

Identifying and Meeting Needs of Youth  
in the Juvenile Justice System

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Office of the Child Advocate

January 15, 2014



# Role of OCA

## Conn. Gen. Stat. 46a-13k et seq.

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- Evaluate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state;
- Review complaints of persons concerning the actions of any state or municipal agency providing services to children and of any entity that provides services to children through funds provided by the state, make appropriate referrals and investigate those where the Child Advocate determines that a child or family may be in need of assistance from the Child Advocate or that a systemic issue in the state's provision of services to children is raised by the complaint;

# Role of OCA

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- Pursuant to an investigation, provide assistance to a child or family who the Child Advocate determines is in need of such assistance including, but not limited to, advocating with an agency, provider or others on behalf of the best interests of the child.
- 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; Recommend changes in state policies concerning children including changes in the system of providing juvenile justice, child care, foster care and treatment



# OCA Activities on Behalf of Youth in Juvenile and Adult Confinement, 2014

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- Meet with children and youth in facilities (Manson, York, CJTS and Pueblo);
- Respond to citizen concerns regarding youth or conditions of confinement;
- Conduct child-specific advocacy;
- Meet with staff and administration at facilities;
- Investigate conditions of confinement (observation, data, youth interviews, video tapes);
- Recommend system change and collaborate for system improvement.

# Youth in the DOC, Needs or Concerns

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- Census, 14 to 17, Manson and York: approximately 70.

## Needs Moving Ahead

1. Continue to improve developmentally appropriate supports and services and continue to reduce room confinement;
2. Increase access to educational services, ensuring 5 hours, and special education and related services;
3. Increase access to prosocial activities and life skills;
4. Increase opportunities and strategies for family engagement;
5. Increase ability to measure performance and outcomes regarding under 18 recidivism, rehabilitation and education.



# OCA Activities: DOC

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- Meet with youth and facility leadership;
- Youth interviews;
- Regular meetings with DOC leadership regarding system issues and reforms;
- Invitation to train with DOC staff and Uconn Correctional Managed Health;
- Working group on adolescent policies and directives;
- Ongoing collaboration in the creation of new adolescent policies and administrative directives.

# Strengths going forward

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- New directives regarding adolescent care and services, including visitation and mental health response;
- Re-entry committee;
- Strong leadership and facility commitment to improved conditions and services for adolescents.
- Continued reduction of adolescents entering adult criminal justice.



# Next Steps for Youth in Adult Confinement

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- Needs assessment and strategic planning regarding physical plant changes, resources for improved educational access and pro-social activities.
- Measurement of outcomes for adolescent population: educational and mental health needs met; recidivism for 14 to 18 year olds—JJPOC.
- Reducing number of minors referred to adult system (increasing transfer age, minimizing discretionary transfers). Recidivism is heightened for adolescents transferred to adult system
- Ongoing support for staff to understand the needs and rights of juveniles in the adult system.



# OCA and Youth Involved with CSSD, 2014

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- Meet with administration and agency leadership;
- Review of Performance Based Standards and facility operations (Bridgeport);
- Review of youth surveys and ombudsman-grievance processes;
- Review and discussion regarding revision of shackling/transport policies;
- Review of new community-program development;
- Citizen concerns, few.

# CSSD data review

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- Seclusion, restraint (room confinement); suicidality; loss of recreation.
- Room confinement numbers have trended downward and are now (October 2014) substantially below national field averages.
- Extensive suicide prevention methodologies.
- Youth Surveys.



# OCA Review of Conditions for Juvenile Justice Committed Youth: 2014

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- Meet with youth individually and on student council;
- Visit and observe facilities (CJTS and Pueblo);
- Meetings with other JJ and child welfare professionals;
- Respond to citizen concerns: several;
- Data collection and review (seclusion, restraint, suicide/self-harm, video tapes, mental health file review).

# Strengths

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- Institutional availability of interdisciplinary resources across mental health, education and child welfare—potential access to home and community-based services;
- Student Council and youth surveys—opportunity for youth voice;
- Recent engagement of outside clinical consultant.



# Needs, Areas of Concern

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- Overreliance on restrictive measures: restraint and seclusion, out-of-program time, episodes may be greater than 4 hours;
- Restraint and seclusion used for youth with significant mental health needs;
- Need for improved data collection and analysis; reporting and transparency;
- Need for greater support for staff to create trauma-informed program and milieu.

# Remedies, Next Steps

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- Use of evidence-based CQI in all JJ facilities;
- Review and revise program design to ensure therapeutic and trauma-informed, including ready availability or utilization of therapeutic support staff on second and third shifts and integration of trauma-informed principles into all areas of program;
- Strategic plan to align facility practices with national standards regarding youth in juvenile justice system (specifically: Performance-Based Standards and JDAI).



