and staff compliance with agency expectations. The Judicial Branch adopted Mr. Arnone's recommendations and has committed to a series of quality improvement activities, including an increase in staffing, shifting of managerial assignment/responsibilities, enhanced staff training, and consultation with national experts on juvenile justice reform and gender-responsive programming.
16. The CSSD ombudsman has been an agency contractor and has not functioned as a mandated reporter. The ombudsman did not make any reports of suspected abuse or neglect to DCF during the 36 month period reviewed by OCA. CSSD informed OCA that it would seek to amend the ombudsman contract to require that ombudsperson/s will be required to report suspected child abuse/neglect to the Department of Children and Families Careline going forward.

ACCESS TO FAMILY CONTACT/FAMILY ENGAGEMENT

17. CSSD provides visitation hours on evening weekdays and during the day and evening on weekends, with opportunities for additional accommodations as needed. The detention centers offer twice monthly family events to encourage engagement. Data shows that just over 1/3 of children in detention received a family visit while incarcerated. Detention does not offer family therapy due to the historically short-term, pre-adjudicatory nature of the facilities.
18. OCA record review revealed that detention staff appropriately made attempts to contact youths' guardians throughout their stay to address various issues in detention.

OCA FINDINGS - DEPARTMENT OF CORRECTION: MYI AND YCI

OCA found the experiences of male youth at MYI and female youth at YCI to be very different in all of the areas described below.

SUICIDAL BEHAVIOR AND SUICIDE PREVENTION

1. While many youth admitted to MYI have documented histories of suicidal ideation/behavior, MYI reported to OCA that there were **0** incidents of suicidal or self-harming behaviors by youth during the PUR.

¹⁰ During this time frame, the Connecticut General Assembly passed a new budget law transferring DCF's juvenile justice responsibilities to CSSD.

2. Records reviewed by OCA revealed approximately **two dozen youth admitted** to the MYI infirmary for mental health reasons during the PUR including paranoia, hopelessness, and threatening to self-harm.
3. The DOC's YCI reported **2 incidents** of suicidal or self-harming behavior by two different youth during the PUR (there were 6 girls confined at the facility during the PUR).
4. DOC's facilities did not provide OCA with information regarding participation in an auditing framework for assessing the quality or efficacy of suicide prevention/response protocols
5. DOC data and UConn Correctional Managed Health Care data regarding the number of youth admitted to MYI and who were subsequently screened for mental health and suicidality do not match. While DOC acknowledged that there are discrepancies with its reporting, it was unable to explain the reasons for those discrepancies.

USE OF FORCE AND ISOLATION-RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

6. MYI was not able to provide reliable data regarding use of restraint (physical, mechanical, or chemical) or seclusion during the PUR. YCI reported that no girls experienced physical or chemical restraint during the PUR. DOC has committed to improving their data collection.
7. MYI relies on months-long isolation, sometimes solitary, of minors as part of its Security Risk Group protocols (SRG), where a determination has been made that a youth cannot be safely managed alongside other youth due to the youth's active gang affiliation. During the PUR, youth on SRG status were confined in a Restrictive Housing Unit and were in their cells 21 to 22 hours per day with limited access to education, and no access to rehabilitative programming. Youth on SRG may be handcuffed any time they are not in their cells, including for escort to showers, during large muscle movement, and phone calls. While the DOC asserted the effectiveness of its SRG program for reducing gang-related violence, the agency did not provide OCA with supporting data.
8. OCA finds that the SRG program and its reliance on prolonged physical isolation of minors constitutes "administrative segregation" and as such violates Conn. Gen. Stat. § 18-96b, which statute strictly prohibits the administrative segregation of minors and which was intended to prohibit solitary confinement of minors. The DOC disagrees with OCA's characterization of its SRG program as "solitary confinement" or "administrative segregation," terms often used interchangeably in correctional literature/research nationwide.
9. MYI utilizes routine cell confinement of youth in general population for administrative and security purposes, with youth confined to their cells multiple hours per day in between meals and programming.
10. MYI utilizes shorter term physical isolation (1 to 30 days per instance during the PUR) of minors as a behavioral consequence. Cell confinement is nearly total (23.5 hours per day) and youth on this status have no access to school or rehabilitative programming. **All youth on this status are handcuffed any time they are permitted to leave the cell for hygiene or phone calls.**
11. No youth in isolation (short term or long term) at MYI had an individualized behavior plan to support return to the general population. OCA encountered multiple youth who while in isolation presented as lethargic and depressed, some refusing to engage in basic hygiene activities.
12. DOC policies permit use of chemical agents on youth. OCA found multiple examples of youth with asthma diagnoses who were the subject of chemical agent restraint at MYI. Many states have banned

