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INTRODUCTION

On August 28, 2001, the State of Connecticut opened the Connecticut Juvenile Training School ("CJTS") and transferred all boys who were committed to State custody at the Long Lane School to CJTS. By November 2001 significant public attention was drawn to substantial concerns about programming, vocational training, education, restraints, staff injuries and workers' compensation claims at the new facility.

Late in November 2001 the Office the Child Advocate visited CJTS following receipt of many complaints raising concerns for safety and programming for the youth at the facility. The Child Advocate initiated an investigation on November 30, 2001. The Attorney General also received complaints under Conn. Gen. Stat. § 4-61dd, the "whistleblower" statute, which raised serious concerns with respect to CJTS. The Attorney General also commenced an investigation. The Child Advocate and the Attorney General collaborated since the concerns raised with the Child Advocate and the Attorney General were substantially the same.[1]

The primary purpose of this investigation was to assess specific safety issues regarding youth, overall facility functioning, programming and services. This joint investigation included extensive interviews with professional staff at CJTS, including direct care personnel on all levels, managers, medical and nursing staff, mental health clinicians, educational staff, administrative staff, administration and youth. Additionally, there was a comprehensive review of the CJTS records, including medical files, case files, incident reports, log books, behavior plans, intake reports, plans of service, treatment plans, and video tapes.

Our conclusion is that DCF failed to properly plan for CJTS, failed to take proper steps to effectuate the opening of CJTS and failed to properly oversee the quality of services at CJTS, including education, safety and other services. The reasons for our conclusion are discussed below.

[1] The Child Advocate also utilized the Youth Law Center as a consultant in connection with this investigation. The Youth Law Center is a not-for-profit public interest law office with the mission of working to protect abused and neglected children. Their goal is to ensure that vulnerable children are provided the conditions and services they need to grow to healthy, productive adults.

EXECUTIVE SUMMARY

This investigation explored allegations of deficiencies at the Connecticut Juvenile Training School, especially safety issues concerning youth. The purpose was to develop recommendations to improve the overall programming and services at the facility. Key issues that were examined included suicide prevention, excessive use of restraints and seclusion, lack of an adequate behavior modification system, staff overtime and morale issues.

The 1998 death of Tabatha B. by suicide at Long Lane School was the catalyst for the development of CJTS. Following the death of Tabatha B separate reports by the Child Fatality Review Panel and DCF were highly critical of the programming, services and facility at Long Lane School. All of the information that came to light following the death of Tabatha B. led to a strong State commitment to build a facility that would ensure safety and treatment for troubled youths.

This investigation revealed numerous deficiencies at CJTS in numerous areas. This is especially troubling since CJTS is a brand new facility, having opened in August 2001, which cost the State of Connecticut $57 million to build and which was supposed to be a "state of the art" facility. Even Kristine Ragaglia, Commissioner of the Department of Children and Families, admitted to the Hartford Courant on June 25, 2002 that the conditions at CJTS were such that "the 240-bed Middletown facility probably would not get a state license if it were privately run." A concise summary of our concerns is set forth below.

(1) Suicide Prevention

Suicide is one of the leading causes of death of adolescent youth in the United States. Suicide prevention was a major factor in CJTS being developed in the first place. The catalyst for DCF pursuing a new direction, culminating in the development of CJTS, was the suicide of Tabatha B. a number of years ago at Long Lane School. At that time the Child Fatality Review Panel issued a report making a number of recommendations that were necessary to ensure that troubled youth received proper intervention to prevent suicide. However, our review of suicide prevention at CJTS leads us to the conclusion that there is a substantial risk that those youth at CJTS who show warning signs of suicidal behavior could successfully commit suicide, without proper intervention. We found the following:

- Children on safety watches at CJTS are not properly monitored.
- There are examples of children on 1:1 safety watches (meaning safety watches where the children are supposed to be monitored continuously) who have not been monitored continuously during the safety watch, and for which there have been gaps in monitoring up to hours at a time.

- At least one child on a 1:1 safety watch was able to physically injure himself during the 1:1 safety watch without intervention since he was not in fact monitored continuously as required.
- Documentation of safety watches is often incomplete, inaccurate, missing or misfiled.
- In at least one situation there are two inconsistent sets of documentation for a particular safety watch that were submitted by DCF to the Child Advocate, both of which are inconsistent with the facility videotape during the time of the safety watch. As of the time of the issuance of this report DCF has not provided a suitable explanation of how this occurred.
- Clinical and direct care staff at CJTS have not received adequate training, including refresher training, in assessing risk of suicide and suicide prevention.
- There is inadequate supervisory oversight of clinical and direct care staff's roles in assessing risk of suicide and suicide prevention.
- Information concerning suicide attempts or other critical incidents associated with assessing risk of suicide or suicide prevention is not communicated to DCF executive staff in a timely or appropriate fashion.

(2) Safety & Security

Generally, restraints are only supposed to be used when necessary to protect youth from injury to themselves or from injuring others. Restraints are specifically not supposed to be use for punishment, for convenience or as a substitute for programming. We found the following:

- Restraints were significantly over-utilized by staff at CJTS. At one point this even included utilization of restraints at the specific written direction of CJTS Superintendent Lesley Mara for youth threatening to or actually setting off the facility sprinkler system. We also learned of one instance of a 15-year-old youth in restraints 24 hours a day for 5 continuous days.
- The actual use of restraints was significantly underreported in facility records. This makes it appear as though restraints are used less than they are actually used. It also makes it extremely difficult to monitor what is going on at the facility.
- Seclusion is only supposed to be used to prevent immediate or imminent injury to the youth or others, to prevent escape, or in an individual treatment plan. We found the following:
- Seclusion was used routinely at CJTS for inappropriate reasons. We found, for example, that seclusion was regularly used in the following manner: (1) youth were regularly locked in their rooms after school; (2) youth were regularly locked in their rooms during shift change; (3) youth were regularly locked in their rooms during treatment meetings; (4) youth were regularly locked in their rooms during morning and evening hygiene and shower periods; and, (5) youth in the general population

unit were routinely secluded during their daily schedules for over one hour.

- The actual use of seclusion was significantly underreported in facility records. Seclusion used for administrative convenience was invariably never recorded in facility records. There were also examples of disciplinary seclusions not being recorded or reported. This makes it appear as though seclusion is used less than it really is at the facility. As with restraints, often this underreporting makes it extremely difficult to monitor what is actually going on at the facility.

(3) Clinical Services.

Clinical services are extremely important for adjudicated delinquents placed at CJTS. Many of them have serious problems – especially substance abuse. Clinical services are crucial to enabling these youth to function in the real world when they are eventually released. Serious shortcomings at CJTS include the following:

- CJTS has not had an adequate facility wide behavior management system from the time that it opened.
- Youth, staff, and supervisors do not appear to understand the point level system that has been in use.
- Clinical programs in place at CJTS, such as Aggression Replacement Therapy and Cognitive Behavioral Therapy have been implemented very poorly.
- Substance abuse treatment is not being provided for a high number of youth at CJTS who require such treatment.
- A huge number of staff vacancies have made it impossible to provide needed clinical services to youth. This has forced clinicians to focus their time and attention on crisis intervention and pulled them away from providing clinical services to CJTS residents in general. As a result there are significant gaps in programming and follow through.
- There is insufficient space at CJTS for therapy and insufficient space for clinicians to meet with youth. Workstations in units with open desks are clearly not appropriate for clinical services. Despite all of the time and resources that have been invested, planning did not take into account what the needs for clinical space would be. There is simply no excuse for a brand new custom designed facility to be missing adequate space for clinical services.
- CJTS managers who are not themselves clinicians are setting clinical policy even though they are simply not professionally qualified to do so.

(4) Education.

Education is a crucial element of CJTS – the Connecticut Juvenile Training School. Although the youth placed there are in custody, they are still children who need a proper education. Many of them cannot read or read well below grade level. It has

not been possible to provide basic education at CJTS for reasons including the following:

- Although all of the boys at CJTS have significant risk for learning disabilities and behavior problems that are disruptive to learning, they are not all fully evaluated for educational supports as required by federal law.
- Basic items like desks and chairs were not in place when CJTS opened. Although CJTS opened in August 2001, books and supplies were not generally available until December and many were still not in place at the time this report was drafted. By February 2002, only a portion of the library books had arrived and only 5 of 12 computers intended for use in the library had arrived (a related problem is that the new computers went to administrative staff with students getting hand me downs).
- The general educational atmosphere is chaotic. Teaching is significantly disrupted.
- Educational administration is in disarray with constantly changing policies and conflicting policy announcements.
- Educational services at CJTS are supposed to be under the special school district in DCF with licensed educational professionals and administrators making decisions about curriculum and educational services. However, CJTS management who are not certified teachers or administrators have taken over educational administration and permitted security and behavioral modification issues to predominate over education.

(5) Recreation.

Recreation is extremely important. Youth should be kept productively occupied and should have a range of activities available to them. This has not been the case at CJTS.

- Recreation often gets canceled. Youth do not get sufficient recreation time and rarely go outside, sometimes as little as once a week.
- Recreational opportunities are inconsistent among units with some complaining of other units getting more recreation. This inconsistency is itself a source of tension in the facility.

(6) Staff

CJTS would not be functioning at all without the dedicated staff it has. In fact, the most positive aspect of the facility is the commitment of the staff toward the boys. However, staff morale is very poor and numerous staff have been placed in a position where it is virtually impossible to do their job effectively. There are a number of contributing factors to this including the following:

- A huge number of staff vacancies have resulted in excessive utilization of overtime and excessive workers' compensation claims. Extraordinary overtime leads to significant stress and strain on the staff.

- Changes in clinical coverage to the second shift (3pm to 11pm) prompted numerous resignations by clinicians. This resulted in the remaining clinicians being asked to do far more than they could possibly do, causing significant stress and strain. Additional conflict was created by CJTS managers, who are not themselves clinicians, setting clinical policy.
- Educational staff are very frustrated that they could not do their jobs since critical items like desks, computers, textbooks and supplies were not available, notwithstanding their having requested them months before.
- CJTS administrators did not involve direct care staff in the process of change in order to enable them to have some sense of responsibility for, and commitment to, new policies necessary for functioning in the new environment. As a result there is conflict between staff and CJTS administration that severely impedes the correction of deficiencies at CJTS.
- CJTS staff have not had sufficient training in deescalation techniques. Insufficient clinical staff are available at CJTS to assist in situations where direct care staff are unable to deescalate situations themselves.