# ISSUE FOR ALL YOUTH: SECLUSION, ISOLATIVE AND RESTRICTIVE MEASURES

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- May be called solitary confinement, seclusion, room confinement, “no access.”
- Up to 70 % (if not more) of confined adolescent population (national data) has a diagnosable psychiatric disorder. Compounded by learning disabilities, history of trauma and abuse.
- May result in denial of access to programming and socialization. Adolescents particularly vulnerable to isolation. (AACAP)
- Suicide and self-harming strongly associated with isolation. DOJ: more than 50% of suicides of children detained in juvenile facilities occurred while young people were on room confinement (15 minute checks did not prevent many suicides).

# OCA looks at suicidality and self-harming behaviors

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- Preliminary review.
- Multiple attempts.
- Attempts not infrequently occur while child in seclusion/room confinement.



# Seclusion Reforms: 2014

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- New national standards from Juvenile Detentions Alternative Initiative (Annie E. Casey), 2014.
- New advisement from Department of Justice, Eric Holder
- New York Times reporting end of solitary confinement for adolescents at Rikers Prison.

# SECLUSION, ISOLATION AND RESTRICTIVE MEASURES: National Standards

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- Juvenile Detention Alternatives Initiative (Annie E. Casey). a leader in establishing national standards for managing youth in a correctional or detention setting: limits isolation to 4 hours or less and never for purposes of punishment.
- “room confinement” defined as the involuntary restriction of a youth alone in a cell, room, or other area.
- staff must provide continuous 1:1 crisis intervention and observation inside the cell or directly outside the cell. For any youth in room confinement, staff should develop a plan to permit the youth to return to programming as soon as possible. Clear procedures.
- Youth at risk of self-harm should be encouraged to participate in activities and programs if possible. Youth must be monitored on-on-one or transferred to a mental health facility.



# Use of “therapeutic” room confinement

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- Certain national standards and formal settlement agreements (DOJ) require room confinement to be employed upon order and advice of a qualified mental health professional who has personally observed the resident and determined that the use of such confinement is necessary to prevent imminent physical harm and that no other intervention is appropriate.

# Performance Based Standards

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- CSSD facilities employ PBS.
- Isolating or confining a youth in his/her room should be used only to protect the youth from harming himself or others and if used, should be brief and supervised. Any time a youth is alone for 15 minutes or more is a reportable PBS event and is documented.
- Isolation should NOT BE USED AS PUNISHMENT.
- Rigorous data collection, review and comparison to national field averages.



# American Correctional Association

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- Used by DCF
- Permits the removal from general population of juveniles who threaten the secure and orderly management of the facility;
- ACA standards distinguish between 3 types of isolation/removal practices: disciplinary room confinement, protective custody and special management.

# Department of Justice Guidelines

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- “Isolation is a severe penalty to impose upon a juvenile, especially since this sanction is to assist in rehabilitation as well as punish a child... after a period of time, room confinement begins to damage the juvenile, cause resentment toward the staff, and serves little useful purpose.”
- Must be examined once during the day by a physician; visited twice by a member of the treatment staff; provided educational materials and other services.



# CT Law on Restraint and Seclusion

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- CGS 46a-150
- Applies to all schools, programs and facilities operated by LEAS, DCF, DDS, DMHAS.
- Carve out for DOC
- No mention of CSSD
- Regulations for school districts (SDE)
- Regulations for DCF facilities (1994).

# CT law

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- Seclusion and restraint for youth in facilities or programs only when imminent risk of harm
- Seclusion defined as the “confinement of a person in a room, whether alone or with staff supervision, in a manner that prevents the person from leaving, except that in the case of seclusion at Long Lane School, the term does not include the placing of a single child or youth in a secure room for the purpose of sleeping.”
- Seclusion may not be used for discipline.



# Findings: CT

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- CSSD numbers trending down, lower than national PBS field averages. Recent changes in policy to further reduce room confinement.
- DOC (not covered by CGA 46a-150), new directives to reduce room confinement and increase recreation time and access to programming. Historic reliance on room confinement.
- DCF: continued reliance on room confinement and restrictive measures for certain youth with challenging behaviors and/or mental health disorders. Period of room confinement may exceed 4 hours and may continue for multiple days.

# Remedies and Reforms

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Revise and Strengthen state law to further reduce reliance on restraint and seclusion for children.

Data collection and reporting from all youth-serving programs to applicable agencies, advisory committees and the JJPOC regarding:

## Conditions of confinement

- Restrictive measures (including isolation and out of program time) and use of force
- Suicidality/self-harming
- Program and educational attendance and gains



# Reporting and Monitoring

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- Needs profile of youth including mental health/special education/risk profile
- Family visits and therapeutic engagement/preparedness
- Progress towards implementation of evidence-based CQI
- Outcomes: re-entry and recidivism, educational and mental health/rehabilitative gains, timely discharge and community placement, educational enrollment.

# Remedies and Reforms

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- Consider Alternatives to Incarceration.
- Data on recidivism is very poor.
- Safely Home Report.