use of chemical agent on minors, and the U.S. Department of Justice has warned that use of chemical spray on juveniles may violate their rights, including the use of chemical agent on youth with respiratory conditions such as asthma.¹¹ The DOC's policy requires a review of the youth's medical and mental health history prior to the use of a chemical agent. However, the DOC acknowledged that chemical agents are often used to "quell spontaneous situations that threaten the safety and security of staff, inmates and the public," in which case it would be improbable that such medical review would take place under those circumstances.

ACCESS TO MENTAL HEALTH TREATMENT

13. DOC leadership reported to OCA that it "strongly believes that mental health services and non-academic programming at MYI and York meet the needs of the population." However, the DOC "assumed direct responsibility for inmate health care effective July 1, 2018" due, in part, to mounting concerns expressed by the legislature, civil rights groups, and family and friends of inmates about the poor quality of care provided to inmates, resulting in a legislative hearing held in July of 2018. In a September 2018 audit of the DOC, the Auditors of Public Accounts expressed its concern over the health care provided to inmates: "[v]agueness in contract terms, a general absence of measurable performance standards, the absence of recognized standards of care, and the lack of an effective quality control system, impair DOC's capability to ensure proper performance of service by UCHC/CMHC and expose the department to the risk of liability for failure to provide quality care." The OCA commends the DOC for recognizing the deficiencies in its provision of health care services and committing to improving this vital service delivery.
14. DOC facilities reported their policy is to screen all youth for mental health treatment needs and suicidality upon admission.
15. DOC offers mental health treatment services in accordance with a youth's assigned Mental Health Score (1-5). Despite the national data regarding the prevalence of mental health disorders among incarcerated youth and the number of boys at MYI with current or historical mental health diagnoses, the majority of incarcerated boys were assessed by the DOC as either having no history of mental health treatment or not presenting with any current clinical needs. Only 4 boys confined at MYI in July, 2017, for whom Mental Health Scores were provided to OCA, were identified as in need of weekly mental health counseling. DOC asserts that its services meet the needs of the population.
16. OCA examined rehabilitative program participation for 53 boys at MYI confined during the PUR, examining each youth's record of participation for not only the PUR, but the previous 24 months as well, beginning with most boys' date of admission. OCA found that, with an average period of confinement for the 53 youth of 18.6 months, more than half of the boys participated in zero or one program while incarcerated.
17. The DOC acknowledges its problem with data reporting yet asserts that "[m]any of the inmates who were reported as not participating in rehabilitative programming, in fact were participating." DOC stated it is going to remedy its data collection and reporting processes.
18. Girls at YCI were all designated a MH 3 or higher and all of the girls (6 during the PUR) were offered individual counseling from a clinical social worker, one session every week or every two weeks.

¹¹ https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/la_county_juvenile_findlet.pdf

Participation of girls in group programming varied considerably. All girls are assigned a mentor while incarcerated. Due to the small number of girls, programming can change depending on the population.