(7) Management.

The inevitable conclusion flowing from all of the deficiencies at CJTS is that DCF management, both at CJTS and in the Central Office, failed to properly plan for and implement the transition of youth from Long Lane School to CJTS. This is unconscionable for a brand new "state of the art" facility that cost the State of Connecticut $57 million.

- Proper policies and procedures describing all of the programs that should have been in place were not in place when CJTS opened.
- Adequate clinical services were not provided at CJTS.
- Adequate education was not provided at CJTS, including needed furniture, textbooks, library materials, computers and supplies not being available when the facility opened in August 2001, and were not available for a considerable time thereafter
- Staff assigned to CJTS were not properly prepared for the transition and did not have proper training.
- Due to the lack of preparation and training, policies and procedures are being implemented inconsistently and inappropriately at times. This was particularly evident in similarly situated youth being treated differently regarding strip-searching procedure.
- Record keeping at CJTS, specifically including records of restraints, seclusion and strip searches, has been very poor. Without accurate records it is simply not possible to properly oversee the facility.

- CJTS has no clearly defined vision, mission or identity by which to guide its programming in rehabilitating youth.

(8) Quality assurance by DCF has been inadequate. This includes internal quality assurance at the facility as well as external quality assurance.

- Internal quality assurance by the facility was virtually non-existent. Until fairly recently, no DCF staff were specifically assigned to perform this function at CJTS. Even without dedicated quality assurance staff, some of the problems should have been obvious to CJTS managers just by walking through the facility. Youth being locked in rooms or not allowed out of rooms on pain of being sanctioned were obvious to Office of Child Advocate personnel on visits to CJTS and should also have been obvious to CJTS management.
- Most recently DCF administrators assigned a Quality Assurance staff person to assume to the responsibility of "Risk Manager" for only a ninety-day period at CJTS.

External quality assurance – independent oversight – by DCF was also virtually non-existent until very recently. Although CJTS was opened in August 2001 it was not until March 2002, following the Child Advocate and Attorney General expressing concerns to Commissioner Ragaglia, as well as considerable public attention, that DCF performed a program review at the facility. While DCF did a commendable job in performing that review, recognizing numerous deficiencies and requiring a corrective action plan, the DCF oversight came as a result of pressure by other state officials as well as considerable public attention. Clearly lacking was a truly independent oversight process. A brand new facility should have been independently reviewed prior to opening in August 2001 and several times since then, as an ordinary part of an independent oversight process rather than many months later as a reaction to developing concerns.

SUMMARY OF RECOMMENDATIONS

Several recommendations are made at the conclusion of this report. A summary of the recommendations is as follows:

1. Proper protocols should be put in place for the assessment of risk of suicide and for suicide prevention in order to ensure that no child at the Connecticut Juvenile Training School is at risk for attempting or committing suicide.

2. Connecticut Juvenile Training School policy and practice regarding the use of restraint and seclusion must immediately be brought into compliance with Connecticut law.

3. All staff at all levels at the Connecticut Juvenile Training School should immediately receive training in their "mandatory reporter" obligations under Connecticut law.

4. The leadership of the Department of Children and Families should articulate a clear vision and mission for the Connecticut Juvenile Training School, and then enforce their expectations and rules.

5. The Connecticut Juvenile Training School leadership must take immediate steps to provide for the individualized needs of the children in their care. This will include the provision of appropriate treatment and education.

6. DCF administration must ensure that management at CJTS is on site and accessible to all staff at all times and that such management fully understands all aspects of the facility and its programs.

7. The Connecticut Juvenile Training School administration must define, develop and implement protocols for tracking and following up on "critical incidents."

8. The Connecticut Juvenile Training School administration must improve the process of imposing and reviewing sanctions on children at the facility.

9. The actions of officials and employees of the Department of Children and Families should be reviewed to determine whether or not disciplinary action is warranted.

10. Oversight of state operated facilities serving children, such as the Connecticut Juvenile Training School, should be truly independent from DCF functions associated with program development and program administration in order to ensure that DCF decision making is objective.

11. An effective internal quality assurance program is necessary at the Connecticut Juvenile Training School.

12. The management structure and protocols for internal communication at the Department of Children and Families must be revamped so timely and accurate information is presented to responsible managers.

13. The Department of Children and Families should develop a long term planning unit that operates separately from program administration.

Key Persons Involved with CJTS During this Investigation

There are a number of individuals at DCF and the Connecticut Juvenile Training School who played a significant role in the facts that are discussed in this report. This section identifies only those mentioned by name in the report for ease of reference. This list does not reflect the sum total of persons who cooperated with this investigation.

1. **DCF Executive Staff**

Kristine Ragaglia, JD: Commissioner of DCF. She has responsibility for all functions of DCF.

Stacey Gerber, MSW, MS: Deputy Commissioner of DCF. Her responsibilities include oversight of the Bureau of Quality Assurance and of Human Resources.

Thomas Gilman, MCW: Deputy Commissioner of DCF. His responsibilities included oversight of the Bureau of Juvenile Justice until it was abolished in June 1st, 2002. His responsibilities also include oversight of the Bureau of Child Welfare and the Bureau of Behavioral Health, Medicine and Education.

2. **DCF Senior Managers**

Lou Ando, Ph.D.: DCF Bureau Chief, Behavioral Health, Medicine and Education. His responsibilities include oversight of the DCF facilities Riverview, High Meadows and Connecticut Children's Place. In June 2002 he was directed by Commissioner Ragaglia to oversee CJTS and LLS, and provide supervision to Superintendent Mara. Dr. Ando also supervises the Director of Medicine, the Director of Mental Health and the Superintendent of USD II School within the Department.

Gary Blau, PhD.: DCF Bureau Chief, Bureau of Quality Assurance His responsibilities include oversight of DCF licensing; program review, treatment planning process and administrative case review functions as well as the Special Review Unit.

Rudy Brooks: DCF Bureau Chief, Bureau of Juvenile Justice until the Bureau was abolished on June 1, 2002. His responsibilities included oversight of the development of Connecticut Juvenile Training School.

Leslie Mara, JD: Superintendent, CJTS from its opening in August 2001 until September 13, 2002 when she resigned.

Michael Schultz Ed.D: Acting Superintendent, Long Lane School. Prior to this appointment he was charged with overseeing and supervising the Bureau of Quality Managements Internal Review of CJTS.

3. **DCF Managers**

Lisa Flower-Murphy, MSW: Assistant Superintendent, CJTS. Her responsibilities include oversight of clinical treatment and residential programming. In June 2002 she was assigned responsibility for oversight of ombudsman activities, and critical incident reports and procedures.

John LaChapelle: Assistant Superintendent, CJTS. He has oversight of safety, security and residential life. Prior to this assignment, he was Superintendent of Long Lane School.

4. **Other DCF Personnel**

Ron Brone, Ph.D.: Quality Assurance Manager, CJTS. He was appointed in late February 2002. Prior to this position he was a staff Psychologist.

Buck Gregory: Supervisor, DCF Special Investigations Unit at the Hotline. He is responsible for direct supervision of the DCF Social Workers assigned to investigate DCF Abuse/Neglect Hotline reports within CJTS.

Kenneth Mysogland, MSW: Director of the DCF Child Abuse Neglect Hotline.

Arnold Trasente, Ph.D: DCF Program Review and Evaluation Unit. He is currently overseeing the implementation of the CJTS Corrective Action Plan.

Sec. 46b-121h. Goals of the Juvenile Justice System*. It is the intent of the General Assembly that the juvenile justice system provide individualized supervision, care, accountability and treatment in a manner consistent with public safety to those juveniles who violate the law. The juvenile justice system shall also promote prevention efforts through the support of programs and services designed to meet the needs of juveniles charged with the commission of a delinquent act. The goals of the juvenile justice system shall be to:*

(1) Hold juveniles accountable for their unlawful behavior;

(2) Provide secure and therapeutic confinement to those juveniles who present a danger to the community;

(3) Adequately protect the community and juveniles;

(4) Provide programs and services that are community-based and are provided in close proximity to the juvenile's community;

(5) Retain and support juveniles within their homes whenever possible and appropriate;

(6) Base probation treatment planning upon individual case management plans;

(7) Include the juvenile's family in the case management plan;

(8) Provide supervision and service coordination where appropriate and implement and monitor the case management plan in order to discourage reoffending;

(9) Provide follow-up and nonresidential post-release services to juveniles who are returned to their families or communities;

(10) Promote the development and implementation of community-based programs designed to prevent unlawful behavior and to effectively minimize the depth and duration of the juvenile's involvement in the juvenile justice system.

(P.A. 95-225, 5. 1, 52.)
History PA. 95-225 effective July 1, 1996.

Connecticut Juvenile Training School

I. HISTORY AND INTRODUCTION

A. THE DEATH OF TABATHA B.

On September 26th, 1998 15-year-old Tabatha B. was found hanging in her room at Long Lane School, the only secure facility for adjudicated children in Connecticut. She died 2 days later. Following her death, two reports were generated that highlighted major deficiencies in Connecticut's only state-owned and operated facility for adjudicated children. One report was contracted by DCF and produced by Edward Loughran, entitled *Report on the Bureau of Juvenile Justice*. The State Child Fatality Review Panel produced the second report. The findings of both reports described a facility that was severely overcrowded, understaffed, lacking in both resources and a therapeutic milieu. The physical environment was characterized as unsafe and substandard. The staff was described as ill equipped to assess children at risk of suicide. They were also noted to overuse physical restraint and found to be poorly informed about their responsibilities for reporting incidents of abuse and neglect to the DCF Hotline. The Child Fatality Review Panel also noted the lack of independent oversight as a major concern.

Tabatha B.'s untimely death was the catalyst for the building of CJTS.