ACCESS TO EDUCATIONAL PROGRAMMING

19. MYI's U.S.D 1 is the school district run by DOC for youth in its facilities. MYI reports that youth receive 5 hours of school programming a day. OCA found discrepancies in MYI's attendance and discipline data, including data reported to the State Department of Education, and OCA's review of the school attendance records for 21 youth at MYI revealed that most youth missed a **substantial** amount of school during the school year. Documented reasons offered for student absenteeism at MYI were variable and include "teacher absence," "absence (generic)," "custody," and "class not scheduled."
20. Similar to the school districts serving youth in detention, USD 1 reported no suspensions of students from the MYI School, which is likely due to the fact that when a youth has a behavioral incident in school, custody staff are called and facilitate the school removal. However, any school removal for behavior is governed by state suspension laws. This review revealed that the USD 1 staff are not following state and federal special education laws regarding cumulative school removals. The DOC disagrees with OCA's finding based on its opinion that the school suspension statute "makes no sense in the context of the Department of Correction," and that "it is not school staff who is removing inmates from the school – it is custody staff. The school is not effectuating or controlling the removals, or the length of the removals. Special education laws regarding cumulative school removals, therefore, do not apply."
21. MYI has limited resources to provide comprehensive special education and related service delivery to eligible youth, and few youth receive vocational programming. The DOC reports 14 of 109 students at MYI participated in vocational classes during the PUR.
22. OCA's record review revealed that USD 1, revised the special education plans of youth entering the facility to decrease the hours and services previously identified in their Individual Education Plans (IEP).
23. Youth in Security Risk Group experienced the most dramatic limitation to access to education. IEPs of youth in SRG were found to have been modified to reflect significant reduction in education/special education services. Youth in shorter term isolation for disciplinary reasons were found to not receive tutoring or go to school, but youth may have received a packet of educational work sheets.
24. YCI reported 2 girls under the age of 18 began school on September 6, 2016. YCI reported no suspensions or removals from programming. During the PUR, both girls were absent approximately 10% for the following reasons: Court, Legal or Facility Security.

ABUSE/NEGLECT AND MANDATED REPORTING

25. DOC correctional staff and facility administrators are not identified as mandated reporters in state law. The only DOC staff members who are mandated to report suspected abuse or neglect are those whose professional credentials identify them as such, e.g., a medical professional, clinician, or teacher

working in the facility. DOC reported to OCA that it had made two reports to DCF during the PUR. OCA's review of the DCF database revealed no documented reports of suspected maltreatment made to the DCF Careline by anyone at DOC/CMHC during the PUR.

26. DCF has an imbedded staff at DOC-no reports of suspected abuse or neglect were made by the DCF staff on site in the prison.
27. There is no framework for training DOC employees at MYI or YCI on abuse/neglect reporting.
28. There is no agency or independent ombudsman for youth incarcerated in DOC facilities.

FAMILY CONTACT/FAMILY ENGAGEMENT

29. Almost half of boys incarcerated at MYI had no visits during the review period, and only 13 boys were permitted "contact" visits where they are allowed to touch a family member.
30. MYI does not offer family therapy.
31. MYI offers visitation hours to families in the evening throughout the week and during the day and evening on weekends. Contact visits (where a boy and his family member can physically touch) are only offered on weekends. For boys in Security Risk Group, non-contact visitation is only offered on two one-hour sessions during the week, and most boys on SRG had no visits during the PUR.
32. OCA's examination of visitation records for a sample of 53 youth at MYI showed that 45% of boys had no visits during their admission, and an additional 15% of youth had 2 or fewer visits. Only 13 of the 53 youth were permitted "contact" visits. Contact visit privileges are suspended or terminated due to disciplinary tickets. Contact visits are also not allowed at night. Boys reported to OCA that visits are one of the things that mean the most to them, but that some would rather not have a family come to see them if they cannot have contact with them because it is too difficult of an experience.
33. Youth are not permitted free phone calls at MYI, unlike youth in juvenile justice facilities.
34. Visitation resources differ at YCI as compared to MYI, and all youth are permitted contact visits with family.
35. YCI does not routinely provide family therapy for female youth, but family therapy may be facilitated by the unit social worker. During the PUR, two youth had family therapy sessions over the phone on two occasions. All of the youth are entitled to contact visits. YCI has a large general visitation area and a small area that permits children to interact with mothers or family members during visits. OCA's review of visitation data revealed that of the 6 girls incarcerated during the PUR, 4 youth had 1 or no visits (with an average length of confinement of 34 days at the time of review.) Two girls had more than two dozen visits, and both girls had been confined for approximately 10 months.