In response to Tabatha's death, the Department of Children and Families (DCF) administration made a public commitment to build what they hoped would be one of the best juvenile training center for boys in the country. (The girls would remain at Long Lane School for the meantime.) DCF spent 57 million dollars to build a so-called state of the art facility, the Connecticut Juvenile Training School (CJTS). By all accounts, the facility would house a treatment-based program with a full range of clinical services, a comprehensive behavior management program and a school system with special education and vocational programs to prepare boys to return to the community. Strangely enough, the model the Department of Children and Families chose for the treatment-oriented program was a maximum-security juvenile corrections institution in Marion Ohio that was just under construction at the time to house serious, violent juvenile offenders between the ages of 12 and 21. The CJTS facility opened in August of 2001 with an operating budget of 33,204,000 dollars[2].

[2] CJTS total operating budget was $34, 704, 000 in FY 2002 that included $1.5 million for fuel cell payments. Cindy Butterfield, CJTS Fiscal Administrative Manager

B. DCF SHOULD HAVE LEARNED THE IMPORTANCE OF PROVIDING PROPER OVERSIGHT OF FACILITIES SERVING CHILDREN FROM ITS FAILURE TO PROVIDE PROPER OVERSIGHT TO HADDAM HILLS ACADEMY, WHICH CAME TO LIGHT SHORTLY BEFORE CJTS OPENED.

Prior to the opening of CJTS, DCF was just extricating itself from an embroiled relationship with a private residential facility contracted to provide care for adjudicated boys. After a great deal of public attention including a hearing before the General Assembly's Committee on Children, DCF revoked the operating license of Haddam Hills Academy. A subsequent report produced by the Attorney General and the Child Advocate found that Haddam Hills Academy had opened in May 1998 with a highly unusual "provisional license" despite the fact that there was no program description, and few clinical staff or educators to provide services to the boys. The inadequacies of services and subsequent unsafe conditions were chronic ailments throughout the life of the facility.

In early 1998 DCF was under pressure to accommodate an overflow of boys from Long Lane School. Haddam Hills Academy appeared to be the answer. Shortly after the Academy opened DCF began receiving what would be a long line of reports and concerns about the facility that ranged from inadequate programming and supervision to the presence of staff-organized "hit squads" among the youth, and serious child care, safety and management failings. DCF received numerous hotline reports, self-reported "critical indicators" recording injuries and assaults among youth, and expressed concerns from professionals at the facility. Despite all of the information that was provided to DCF, the state agency stood silent on the concerns and continued to license the facility for nearly three more years. During that time, problems persisted and intensified.

The urgent need for space seemed to override any concerns about Haddam Hills. The theme for excuses for developing problems was "*It's a new program. It's going to take a little bit of time. And we need the program* (Schultz, p282).[3]" There was an astonishing amount of DCF Central Office involvement in Haddam Hills Academy over the life of the facility. As noted in the joint Attorney General and Child Advocate Report, the facility never should have been licensed and children never should have been placed there. This was also acknowledged by all levels of management at DCF, including Commissioner Ragaglia. It would be bad enough that the boys' treatment needs went unmet – there were no substance abuse programs, no therapeutic services and limited educational programs. Beyond those failings, the boys were maltreated. It was clearly evident that Commissioner Ragaglia and her top executive staff were well aware of the serious problems at Haddam Hills, yet they continued to stand silent and failed to ensure the safety of the boys placed there. When the Commissioner finally revoked the Academy's license she appeared to

[3] Schultz, M. Testimony before the Office of the Attorney General, page 282, in Report of the Attorney General and the Child Advocate: Department of Children and Families Oversight of Haddam Hills Academy. May 30, 2002.

acknowledge the lack of planning and oversight that led to such a dismal failure, stating in testimony before the Office of the Attorney General, *"But I would not hold this up as an example of our best work as our agency."*[4] Commissioner Ragaglia stated in a newspaper report on the findings of the Attorney General and the Child Advocate that, "*because of the 'difficult population' DCF serves, there are always going to be issues. I don't think there will ever be a time when things like this won't happen."*[5]

DCF will likely continue to serve a "difficult" population in that children who have been abused and neglected tend to have corresponding complex mental health needs and children with behavior disorders (who may be one and the same) have intensive needs as well. However, the fiasco at Haddam Hills Academy involved an unacceptable absence of planning, oversight and accountability. Boys were denied services at Haddam Hills Academy, their educational needs were not met and some of them were beaten. It is the responsibility of the Department of Children and Families to ensure things like that never happen again.

C. NOTWITHSTANDING DCF'S VERY RECENT FAILURE WITH HADDAM HILLS ACADEMY, DCF AGAIN FAILED TO PROPERLY PLAN FOR AND OVERSEE THE OPENING OF CJTS.

The joint report on Haddam Hills Academy by the Attorney General and the Child Advocate was released in May of 2002. While the Attorney General and the Child Advocate were still assessing the implications of their Haddam Hills Academy report they were beginning to receive strikingly similar allegations concerning CJTS. The new training school opened ahead of schedule during August of 2001. As early as November, reports in the news media began to appear citing problems of inadequate supplies, staff shortages and a lack of services and educational programs for the boys. Again, a facility was opened in a rush to meet a need. Even the resident boys recognized the lack of planning. The Hartford Courant quoted one 16-year-old as stating, *"You all should have had theses things in place before we got there. The old Long Lane was much better."*[6]

The Office of the Child Advocate (OCA) and the AG launched a joint investigation of CJTS three months after it opened, based on reports of supply shortages such as books and desks at the school; staffing shortages all around; and the total lack of a behavioral management plan for the facility, among other things. The Child Advocate acted pursuant to Conn. Gen. Stat. § 46a-13k et seq. in response to complaints received by the Child Advocate. The Attorney General responded as a result of "whistleblower" complaints under Conn. Gen. Stat. § 4-61dd. The Child Advocate and Attorney General collaborated in all aspects of this investigation.

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[4] Commissioner Kristine Ragaglia in testimony before the Office of the Attorney General, p138 in Report of the Attorney General and the Child Advocate: Department of Children and Families Oversight of Haddam Hills Academy. May 30, 2002.

[5] Soper, K. (2002). Blumenthal, child advocate say DCF culpable for Haddam Hills abuse. Journal Inquirer, Hartford. Friday 31, 2002, page 21.

[6] Poitras, C. (2001). *Trouble at Long Lane Replacement: New juvenile facility hits snags in first three months.* Hartford Courant, Thursday, November 15th, page B1.

Over the course of a ten month investigation, the OCA and the AG unearthed multiple seriously unsafe situations and practices at CJTS, including the breach of Connecticut state law and both DCF and CJTS policy. The initial complaints of inadequate supplies, staff, and services where highly suggestive of poor planning and negligence to some degree. There were significant lapses in staff training and retention, there was an alarming delay in establishing a behavioral management program that is still not fully functioning; boys are not being treated for mental and behavioral health disorders; the educational program is severely weak and special educational needs are not being identified or addressed.

There are serious concerns that boys are being maltreated at CJTS. The rate of restraints and seclusion is high and not being accurately reported. Most disturbing however, is that as we approach the fourth anniversary of Tabatha B.'s death, boys are still at imminent risk for suicide. They are not being protected from themselves adequately and there is no evidence that their underlying health needs are being addressed.

One year and over ninety million dollars after the opening of CJTS, there is still a substantial risk that children at CJTS could succeed in committing suicide due to inadequate suicide prevention procedures.

Just as with Haddam Hills Academy, Commissioner Ragaglia and all of her top executive staff were clearly aware of what was going on at CJTS. And yet again, just as with Haddam Hills Academy, DCF has stood silent while boys have been and may still be maltreated and placed at imminent risk. Only this time, the boys are being mistreated and placed at risk in a DCF-owned and operated facility – touted as a national model facility which has already cost the State more than $90 million to construct and operate – for which DCF has the sole responsibility to operate, oversee, and ensure quality care.

News items about problems at the facility appeared in the media consistently from November 2001 through the spring of 2002. Immediately as this investigation began, both the Attorney General and the Child Advocate communicated multiple concerns to the CJTS and DCF administrations regarding conditions at CJTS. Throughout, Commissioner Ragaglia stood silent to the boys at CJTS. It was not until March of 2002 that the Commissioner finally sent in her own quality management staff to investigate the facility.

Around the same time, an independent program review was conducted by the Center for Criminal Justice Research. Their findings were issued in April. Among other things, they rated the program characteristics of the facility "unsatisfactory."[7]

[7] Latessa, EJ, & Pealer, J. (2002). Correctional program assessment inventory: Conducted on the Connecticut Juvenile Training School. Center for Criminal Justice research, Cincinnati Ohio.

The findings of the Tabatha B. Fatality Review Report, included inadequate resources and staffing, lack of oversight, failure to meet mental health needs of the youth, abuse and neglect of the youth, routine use of physical and mechanical restraints in violation of policy, deficient record keeping, and ultimately failure to keep Tabatha alive. All of those findings, with the exception of a completed suicide, were found to apply to CJTS. The Tabatha B. findings had little impact on the administration of the new facility in Middletown.

On June 10, 2002, Commissioner Ragaglia forwarded the DCF Bureau of Quality Management (BQM) Program Evaluation Report to the Child Advocate and the Attorney General. The BQM report cited serious deficiencies in five core categories of concern at the facility:

1. *Safety and Security*
2. *Human resources*
3. *Organizational Systems*
4. *Service Delivery and Program Development*
5. *Quality Assurance*

Safety and security were identified by the DCF BQM Report as the primary concern of the majority of staff, resident boys and visitors surveyed. Human resources concerns included: low staff morale, leadership issues, cross discipline relationships, training and development and supervision. Among organizational systems issues, the lack of a clear mission, philosophy, structure, management and communication were identified as being problematic. Concerns regarding service delivery and program development focused on the appropriateness of match between the individual needs of the boys and available services and programs. Finally, quality assurance, in the areas of staffing, policy and procedure, ombudsman effectiveness, and communication with the Central Office were all identified as focus of concern. The Commissioner promised the AG and the Child Advocate that she had, "*already instructed CJTS to develop a corrective action plan within the next 30 days.*" [8]

The subsequent CJTS Action Plan addressed ten areas of focus in ways that largely concentrated on developing quality assurance mechanisms, improving relationships and valuing all staff input (See Appendix A). Several committees and councils were recommended, along with an advisory board. Astonishingly, nearly a year after the "state-of-the-art" correctional facility was opened, the action plan in response to the BQM report included defining the CJTS philosophy, mission and model. As of the writing of this report (Early September 2002), a philosophy, mission and model had yet to be defined.

[8] Ragaglia, K. June 10, 2002 letters to Child Advocate Milstein and Attorney General Blumenthal.

The death of Tabatha B. and the highly publicized maltreatment of the boys at Haddam Hills Academy changed nothing at the Department of Children and Families concerning planning and oversight for CJTS.

This report concludes that the boys at CJTS are at imminent risk of injury and even death for the lack of suicide prevention procedures. They are being maltreated though the misuse of physical restraints and seclusion methods. And the lack of sufficient mental health and educational services borders on neglect in DCF's failure to provide proper care and attention to the boys placed in the department's care.

D. WHO ARE THE BOYS OF CJTS?

To understand the inadequacies of CJTS, it is necessary to understand the unique characteristics of the boys placed there. CJTS was intended to serve a population of male youthful offenders between the ages of 12 and 16. "The youth admitted to CJTS have experienced histories of profound abuse and neglect, severe conduct disorders, and severe psychiatric disturbances."[9] An estimated 75 percent of juvenile offenders in general have experienced significant family-related problems including abuse and neglect. The incidence of depression among juvenile offenders ranges above fifty percent of the population. The incidence of learning disabilities and behavior problems is also high. Given the complexities of their backgrounds and current circumstances, boys placed at CJTS require highly specialized and individualized care.

Only about a quarter of the boys at CJTS are incarcerated for violent crimes. Connecticut Superior Court for Juvenile Affairs transfers to the regular criminal court (adult) all cases of children charged with serious offenses[10] provided that the child had attained the age of 14 at the time of the alleged offense. The largest pool of boys at risk of commitment to CJTS, therefore, are those with misdemeanors and felony convictions who have not succeeded in community placements, children who have committed serious acts when they were younger than 14, delinquent boys with serious mental health and behavioral problems who cannot be managed in other DCF facilities, boys who have violated court orders or probation or those who have not succeeded in residential treatment placements. The most serious juvenile offenders, those charged with serious juvenile offenses (SJO) and who are at least 14 years old, are transferred to the regular criminal docket (adult) and then to the Manson Youth Institution. Similar to the Marion Ohio facility that CJTS was modeled on, Manson is a "level 4" high-security correctional facility that houses serious male offenders ranging in age from 14 to 21[11].

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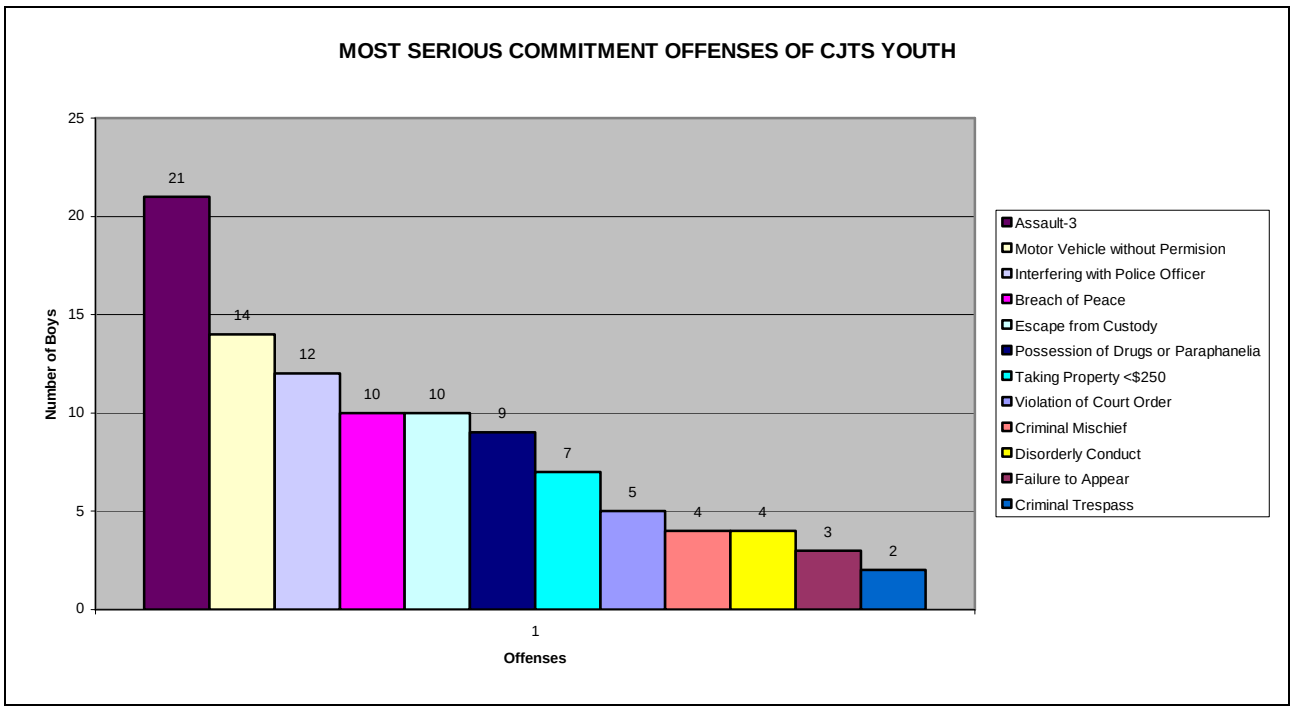
[9] Department of Children and Families (2002). Connecticut Juvenile Training School Program Evaluation Report, Bureau of Quality Management, Hartford, June 10.

[10] Serious offenses: Capital, Class A (eg. Murder, kidnapping 1st arson 1st) and B felonies (eg. sexual assault in the 1st degree, burglary 1st, arson 2nd larceny 1st and robbery 1st)

[11] In August of 2002, Manson Youth Institution had a census of 687 youth under 20 years old who were convicted of serious and violent crimes. Of the total census, 381 were boys under the age of 18 including 24 boys under 16. At the same time, there were 170 16 and 17 year old boys awaiting sentencing in adult jails around the state.

Data provided by CJTS on commitment offenses for youth incarcerated during March 2002, showed that, of the most serious offenses for which each youth was committed, only 37 of the 152 youth at the facility were committed for offenses against persons. This number includes 21 youth for whom the most serious offense was Assault-3, i.e., a fight. The most serious commitment offenses included 4 youth charged with criminal mischief (damage to property), 2 were charged with criminal trespass, 10 were charged with escape from custody, 12 with interfering with a police officer, 9 charged with possession of drugs or drug paraphernalia, 14 charged with use of a motor vehicle without the owner's permission, 10 charged with breach of the peace, 4 charged with disorderly conduct, 3 charged with failure to appear in court, 7 charged with taking property worth less than $250, and 5 charged with violation of a court order.



Commissioner Ragaglia described CJTS as a rehabilitation facility for boys in the juvenile justice system. In a news-radio interview[12] on July 22, 2001 she described the youth at CJTS as follows:

> *"Sometimes they're just violating an order of a court and have been before the court so many times, the judge needs to send them somewhere to give them a wake-up call, or they have somewhat serious offense, like arson or robbery or assault… The majority of the kids come from urban areas … most of the kids have grown up in homes that have seen domestic violence, have seen drugs, have*

[12] Ragaglia, K and Frances, C. (2001). "DCF takes the wraps off new juvenile training school". WTIC Face Connecticut Program, Sunday, July 22.

grown up with gang wars going on outside their homes, and have seen the effects of all that, and have tried to deal with that kind of a life."

The Commissioner's description reflects what is known about the needs of children in correctional facilities around the country. Particularly in the age group between 12 and 16, the basic needs of adolescent development combined with the experiences of dysfunctional home situations have been related to the likelihood of boys being incarcerated. Once incarcerated, the boys are considered at extremely high risk for complicating mental and behavioral health problems as serious as suicide and aggression.

E. SUMMARY OF DCF'S UNDERSTANDING OF THE BOYS' NEEDS AT CJTS

The Commissioner expressed understanding of this population of boys and DCF has had years of experience working with adjudicated youth. Given that experience and understanding, the expectations of a rehabilitative, treatment-oriented facility would reflect that knowledge and sensitivity. It would be expected that a treatment-oriented program would be specifically designed to address the psychiatric, emotional, and behavioral needs of boys with traumatic and dysfunctional histories. The care planned for the boys would include an emphasis on depression, post traumatic stress disorder, attention deficit hyperactivity disorder, substance abuse, and learning disabilities – all of the problems associated with childhood abuse and neglect that at times translate to conduct disorders and other troubling behaviors.

The population of boys served by CJTS is a "high-need, low-risk" population for their mix of complex mental and behavioral health care needs and their relatively low security risk given the nature of their offenses. The design of CJTS includes security technology that can accommodate a population that is a high security risk with low-needs for support and care. The model that DCF chose to copy their rehabilitative/correctional programs from contradicts the intended treatment model. The facility in Marion Ohio was designed to ensure public safety, as it would accommodate serious and violent juvenile offenders adjudicated for charges including rape and homicide. The Ohio facility did not emphasize educational and treatment needs as evidenced by the lack of space for both. A technologically advanced security system was the source of praise for that "state-of-the-art" facility, not treatment or educational programming.

Despite appearing to be familiar with the population of boys placed at CJTS and the nature of their mental and behavioral health needs, DCF has failed to meet those needs. The department has developed a facility that is not designed nor staffed and supported in such a way as to address the special needs of boys adjudicated for mild to moderate offenses. Specific deficiencies at the facility include: misuse of restraints and seclusion, lack of an effective behavior management program, inadequate clinical services, inadequate educational and vocational services and general infrastructure deficiencies including the absence of a mission, staff shortages and no quality assurance. In the worst and most concerning circumstances, some of the boys have been placed at imminent risk of harm or even death by self-inflicted injury and suicide.

II. SIGNIFICANT CONCERNS AT CJTS INCLUDE INADEQUATE SUICIDE PREVENTION PROCEDURES AND MISUSE OF RESTRAINTS AND SECLUSION.

The most pressing concerns about CJTS are the risk of completed suicide and the misuse of restraints and seclusion. Contributing factors to these problems are the lack of an operating behavior management program and poorly trained and supported staff providing substandard clinical, therapeutic, and educational services.