OCA FINDINGS – CJTS

SUICIDAL BEHAVIOR/SUICIDE PREVENTION

1. While many youth admitted to CJTS have documented histories of suicidal ideation/behavior, CJTS reported to OCA that there were **0 incidents of suicidal or self-harming behaviors by youth** during the PUR. OCA's review of youth-specific records, however, revealed multiple incidents of youth expressing suicidal thoughts or engaging in self-harming behavior.
2. During a previous review of conditions of confinement at CJTS from 2014 to 2015, OCA found more than 4 dozen incidents of suicidal or self-harming behavior.¹²
3. CJTS did not provide OCA with information regarding participation in an auditing framework for assessing the quality or efficacy of suicide prevention/response protocols.

USE OF FORCE AND ISOLATION-RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

4. OCA's review found significant discrepancies in reported data regarding the use of restrictive measures.
5. OCA's review found multiple examples that CJTS staff used cell/room confinement (physical isolation) as a disciplinary sanction.
6. CJTS reported that between 30-40% of youth were subject to a restraint during the PUR.

ACCESS TO MENTAL HEALTH TREATMENT

7. CJTS had an expected length of confinement of 6 months. Youth were screened for mental health treatment needs and suicidality upon admission, and clinical staff developed treatment plans and goals for all youth.
8. OCA's review of youth specific records indicated that even youth with complex mental health treatment needs received, on average, out-patient level of care (3.7 sessions per month), utilization of individualized and group programming by youth varied considerably, and some youth participated in few or no group programs during the review period.

ACCESS TO EDUCATIONAL PROGRAMMING

9. CJTS's school is run by U.S.D. 2, the school district administered by DCF for youth in DCF-run facilities. CJTS provided information that for the 103 students in the CJTS School during the PUR, 40 students received at least one suspension, and 10% were suspended on multiple occasions.
10. More than 60% of youth at CJTS were identified as eligible for/receiving special education services.

ABUSE/NEGLECT AND MANDATED REPORTING

11. All DCF employees at CJTS are mandated reporters and receive training regarding reporting obligations.

¹² OCA Report: Investigative Facility Report Connecticut Juvenile Training School and Pueblo Unit, and Addendum, available on the OCA website: https://www.ct.gov/oca/lib/oca/oca_investigative_cjts_pueblo_report_july_22_2015.pdf; https://www.ct.gov/oca/lib/oca/ocaaddendumfinal_9_1_5.pdf

12. Over a 34 month period (through 2018) there were 45 reports to DCF of suspected abuse or neglect of children at CJTS. These reports, like any facility report of abuse or neglect, are investigated by DCF's internal Special Investigations Unit (SIU). 7 of the 45 reports were substantiated by DCF as child abuse or neglect. Several investigations led SIU to identify program concerns at CJTS, including staff failure to follow protocols for use of force, failure to document incidents adequately or accurately, and failure by management to de-brief with staff after incidents involving physical restraint.
13. The DCF/CJTS ombudsman is a DCF employee. The ombudsman has filed multiple reports of suspected abuse or neglect to DCF during the last three years.

FAMILY CONTACT/FAMILY ENGAGEMENT

14. Data review for 89 youth who were at CJTS during the PUR showed that **51%** of those youth were discharged home. More than half of the 46 boys discharged home (**26/46**) had **1** or **0**, in-person family therapy sessions during the PUR.
15. Data review showed that while **76%** of all youth had at least one family visit during the PUR, **24%** had no visits.

AGENCY RESPONSES

The OCA shared a draft of this report with of the state agencies identified herein, including Court Support Services Division of the Judicial Branch, the Department of Correction and the Department of Children and Families. All agencies were given the opportunity to share with OCA any comments or concerns regarding the draft findings and recommendations. Efforts have been made to incorporate or reference such feedback in the final report. Both CSSD and DOC leadership have affirmed their commitment to ongoing assessment of internal policies and practices necessary to ensure safety and well-being of youth in custody. This includes critical examination of data collection and review structures to ensure facility adherence to agency policies and reliable data reporting. As the state's lead agency for child protection and children's mental health, the Department of Children and Families has acknowledged its ongoing responsibilities to ensure the safety and well-being of youth served in the justice system, despite DCF no longer having jurisdiction over adjudicated youth.