A. CJTS DOES NOT ADEQUATELY PROTECT CHILDREN FROM RISK OF SUICIDE

Suicide is a Leading Cause of Death Among Adolescents

1.Background

Suicide is the third leading cause of death among adolescents aged 15 to 19 in the United States and Connecticut[13]. Among youths 10 to 14 years old, suicide rates increased 100 percent in the past 20 years[14]. While the suicide rate among young people is greatest among white males, from 1980 to 1996 the suicide rate increased most rapidly (and more than doubled) among black males ages 15 to 19. During the past decade, there have also been dramatic and disturbing increases in reports of suicide among children. Suicide is currently the fourth leading cause of death among children between the ages of 10 and 14 years.[15] The people most at risk for committing suicide are those who have several of the following characteristics:

- Have attempted suicide in the past
- Have a family history of suicide
- Have a firearm in the home
- Consume alcohol and/or abuse other substances
- Are depressed (changes in sleeping patterns and appetite, feeling worthless)
- Have experienced violence (physical, sexual, domestic, or child abuse)

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[13] CDC, 1995. "Suicide among children, adolescents, and young adults – United States, 1980-1993" Morbidity and Mortality Weekly Reports, 44 (15) 289-291. Chapman, J., Wasilsky, S. & Zuccaro, M (2000). Assessment of the psychiatric needs of children in Connecticut juvenile detention centers: A report to the Deputy Chief Court Administrator's Task Force on Overcrowding.

[14] Center for Disease Control, (2001). Suicide in the United States. CDC unpublished mortality data from the national Center for Health Statistics Mortality Data Tapes, Atlanta, GA: in Rew, L., Thomas, N., Horner, S., Resnick M., & Beuhring, T., (2001) Correlates of recent suicide attempts in a triethnic group of adolescents. Journal of Nursing Scholarship, 33:4, 361-367.

[15] U.S. Public Health Service, *The Surgeon General's Call To Action To Prevent Suicide*. Washington, DC: 1999.

- ❑ Are experiencing unusual stress due to adverse life events, such as separation from a loved one
- ❑ Have spent time in jail or prison
- ❑ Have a medical condition
- ❑ Move frequently from one location to another
- ❑ Experienced poor parent/child communication
- ❑ Feel socially isolated

2. Children in the Juvenile Justice System are at heightened risk for suicide

Suicide among court-involved youth is strongly linked to substance abuse, particularly when combined with the presence of an affective disorder such as depression.[16] Diagnoses associated with involvement in the juvenile justice system parallel those associated with youth suicide. They include mood disorders, disruptive disorders, and substance abuse.[17]

Having identified adolescent suicide in general as a major public health problem in the United States, the US Centers for Disease Control (CDC) described strategies as early as 1995 for preventing suicide among young persons. They included a specific call to action among training school and community leaders to identify young persons at highest risk for suicidal thoughts, threats and attempts."[18] The charge to administrators of training schools is based on the recognition that children and adolescents who are incarcerated or known to the juvenile justice authorities are at high risk for committing suicide. Of particular concern are children in the initial hours of incarceration because fifty percent of all in-custody suicides occur within the first 24 hours of lock-up. One half of those occur within the first 3 hours[19], and deaths frequently occur in isolation[20].

Recommendations for addressing suicide include active treatment for adolescents who are identified as being at high risk. They also include the availability of crisis intervention services and vigorous treatment and supports for children who have made suicide attempts[21].

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[16] Brent, D. (1995). Risk factors for adolescent suicide and suicidal behavior: Mental and substance abuse disorders, family environmental factors, and life stress. Suicide and Life Threatening Behavior, 25 Supplement, 52-63, in Chapman, et al (2000).

[17] Kaplan, S., Pelcovitz, D., Salzinger, S., Mandel, F. & Weiner, M., (1997). Adolescent physical abuse and suicide attempts. Journal of American Academy of Child and Adolescent Psychiatry, 36 (6), 799-808, in Chapman, et al, (2000).

[18] CDC, (1995). Suicide among children, adolescents and young adults – United States, 1980-1992. Morbidity and Mortality Weekly Reports, 44(15)291, in Child Fatality Review Panel, (1998) Investigation into the Death of Tabatha B., Office of the Child Advocate, Connecticut.

[19] National Center for Institutions and Alternatives, (1998). Model suicide prevention programs part I. Jail Suicide/Mental Health Update, 7(3), 1-9.

[20] McKee, G. (1998). Lethal vs. nonlethal suicide attempts in jail. Psychological Reports. 82, 611-614 in Chapman, J. et al, (2000).

[21] Garland, A.F., & Ziegler, E., (1993), in, Child Fatality Review Panel, (1998) Investigation into the Death of Tabatha B., Office of the Child Advocate, Connecticut.

3. Suicide safety and prevention at CJTS is poor.

There is no question that administrators and clinicians at CJTS recognize the importance of suicide prevention at the facility. One manager noted that,

> *"Suicide prevention… is our highest priority, to protect kids who may injure themselves… we're most vulnerable… if kids hurt themselves." "Well, suicide in general tends to be an issue… with incarcerated groups… the demographics of our population automatically raises the risk of suicide. Once a kid is incarcerated… even if he's not mentally ill… he may try to hurt himself because of the circumstances that he's in…*

Policy is in place, albeit in draft form, requiring the assessment and prevention of suicide among residents of the facility. LLS[22] Policy 82-21-1 incorporates the basic expectations for response to suicidal adolescents (See Appendix B.). The policy states "CJTS will ensure youth safety by procedures for the screening, assessment and supervision of youth at risk for suicidality." The policy prescribes how safety will be ensured through a series of steps involving assessment, identification of risk, and various levels of direct observation of the child or youth of concern. During this investigation suicide assessment and prevention practices were found to be inconsistent or not in compliance with that policy. Specifically, access to qualified clinicians and ongoing follow-up was inconsistent and often unavailable. Documentation of assessments and safety watches were poorly maintained and often incomplete. Furthermore, documentation did not consistently match actual practice observed or other reports of incidents.

A Boy Intent on Killing Himself: Eric[23]

16-year-old Eric was admitted to CJTS on 3/11/02. At the time of admission, a safety assessment was conducted and he was determined to be at risk of suicide. Ten-minute Safety Watches[24] *were ordered to assure he did not harm himself.*

Eric's history included multiple psychiatric hospitalizations, periodic depression, and multiple placements in a variety of homes and facilities. A Suicide Alert Sheet dated 3/11/02 contained the information that, "Eric has a long history of periodic depression, suicidal ideations and periods of being out of control." From the admitting assessment, Eric remained

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[22] CJTS has yet to establish its own policy. Long Lane School policy has been used as applicable at CJTS.

[23] The name of this child, as well as any other child referred to in this report, has been changed to protect the identity of the child.

[24] CJTS 82-21-1: Safety Watch: "A youth may be placed on any of the following watches by the clinician based on screening/mental health assessment of youth. The ten (10) minute safety watch is for those youths who have some risk for suicidal behavior. Staff should observe these youths and document behavior at staggered intervals not to exceed every ten (10) minutes. The five (5) minute safety watch is for those youths whose risk of suicidal behavior is seen as being significant. Staff should observe these youths and document behavior at five (5) minute intervals. The One to One (1:1) safety watch is for those youths whose risk for suicidal behavior is seen as being imminent. The staff's exclusive duty is to directly observe and protect the youth at all times. The behavior of youths on 1:1 safety watch status will be described every fifteen (15) minutes on the safety watch sheet."

on a 10-minute safety watch until 3/18/02, when his assigned clinician[25](clinical social worker) removed the watch based on an assessment that the boy had stabilized.
On 3/27/02 Eric's clinician requested a referral for the boy to have a psychiatric evaluation. The rationale for the request included, "Eric has a history of suicidal ideations and self-mutilation including cutting/marking himself. Eric admits to being depressed, feelings of anger and sadness, and when angry, thinks about harming himself."
A Social History of Eric revealed that he was "a victim of physical abuse by his father and mother's boyfriend. Eric and his brother sexually assaulted their younger sister several years ago."

In the course of this investigation, an Incident Report was found in Eric's file indicating that he was hurting himself on 3/20/02 or 3/28/02 (unable to determine due to handwriting). No other report of this incident was documented in notes or clinical records. The Incident Report indicated, "Eric was upset and angry with staff. Eric had blood on his hand and also on the floor in his room. Eric stated that he was punching the wall because he was angry."

On 3/28/02, Eric was placed on a 10-minute safety watch for threatening to kill himself and demonstrating out of control behaviors. He was taken off the 10-minute safety watch on the next day because his clinician assessed him to be stable and Eric agreed to contract for safety[26].

On 4/15/02, an Individual Behavior Plan (IBP) was developed for the boy. The major behavioral issue identified in the plan was that he refused to return to his room and threatened to harm himself when he was confronted. The goals for the plan were that Eric would be compliant with directives and the program consistently, and he would eliminate making threats to harm self and handle frustrations appropriately. There is no record of any further suicide watches for the rest of that month.

On 5-4-02 1:55pm Eric was placed on a 10-minute safety watch after he presented with self-injurious behaviors, punching himself in the face and smearing blood on his window.