CSSD RESPONSE

In response to OCA findings related to access to mental health screening and treatment, CSSD leadership reported confidence in its screening and short-term assessment policies and practices, emphasizing that pretrial detention, typically short-term, has significant limitations regarding mental health treatment and has not been considered a treatment environment. In response to the recent shift in statutory responsibilities for adjudicated youth, CSSD is currently engaged in efforts to modify its policies and programming to effectively meet the needs of a significantly more complex population of youth who will experience longer detainment. CSSD has added staffing to its detention centers and enhanced training and supervision to meet the needs of youth in their care. In addition, CSSD has developed several family engagement videos that are posted on its websites and available to be shown to parents during visitation. CSSD has also indicated that it expects data reporting discrepancies to be reduced with modifications to its data management system in 2019.

DOC RESPONSE

Leadership of the Department of Correction has reported that it remains committed to working with stakeholders seeking to improve outcomes and conditions of confinement for youth. Leadership responded

to OCA findings that agency policies and practices are consistent with best practice for adult correctional programs and while they have made some effort to adapt practice for the state's youngest offenders, they believe youth would be better served **outside of an adult correction system**. DOC further responded that these youngest offenders frequently present with the most challenging behaviors and restrictive measures utilized are needed to ensure staff safety and facility security. DOC does not agree with the OCA finding that its use of isolation for behavior management constitutes solitary confinement. DOC acknowledged limited staffing resources and flexibility. MYT's physical plant is structurally incompatible with implementing age/developmentally appropriate programming. DOC indicated that it intends to seek consultation with national experts with whom it has been working to develop effective programs for incarcerated young adults.

OCA RECOMMENDATIONS

There is a need for a greater transparency and accountability with regard to conditions for children and youth in congregate care and confined/secure settings. While there is public information regarding conditions and incidents of abuse and neglect in certain types of regulated programs serving vulnerable populations (i.e. daycares and nursing homes), there is little to no published information regarding the safety and quality of youth-serving programs, including group homes, residential treatment facilities, juvenile or criminal justice facilities, whether such facilities are licensed by or run by the state. OCA recommends that a framework be urgently developed for the collection and publication of critical performance and outcome measures expected for secure and non-secure youth-serving facilities, including measures related to concerns of abuse and neglect, program/licensing concerns, and corrective actions.

SUICIDAL BEHAVIOR AND SUICIDE PREVENTION

1. Connecticut should standardize how suicidal and self-harming behavior is collected and reported for youth in confinement.
2. Consistent with expert recommendations, all juvenile-serving correctional 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."¹³
3. All youth-serving facilities should undergo an annual audit of the facility's physical environment for suicide resistance.
4. Closed-door cell confinement should be limited for juveniles and prohibited for juveniles who present with risk for potential or actual suicidal behavior. All room checks should be conducted at staggered intervals.
5. Staff must receive evidence-based training in identifying risk factors for suicide among the juvenile population to ensure that vulnerable youth are identified, supported and monitored. Threats of self-harm should never be dismissed as "attention seeking." According to 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."¹⁴
6. Staff training should include information regarding the risk to youth created by any transition, including transitions home.
7. Any instance of suicidal behavior should trigger a comprehensive case review with participation from clinical and facility operations staff.

¹³ OJJDP/NIC Guide, *supra*, N. 2, Ch. 11, Boesky, P., "Mental Health."

¹⁴ *Id.* at 18.

8. Suicide screening should be done not only at intake but on a continuous schedule for all confined youth.

USE OF FORCE AND ISOLATION—RESTRAINT, SECLUSION AND RESTRICTIVE HOUSING

1. Consistent with the recommendations from the Department of Justice, the American Psychiatric Association, the National Commission on Correctional Health Care, and other professional organizations, Connecticut should ban solitary confinement of minors.
2. State law must be revised to clarify what constitutes impermissible solitary confinement, but consistent with most national associations' definitions, the state should ensure that it prohibits isolation practices that confine children to their cells for the vast majority of a 24 hour period without access to meaningful rehabilitative and education services, pro-social interaction and other needed services and interventions.
3. Given the paramount importance of ensuring a safe and secure milieu for juvenile offenders and the staff who work with them, the DOC and, where applicable, CSSD should work with national experts to improve safety outcomes without relying on the physical and social isolation of minors. The agencies should seek technical assistance, as needed, to support the prevention of behavioral incidents that typically lead to harsher discipline or isolation measures and an unsafe environment.
4. Connecticut correctional facilities should follow toolkits developed by the Council of Juvenile Correctional Administrators (CJCA) to assist with reducing isolation of juveniles. CSSD is using these tool kits now and working to reduce reliance on cell confinement as part of its youth in custody practice model.
5. State law should prohibit the use of chemical agents on children/youth by all local and state agencies.
6. State law should prohibit the use of prone restraints with minors across all state and local agencies. State law currently bans prone restraints for students and most state agencies, including DCF and DDS have banned use of prone restraints due to concerns over airway restriction and other negative physical effects. These critical considerations do not change even if the youth's service or custodial setting changes.
7. Similar to state laws that govern treatment and emergency intervention for youth with disabilities or challenging behaviors, correctional facilities must be required to implement behavior intervention plans for youth whose behavior interferes with the safety of others and limits the youth's participation in rehabilitation activities.
8. The state should standardize statutory definitions and policies regarding the use of force and the use of punitive and restrictive measures for minors, regardless of correctional setting. Today there are conflicting definitions of use of force or isolation applicable to incarcerated youth, and statutes frequently provide no definition at all.
9. Professional agencies meeting with youth in correctional/secure settings should consider the use of screening tools to assist with the discussion of certain conditions of confinement with children. Custodial agencies should provide a mechanism for professional visitors to meet with children on the units where they are confined.
10. All agencies must ensure that they can collect and produce accurate data regarding the use of force and physical isolation on children. Each agency should have a reliable continuous quality improvement plan that addresses the use of emergency and isolation measures.

ACCESS TO MENTAL HEALTH TREATMENT

1. All facilities must ensure they have accurate record-keeping and data collection processes regarding youth's access to and utilization of mental health and rehabilitative programming.
2. All facilities should be required to report regarding youth/family utilization of clinical and rehabilitative programming.

3. All youth facilities should have trauma-responsive rehabilitative, pro-social, and clinical programming embedded into their daily schedule, seven days per week.
4. All youth facilities should be adequately resourced to ensure provision of 7-day per week intensive pro-social, rehabilitative and clinical programming.
5. All facilities must ensure staff are trained in how to maintain a trauma-responsive milieu and how to recognize signs of trauma in youth's behavior.

ACCESS TO EDUCATIONAL PROGRAMMING

1. All facilities must have clear and specific frameworks for ensuring compliance with all state and federal education laws regarding attendance, discipline, special education, and record-keeping.
2. All facilities must be required to report regarding the provision of educational services to incarcerated youth, including data regarding attendance, discipline, special education service delivery (with information regarding availability and utilization of special education and related services).
3. Facilities must ensure effective intake and discharge procedures for educational programming purposes. No youth should be discharged without an educational plan which includes a plan for immediate enrollment in an appropriate program.
4. The State Department of Education should provide guidance to school districts regarding necessary practices to facilitate record-sharing, educational meeting participation, and enrollment for justice-involved youth.

ABUSE/NEGLECT AND MANDATED REPORTING

1. State law should require that all facility staff working with children in confinement and all staff under contract to work with children in confinement be mandated reporters of suspected abuse and neglect.
2. All facilities for incarcerated youth should maintain an independent ombudsman to meet regularly with children, tour the facility, address concerns with administration and outside parties, and make reports of abuse or neglect where applicable. All ombudsmen/women should be mandated reporters of suspected abuse or neglect.
3. All youth-serving facilities must pay close attention to strengthening their frameworks for mandated reporting, not just of suspected abuse or neglect by third party caregivers but by facility staff as well.
4. All employees must be trained to understand that it is not their role to evaluate or investigate allegations of suspected child abuse or neglect, and that their only obligation is to report a "reasonable suspicion." Protocols, training and guidance for staff should acknowledge that suspected abuse or neglect may often need to be reported internally and externally. Agencies must emphasize compliance with legal requirements for reporting to law enforcement and child welfare authorities, while ensuring clear internal reporting protocols for suspected child abuse or neglect and other incidents of child maltreatment. Policies should specify what staff behavior the facility will respond to internally and what behaviors must be reported to authorities.¹⁵
5. Policies and training regarding staff-youth boundaries should recognize a balance between "encouraging positive and appropriate interactions and discouraging inappropriate and harmful interactions."¹⁶ Not all physical/verbal expressions of support between staff and a youth are inappropriate. A pat on the back or physical expressions of comfort or consultation may be an appropriate response, depending on context, age of youth, and environment.
6. Agencies should ensure human resource policies include specific disciplinary actions for failure to comply with mandated reporting requirements.