On 5/5/02 Eric made another suicidal gesture. From 8:42 pm until 9:33pm he was placed in mechanical restraints. At 9:30 pm he was seen by the on-call clinician who determined Eric to be OK and continued 10-minute safety watches No suicide alert form was found or provided by CJTS of this consultation. There was only a notation in the unit file and log book describing the incident. At 10:23 pm, Eric was assessed to be out-of-control and staff informed the nurse that he was smearing blood on the windows. At 10:42 pm a nurse ordered 1:1 safety watch status with the door of Eric's room "to be closed". The suicide alert form stated, that the Duty Officer was notified; clinician on call will be notified by the Duty Office. The unit shift change occurred around 11:00. A review of unit videotape from that night revealed the staff person assigned to 1:1 safety watch approaching Eric's door at 11:07. The staff set two chairs in place in front of Eric's closed door. Approximately every 10-20 minutes the staff person was noted to get up and check in the window of Eric's door. At 11:51 Eric got up and went into the bathroom for approximately 4 minutes. The 1:1 staff did not follow him or keep him in view. From approximately 2:47 am to 5:05 a.m., the 1:1 staff made no movement in the chairs and appeared to be sleeping. The only movement in the corridor throughout the early morning was the unit staff person assigned to check rooms for all residents. That person pressed a

[25] Clinician: May be a clinical psychologist or a licensed clinical social worker
[26] Contract for Safety: develop a plan for alternative actions than self-harming ones. Agree to commit to the plan or contract.

button at Eric's door several times but did not enter or look in the room[27]*. Room checks were conducted inconsistently with varying intervals of 20-40 minutes apart.*[28]

Also on May 5th, an Internal Charge Sheet[29] *was generated by YSO staff on Eric reporting that on May 5, at about 11:30 pm "Sam was seen by this YSO scratching his initials into his left bicep. Resident charged for self-mutilation". In addition, Eric "proceeded to destroy a state issued blue T-Shirt. Resident charged for destruction of property". This incident report was signed by the YSO assigned to be providing 1:1 coverage for Eric at 12:40 am. The YSO did not document any attempts to counsel or comfort the resident who had been on 1:1 suicide alert since 10:42 that evening for self-mutilation and suicidal behavior.*

On 5-6-02, At 7:30 am, the morning nurse discovered that Eric was bleeding from a self-inflicted wound from his chest to his abdomen) that he had rubbed aggressively with a button. Between 9 and 10:00 a.m. Eric was allowed to move around the unit until he began to act aggressively and threaten self-harm. Agency Police Officers were called to the unit to move Eric into his room. He was seen by the on-call clinician at 11:00 and eventually transferred to the Special Needs Building that day. A psychiatrist did not see or evaluate him.

The related documentation for the 5/5/02 incident was discovered by OCA staff in a stack of papers and was not filed in the child's record until July of 2002. A required Critical Incident Summary/Update Form was not completed, signed, nor accurately dated to reflect the timing of Eric's self-injurious behaviors OCA staff also noted the Unit Manager had signed off on incomplete log sheets

ANALYSIS

While under a suicide safety watch, "Eric" went unobserved and therefore unprotected for long periods of time. Despite having injured himself and repeatedly threatening to harm himself, there is no record that he received any psychiatric intervention for his suicidal behaviors. More over, documentation for his suicide safety watches was not complete and did not reflect actual events.

4. Clinical staff are not properly responding to boys in suicidal crisis

According to Policy 82-221-1 Intervention for Suicidality,

> "Any staff member who has reason to believe a youth is potentially suicidal, through gesture, words, or behavior will put the youth under direct observation and then immediately phone Clinical Services for a clinician to assess the youth;

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[27] A computer-generated alarm prompts staff to perform room checks on the boys. A button outside each room must be pressed to indicate the room check has been performed and to turn off the alarm.

[28] The CJTS policy on frequency of room checks is not clear. During an August 5, 2002 meeting in OCA Asst. Supt. Flower-Murphy was unable to state with what frequency room checks are required overnight.

[29] Charges: When a boy commits an infraction or violates a house rule he is "Charged" for the infraction. A charge sheet records the infraction, evidence of a hearing, and subsequent consequences. Charges against Eric were for destruction of property (a CJTS t-shirt) and self mutilation which is against house rules.

or, in the absence of an on site clinician phone Medical Services for the nurse on duty to respond… "

OCA heard several complaints from CJTS staff about clinicians not being available to youth in crisis. A review of a sample of documentation concerning youth suspected of being at risk for suicide indicated that there were repeated delays in response from on-call clinicians whom staff were attempting to summon to assess a youth at risk. Phone calls to clinicians on call were recorded as not being returned or were returned more than an hour later. Direct Care Staff who were interviewed for this report stated that corresponding documentation has shown that on-call clinicians did not always assess boys in person. OCA found several examples of situations where clinicians conducted assessments of boys over the phone, ordered clinical watches and/or a safety suits[30] and never came in to examine the youth until the following day.

A Unit Supervisor reported, and review of logbook entries confirmed, that on one occasion a clinician had to be summoned by the supervisor to come in to assess a youth on site as the clinician had continually ordered a safety suit for a youth without a face-to-face assessment for two days. Resident youth and CJTS direct care staff reported to OCA staff that they had made requests to see a clinician over weekend shifts that in their experience were not responded to for up to 24 hours. And staff reported experiencing no response at all to some consultation requests from on-call clinicians.

OCA staff noted in record reviewing that CJTS nurses completed a large number of safety watches and suicide assessments. According to CJTS policy, when clinicians are not available on site, the nursing staff is contacted to do the initial assessment of a boy suspected to be at risk. The majority of nurse-directed consults occur on second and third shifts when clinicians are not on site. In those instances, documentation in the youths' files did not clearly indicate as to whether the nurse actually discussed the situation with the clinician on call or if they were simply notified. The Director of Nursing raised concerns about suicide watches as related to the scope of nursing practice in the facility. In a letter to the staff in December 10, 2001 e-mail she stated: "*Nurses can place a child on a watch but this needs to be followed by a clinician seeing the child. This is not our responsibility as a department to be the one making this determination without clinical presence seeing the child.* " Delays for clinician assessment and intervention were noted to be as long as 12 to 24 hours after a nurse ordered one-to-one status. One youth was placed on a 1:1 watch for four days without seeing a psychiatrist. The policy does not define the time allowed between a nurses' initial assessment and follow-up by a clinician or indication for a psychiatric evaluation.

[30] A safety suit is a cushioned vestment that wraps around the arms and trunk and extends to the floor like a long dress. It is designed to protect against self-inflicted injury. An individual's personal clothes, including undergarments, may be removed before applying the suit.

5.<u>Documentation of clinical interventions and suicide safety watches is often incomplete and inaccurate.</u>

OCA staff reviewed a sample of records for boys assessed to be at risk for suicide. Nearly all of them were found to have incomplete documentation of safety watch procedure. Specifically, documentation of youth behavior at prescribed intervals often stopped being recorded at mid-shift and was not signed by a supervisor or supervising staff member as required. Descriptions of youth behavior also lacked detail and there was little variation in descriptions of boys' moods or behaviors

Clinical documentation of suicide assessments and watch status reports were not consistently filed in youth's files. Suicide Alert Forms, required by LLS Policy 82-221-1, were missing from the files of some boys assessed by on-call clinicians to be in need of safety watches. Additionally, the documentation found on Suicide Alert Forms, Safety Watch Status Flow Sheets, and Critical Incident Summary/Update Forms were frequently incomplete, and therefore communicating inaccurate information. For example, one boy was placed on 1-to-1 suicide watch for several days. A third shift suicide log sheet indicated that the boy was sleeping in his room the entire shift. Two days later a nurse requested a medical review based on the assessment that the boy reported symptoms of sleep deprivation for several days.

6. <u>Documentation of safety watch procedure does not consistently match staff activity</u>.

During the course of this investigation, OCA had the opportunity to observe staff doing safety watch activities on site and retrospectively on CJTS videotape. On more than one occasion, staff members were observed not to be making the safety checks prescribed by the clinical risk assessment. OCA staff noted staff assigned to maintain 1:1 supervision of boys at risk who, for long periods of time, did not maintain direct observation as required by policy. One staff person was observed on videotape allowing a youth on one-to-one supervision to walk around the unit unsupervised and be in the bathroom alone for over three minutes at a time in direct violation of the safety policy. "Eric's" 1:1 staff appeared to be asleep while the boy mutilated his abdomen and chest.

For those situations where OCA observed apparent lack of compliance with safety watch protocol, OCA staff reviewed the associated documentation of safety watches in each boy's files. In all instances staff had documented that ten-minute interval checks of the youths' status had been checked. In one instance, videotape revealed that three hours had elapsed before a staff supervising a youth on one-to-one checked the youth in his room, yet the log sheets indicated that the boy had been checked every ten minutes. When OCA requested information about oversight of suicide watches, the CJTS Director of Quality Assurance, Ron Brone stated in a July 10, 2002 e-mail to Dr. Ando that was forwarded to the Child Advocate that, "*The best evidence that a youth is being monitored are the Safety Watch Log Sheets.*"

Keeping a Boy Alive
Who is Watching a Boy Intent on Killing Himself?

- 6/24/02 OCA notified DCF and CJTS administration of concerns regarding suicide safety watches
- 6/25/02 OCA requested from CJTS administration a list of all youth on suicide precautions since 6/1/02 and the videotape of Eric's watch on 5/5 through 5/6/02.
- 6/24-25 and 7/12 and 7/15/02 OCA visited CJTS to review and copy Eric's file and attempt to locate missing documents from suicide watches.

- 7/10/02 CJTS Ron Brone who was assigned to locate requested documents responded to OCA requests in an E-mail: *"I was able to locate the log sheets from the time he was placed on watch 12:53 on 5/4/02 until 9pm on 5/9/02, with the exception of the following shifts: 1st shift on 5/5, 1st shift on 5/7, all shifts on 5/8 and 1st and 3rd shifts on 5/9."*
- 7/16/02 After reviewing the long-awaited requested video of Eric's suicide watch, OCA staff, concerned with the lack of supervision provided to Eric, made a report to the DCF Hotline for Abuse and Neglect as required by law.
- 7/15/02 DCF Bureau Chief Dr. Lou Ando informed OCA he had the missing log sheets from Eric's record.
- 7/16/02 OCA requested available log sheets from Dr. Ando.
- 7/18/02 Hotline Supervisor Buck Gregory requested the source of information on OCA's Hotline report and also requested to know response from DCF administration.
- 7/23/02 Hotline Investigator Dave Mongrain contacted OCA to discuss difficulties locating the same missing documents from Eric's record that OCA was seeking. He reported he had yet to view the videotape of the suicide watch.
- 7/26/02 OCA received a packet of copies of Log Sheets from Dr. Ando.
    - Included were Log Sheets that Ron Brone had been unable to locate and completed sheets not seen previously. Those sheets had supervisor's signatures on them where the other documents did not, despite policy requiring signatures.
    - One Log Sheet that OCA had found in the boy's record was not included in Dr. Ando's packet. Another Log Sheet for the same date and time period appeared in Ando's packet with indication that a different level of safety watch was ordered for that time period.
    - The documents showed evidence of having been faxed to Dr. Ando from CJTS on 7/12/02, three days prior to the report being made to the Hotline. These sheets were not found in the boy's file. The Hotline investigator was still not able to locate the same documents.
    - The documents could not have been part of the boy's file. OCA concluded that there were two sets of documents, neither of which corroborated the suicide safety watch activities captured on videotape.
    - 8/5/02 the Child Advocate invited DCF Deputy Commissioner Stacy Gerber, Bureau Chief Gary Blau and Hotline Director Ken Mysogland to a meeting to discuss concerns about the documentation of Eric's suicide safety watches and the fact he was able to mutilate himself while being on a suicide safety watch. CJTS Assistant Superintendent Flower-Murphy attended as well.
    - The preceding chain of events was discussed.
    - OCA also expressed concerns about the viewing of videotapes. Despite several requests for the videotape, no one at CJTS viewed the tapes that OCA was concerned about.

- Director Mysogland reported that his investigator had seen the tapes and was planning to watch 5 more covering a 24-hour period and then compare them with supporting documentation.
- The Child Advocate requested that an internal review be conducted to determine the legitimacy of the documentation of Eric's suicide watch and review practice and procedure at CJTS.
- No one present at the meeting, including CJTS Assistant Superintendent Flower-Murphy could state what, if any, is the formal quality assurance practice of reviewing facility videotapes.

- 8/7/02 OCA sent a letter to Deputy Gerber reviewing the concerns discussed at the meeting and requested a response within ten days regarding actions taken to ensure Eric's safety and access to treatment; to describe quality assurance mechanisms to ensure the safety of all the boys; and any findings from investigating the inconsistencies in documentation at CJTS.
- 8/13/02 OCA received a call from Director of DCF Hotline Ken Mysogland asking if Hotline investigator David Mongrain could come to meet with Assistant Child Advocate Panciera to review the 5/5-6/02 videotape of Eric's safety watch. Director Mysogland reported that the tape Investigator Mongrain reviewed was not clear so he wanted to see exactly what OCA saw. The tape was reviewed with Investigator Mongrain at the Child Advocate's Office. Investigator Mongrain reported that he had yet to receive any of the requested tapes on Eric. He viewed and borrowed three tapes from the OCA.
- 8/19/02 The Child Advocate returned a phone message to Deputy Gerber who reported that Eric had made another suicidal gesture on 8/12/02 and that she was dissatisfied with the response by staff to the boy's gesture.

o No Hotline report had been made
- The boy was not placed on suicide alert
- DCF administration was not informed until a week later.
- DCF Director of Psychiatry Dr. Pat Leebens was assigned to review Eric's record and examine him personally to determine what whether he was safe and what his treatment needs were.

- The Child Advocate sent Deputy Gerber a letter summarizing the phone conversation and requesting follow-up.
- 8/20/02 OCA staff visited Eric who reported that his most recent suicidal gesture, wrapping a laundry bag rope around his neck, was a joke. He also reported that he was getting no services or supports at CJTS and that he felt he needed to leave the facility. Eric stated that he is unable to control his anger and he takes it out on himself instead of others. He feels as if the only way to get attention is by trying to harm himself.
- 9/12/02 OCA received a letter from Bureau Chief Lou Ando responding to the Child Advocate's letter of 8/20/02 regarding Eric's 8/12/02 suicide attempt and the facility's response to it. Dr. Ando wrote that Eric's therapeutic needs were being addressed; that mandated reporter training was being conducted at the facility; and a risk management program was being developed.
- As of the publication date of this report, concerns regarding inconsistencies in documentation of suicide watch activities raised by OCA during the August 8th meeting, and the August 7th letter have yet to be responded to by DCF or CJTS. Eric has been referred to two one-hour sessions with a psychiatrist per week.

ANALYSIS

"Eric" is a boy who was identified to be at considerable risk for self-harm and suicide right from his admission to CJTS. His experience with suicide safety watches exemplifies the imminent risk boys are living with at CJTS. The questionable performance of staff duties and related documentation also suggests a disregard for seriousness of suicide safety.

7. Contrary to CJTS Administration's reports, boys at risk of suicide may be required to wear a safety suit for protection from self-inflicted injury.

The safety suit is a quilted vestment that wraps around the arms and trunk and extends to the floor like a long dress. Clinical assessment may require boys to remove all of their clothing, including their undergarments when wearing the safety suit. On the unit, a boy in a safety suit is quite noticeable as the garment is large, dark and bulky. All of the boys are familiar with the garment and there appears to be a great deal of humiliation associated with its use. One boy interviewed by OCA stated that everyone hated wearing the suit because, "*Who wants to wear a dress?*" OCA noted in record review that the safety suits were being used and/or ordered for boys frequently. Possibly as many as 50 orders for use of the suits were noted in record review during the course of this investigation. Contrary to OCA's findings, Assistant Superintendent Lisa Flower Murphy stated in sworn testimony before the Office of the Attorney General that safety suits are used, "*Not very often at all.*" (P 43). One CJTS manager's account concurred with the Assistant Superintendent, suggesting that safety suits had not been used at all at the new facility.

Ms. Flower-Murphy went on to testify that she did not know if there was a log for safety suits or how it was logged. She indicated that the Director of Clinical and Director of Psychology, whom she supervises, would oversee the process for prioritizing youth on safety watches and in need of clinical review. However, Ms. Flower-Murphy stated that they have not reported that information to her, so it's not part of their supervision. Ms Flower-Murphy testified, "*I read the log (Duty Officer's log book) every day and that's how I know who is on one-to-one and who is on any other kind of a watch*". She further testified, "*every single day and weekends. I get the whole weekend log. All of the administration reads it every day. It gives you a very good overview of exactly what is going on in the facility as far as the kids that are having problems*." (P. 47 and 48) The Assistant Superintendent's testimony contradicted documentation OCA found in unit and Duty Officer log books, Suicide Alert Forms and in the residents' records that indicated safety suits were ordered and used.

Analysis of Suicide Safety Suit Use

It became apparent that neither facility administration nor those in charge of mental health services were aware of the practice of using safety suits at CJTS. This represents a breach in oversight of an intervention with potential for serious side effects. It also suggests a lack of sensitivity for the emotional well being of the boys that could be construed as maltreatment. The questionable legitimacy of use when close observation could achieve the same purpose suggests a disregard for the boys' discomfort. Other factors may be influencing the decision to use safety suits, including staff shortages, that have no clinical validity.

8. Limitations of staffing and training in suicide prevention preclude safe policy compliance.

Staff members reported a significant staffing shortage that interferes with their ability to maintain safety watches. Although Assistant Superintendent Flower-Murphy testified that she "*never heard of watches not being done,*" there has been discussion among clinicians that they have been pressured by staff not to order 1:1 safety watches due to the burden on staffing. Some clinicians conjectured that the use of a safety suit might be seen as an alternative to constant observation.

The CJTS draft policy 82-221-1 on Suicide Safety and Prevention requires, among other things, that "all staff with direct care, medical or mental health responsibility for youth shall receive suicide prevention training as part of Pre-service Orientation as well as annual refresher training" (see Appendix C). None of the direct care staff, or clinicians who were interviewed during the course of this investigation reported receiving any training regarding suicide safety and prevention at CJTS. Assistant Superintendent Flower-Murphy testified that she did not know who did suicide safety and prevention training for any of the staff or whether it had been done but she presumed that it had.

A CJTS manager reported that in the past at Long Lane School, a two-day training program was taught by a mental health person. Since transition to CJTS the manager was not aware of any mental health person being assigned that responsibility. It is not actually clear whom, if anyone is conducting trainings for suicide prevention.

Analysis of Suicide Safety and Prevention

Boys like "Eric" may be so troubled, hopeless and desperate about their circumstances that lead them to intentions of killing themselves. The lack of response to their suicidal gestures sends a message that can be devastating to an adolescent's self worth.

By the very nature of their personal situations and placement at CJTS, the youth in residence are at a high risk for suicide. Yet they are not being adequately assessed for that risk. Those youth who are assessed and determined to be at risk are not being monitored according to policy and they are not getting sufficient clinical attention.

Clinical professionals were found to be inconsistent in their availability to youth in crisis at CJTS. Alert staff generally identified the youths' needs and attempted to have the boys' safety assessed by clinical staff or in their absence, nursing staff who would order suicide safety watches. Staff reports and boys' records provided evidence that clinical staff were frequently unavailable. Instead, nurses are assessing troubled boys for safety and ordering various levels of observation. Observation, however, is not a form of treatment; it is only a safety mechanism. A child at such risk as to require constant observation in order to remain safe is clearly in urgent need of some form of psychiatric care. Delaying intervention, sometimes for up to 4 days, allows a crisis to intensify and may even contribute to the exacerbation of the underlying disorder. This

suggests clearly improper psychiatric and medical care. And yet even observation to maintain immediate safety is not being carried out, nor communication occurring regarding a child's status relayed, as it should be.

The most significant aspect of suicide precaution is direct observation and support to the youth in crisis. This ensures the immediate prevention of any further self-harm. Documentation of events, behaviors, instructions for care, and description of safety needs are all forms of communication. Communication of any and all behaviors that may be of concern guides the clinician to make the best possible assessment of a child's needs and determine necessary treatment. Missing information produces an inaccurate portrayal of a youth's suicide status, behaviors, or level of risk. There appears to be a lack of appreciation for the need to communicate a boy's assessed risk. The possibility of safety watch documentation being altered suggests that staff may not comprehend the importance of documentation as a form of communication but rather a tedious task. The fact that "Eric" was not carefully watched is unacceptable given the known risk he and other boys like him at CJTS are at. What is more frightening is the disregard for the seriousness of suicide watches and the blatant devaluing of the safety procedure through falsifying records of watches.

The current policy is unclear as to how frequently safety status must be re-evaluated and also unclear about limits on how long a child can go without clinical assessment. Assistant Superintendent Lisa Flower-Murphy, who was assigned in January 2002 to oversee the clinical department, testified at the Office of the Attorney General that *"youth on a watch or in safety suits would have to be re-evaluated every 24 hours, so they have to be seen by a clinician."* However, given the current situation, a youth could be placed on suicide precautions on a Friday afternoon, and be seen only two more times for a safety assessment only, until sometime Monday when his regular clinician reports to work and schedules a therapeutic session.

There is also no policy addressing when and how a psychiatric evaluation of a child on suicide watches must be conducted unless there is an actual suicide attempt or injury. Children in the community who express suicidal thoughts or behaviors are generally immediately seen and evaluated by a qualified clinician or psychiatrist in an acute setting. Residency at CJTS seems to preclude that level of care.