¹⁵ *Preventing Child Sexual Abuse Within Youth-Serving Organizations, Getting Started on Policies and Procedures*, Center for Disease Control (2007) at 17, report available on the web at: <https://www.cdc.gov/violenceprevention/pdf/preventingchildsexualabuse-a.pdf>.

¹⁶ *Id.* at 9.

7. Agencies should include continuous quality improvement plans for ensuring effective strategies to prevent child maltreatment and encourage compliance with mandated reporting obligations.
8. Sexual abuse prevention training should be required for all facility staff. Training regarding abuse and neglect, including staff sexual abuse of children, must be data-driven, scenario-based and interactive. Recognizing concerns of staff sexual misconduct and responding timely and effectively can be difficult due to what experts identify as the cognitive dissonance barrier that affects staff perception or detection—meaning that most people will disbelieve that anyone they know or work with would sexually mistreat a child. However, statistics regarding sexual abuse of adolescents, self-reported in surveys, strongly suggest that prevalence rates for adult/staff/teacher sexual misconduct with children are much higher than what is reported and investigated. Effective training and preparation of staff to understand the prevalence of such incidents and respond to concerns, even rumor and innuendo, can assist with better prevention and response to concerns of staff sexual misconduct. Agencies must have clear requirements for “reporting suspicious adult behavior, and an effective complaint system including definitions, administrative consultation protocols, investigations and criminal referral processes, parental notification requirements, administrative resolution steps and immunity and retaliation considerations.”¹⁷ Policies must emphasize that suspicion is enough, particularly because most sexual abuse will happen when perpetrators believe they will be undetected and reporters will often not be direct witnesses to sexual misconduct.
9. Staff training must include an understanding of trauma, its impact on youth behavior and the need for gender-specific and responsive programming for incarcerated children, with explicit attention to populations uniquely vulnerable to abuse and neglect, such as children who are LGBTQ-I and those with disabilities.
10. Supervision and training for staff in youth-serving facilities must address policies regarding use of technology, electronic communication, social media, and smart phones.
11. All facilities should have a clear framework for the use of video cameras and the review of video footage to support a safe environment for children and staff and enhance quality assurance activities.
12. All facilities should have a data-driven approach to risk management, including identifying the most common factors in incidents of concern between children or between staff and children/youth.

FAMILY CONTACT/FAMILY ENGAGEMENT

All facilities should consider how to strengthen youth’s ties to their families and community institutions while the youth is in secure care. The Department of Justice’s OJJDP Policy Guidance includes numerous recommended “focus areas” for states and local communities, some excerpted below with additional recommendations from OCA:

1. Facility staff should receive specific training in effective youth and family partnership and engagement strategies.
2. Facilities should allow developmentally healthy and appropriate activities and recreation for youth and family members during visitation to strengthen family bonds and minimize the trauma of separation.
3. All youth-serving facilities should be required to permit contact visits with youth unless a timely and specific risk assessment tool determines that the provision of a contact visit creates a risk of imminent harm to the youth or others.

¹⁷ United States Department of Education, “*Readiness and Emergency Management for Schools Technical Assistance Center: Educator Sexual Misconduct, What School Staff Need to Know and Do*”, Vol. 3 Issue 2 (2008), available on the web at: https://rems.ed.gov/docs/HH_Vol3Issue2.pdf.

4. All youth-serving facilities must have strategies to support therapeutic family engagement as either part of a treatment model, where applicable, or part of a discharge planning process.
5. All youth-serving facilities should be required to collect data and report regarding the efficacy of its family engagement and visitation policies and practices.
6. Advisory group membership/s should include current and former system-involved youth and their families.