Staff members reported to OCA that a significant staffing shortage precludes the ability to maintain safety watches. Additionally, they claim they are not receiving training in recognizing and preventing suicidality and are not aware of their responsibilities. OCA found no evidence to dispute this claim. They also may not recognize the significance of their responsibilities. In addition to a degree of critical thinking required, there must also be a cultural appreciation for the danger children can be in. Beyond the concept of immediate safety, the institution must also embrace the idea that safety is only a temporary state until treatment can address the underlying problem.

It is evident that maintaining the physical safety of the residents is directly related to staff awareness, availability, supervision, and clinical care and support. In addition to an overall lack of administrative oversight to ensure youth safety, there is a significant

deficiency in the supervision of staff and clinical interventions. Documentation on safety watch log sheets cannot be relied upon as the only check and balance for the assurance of safety.

Tabatha B. died in 1998 after hanging herself at Long Lane School. Four years later, the CJTS staff members are still failing, "to recognize the significance of Tabatha's multiple suicidal behaviors exhibited prior to her death, and fai(ed) to conduct a comprehensive assessment of [her] mental health issues.[31]" The findings and recommendations of the Tabatha B. Fatality Report have not been fully implemented or appreciated. Boys at CJTS are at imminent risk of suicide due to staff beingpoorly prepared or supported to recognize and communicate risk; to maintain constant observation for immediate safety; or to facilitate appropriate clinical response.

B. CJTS FAILS TO FOLLOW PROPER RESTRAINT AND SECLUSION PROCEDURES

1. Introduction

Four years ago, a 12-year-old boy died while being physically restrained in a Connecticut facility.

In May of 1998, the Child Fatality Review Panel released a fatality review on the March 1998 death of Andrew M. The Chief Medical Examiner of the time ruled that the cause of Andrew's death was "traumatic asphyxia, resulting from compression of the chest due to weight of an adult individual applied during a so-called 'therapeutic restraint hold.'"[32] Andrew's death occurred when a staff person determined the boy's behavior warranted him to be secluded and placed in a physical restraint in a face down position.

The Panel concluded, in addition to the indication that the child never should have been restrained, that the restraint method had been used improperly, that staff were not trained to deescalate the child's behavior and that staff were not trained to perform the restraint correctly.

The Panel's recommendations for physical restraint policy from the case of Andrew M. were a catalyst for the passage of Public Act 99-210, An Act Concerning Physical Restraint of Persons with Disabilities. Chapter 814e of the General Statutes of Connecticut addresses "*Physical restraint, medication and seclusion of persons receiving care, education or supervision in an institution or facility*." The chapter contains relevant definitions (§46a-150); prohibits life-threatening physical restraint (§46a-151); restricts physical restraint, seclusion, and use of psychopharmacologic agents; sets forth requirements for continual monitoring and documentation of any use of restraint or seclusion (§46a-152); requires recording of each instance of restraint or seclusion; requires review of those records by state agencies and reporting of

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[31] State of Connecticut Child Fatality Review Panel, (1998). Investigation Into the Death of Tabatha B. Office of the Child Advocate. Connecticut.

[32] State of Connecticut Child Fatality Review Panel, (May, 1998). *Investigation Into the Death of Andrew M. Part I: The Immediate Circumstances*. Office of the Child Advocate.

serious injury or death to the Office of Protection and Advocacy and to the Office of the Child Advocate (§46a-153); requires internal monitoring, training, and development of policies and procedures and subjects facilities to state agency inspection (§46a-154).

The findings in Andrew M.'s death and subsequent establishment of state statutes, in addition to federal statute on the subject, were to be the foundation of safety and protection of basic human rights for Connecticut individuals placed in institutional facilities.

2. Findings at CJTS

As stated earlier in this report, a large percentage of the boys placed at CJTS are diagnosed with mood disorders including depression, attention deficit hyperactivity disorder, conduct disorder and other behavioral problems. While their behaviors may manifest as dangerous threats to themselves and others, the nature of their disorders complicates the effects of how they are responded to. For example, adolescents with oppositional defiant disorder are likely to have an increased "personal space" zone and to become aggressive when that zone is "invaded". Their antagonism often escalates when given a direct order. Adolescent boys in the throes of severe depression may appear angry and aggressive. Although their initial behavior may appear to require intervention such as restraint or seclusion for safety purposes, that intervention may cause their behavior to escalate into a cycle of intensified out-of-control behavior and the need for physical intervention. Adolescents with attention deficit hyperactivity disorder may have excessive restlessness, difficulty maintaining attention to relevant events and impulsive responding that is not adaptive[33] and therefore appear to be noncompliant.

The use of restraint and seclusion to protect individuals from injuring themselves or others in clinical settings dates back to the 18th Century.[34] The debate regarding the use of these interventions has paralleled. On one side of the debate, restraint and seclusion protects individuals, others, and property from harm. On the other side of the debate, "seclusion and restraint experience can be perceived by patients as an aversive and coercive experience with the potential for the development of post traumatic stress symptoms."[35] Given preexisting mental and behavioral disorders, restraint and seclusion could exacerbate the underlying illness. Ultimately, the use of restraint and seclusion to control a child or youth's behavior is generally expected to be only in cases of last resort where other measures to defuse out-of-control or violent behaviors have been exhausted. This perspective is reflected in Connecticut General Statutes as well as CJTS (LLS) policy (See Appendix D).

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[33] Kagan, J (Exec Editor), 1998. The Gale Encyclopedia of Childhood & Adolescence. Gale: Detroit.

[34] AACAP Official Action, (2002). Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions, with special reference to seclusion and restraint. Journal of the Academy of Child & Adolescent Psychiatry, 41:2 Supplement, February.

[35] Ibid, p. 8S.

CT Gen Stat Sec. 46a-150 **Table 1.**

Definitions

Physical behavior intervention is defined as any measure used to limit the movements or actions of a resident, including physical restraint and seclusion.

Physical Restraint is defined as any mechanical or personal restriction that immobilizes or reduces the free movement of a person's arms or legs or head. (Exceptions apply) Physical restraint may be **Mechanical Restraint**, implying the use of handcuffs, leg shackles, "Posey" neoprene soft restraints, "Texas belts" which are leather belts with handcuffs attached at the waist (two-point) or both hand cuffs and leg shackles attached at the waist (four point), or restraint beds with leather straps that bind the arms and legs of the individual being restrained to a bed located in an isolated "mechanical restraint room".

Seclusion is 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.

C. Misuse of Restraints at CJTS was a Concern Expressed to OCA Early in the Investigation.

There were specific concerns regarding staff training in use of restraints, and the perceived over-utilization of mechanical restraints by staff due to limited alternatives in behavioral interventions. As the relevant statutes and policy imply, restraint is an intervention of last resort. The expectation would be that a secure facility with an established behavior management program would have minimal use of physical intervention to manage behavior.

Because restraint is meant to be a measure of last resort, staff are expected to attempt to defuse any heightening behavior first. Ordinarily, an agency's behavior management program would address varying intensities of behavior with varying levels of response. In the absence of a fully operating behavior management program the incidence of restraints will be higher. If a boy's behavior continues to escalate and he is at risk for harming himself or others, and less restrictive strategies to deescalate have been exhausted, then restraint is indicated as a safety measure.

The steps towards restraint as required by LLS policy 82-19-2 require staff to first attempt to defuse an incident through verbal intervention with the goal of calming, interrupting, and redirecting behavior, and encouraging the resident to communicate his distress. Verbal intervention should continue for as long as the resident is responsive. Verbal intervention should also be used if immediate physical intervention is indicated. Residents should be warned whenever possible that physical intervention is imminent in order to allow a last chance to comply. Except in specific emergency situations staff are to call for assistance before initiating a restraint, gather in numbers, come to consensus on appropriate intervention, and take direction from the supervisor. Per policy, the only staff persons authorized to carry out physical

restraints are those who have completed and demonstrated competency in the Handle With Care Program[36].

Any incident of physical restraint must be recorded on an Incident Report by the end of the shift, including an account of the events leading to the restraint; lower level interventions attempted; reason for employing the restraint; types of restraint holds used; the outcome of the incident; any injuries incurred or treatment follow-up; and an account of all staff involved.

Medical services must be notified within ten minutes of the initiation of a restraint, and a nurse must respond to assess the physical condition of the boy in the restraint. Boys in restraints must be constantly supervised on a 1:1 watch status. Direct care staff must contact the duty officer and nurse every hour until the boy is in sufficient control to be released. A supervisor may authorize release of a youth who remains in control over a minimum of two consecutive ten-minute observation periods and makes a verbal commitment to maintain safe behavior.

LLS Policy 82-19-3 requires that if a mechanical restraint goes beyond four hours, staff must contact a clinician for determination of the need for an on site evaluation of the boy. If a youth is restrained three or more times in any month or for any single incident that lasts more than four hours, a treatment team must develop an individual behavior intervention plan[37] for him.

CJTS Policy 82-3-3 and state statute drive documentation for physical restraints. As indicated in Table 2 any incident of restraint must be fully documented in several records. Presumably, the recording of the event in multiple records is a mechanism to assure that there is correct supervision and consultation on restraint procedures that occur.

CJTS 82-3-3 Logbook	**Table 2.**
The logbook is a legal document and shall provide an accurate and complete record of both routine activities as well as a critical incidents and emergency situations involving youth and/or staff. Logbooks shall be maintained in all living units, the Special Needs Control Center, and master Control as well as the Duty Officers and Agency Police… Any incidents which involve physical behavior intervention (use of force, use of mechanical restraints, use of seclusion) or any use of "Time out" periods, however brief, shall be logged in the living unit logbook and the Duty Officer's logbook.	

[36] The Handle With Care Behavior Management System combines patented verbal intervention components with physical intervention technology based on a safe, biomechanically efficient passive restraint method that provides an unprecedented level of therapeutic control without inflicting pain or injury.

[37] Individual Behavior Plan (IBP): Draft CJTS Policy 87-3-1 requires, "The Unit Team will meet to develop an Individual Behavior Plan for any youth who requires use of seclusion in excess of eight hours. IBPs must include a statement of purpose and an analysis of the problem, a listing of the target behaviors to be modified, a description of the goals and objectives of the plan, procedures to be followed and the method for reviewing and assessing youth progress.

D. "Any Time a child is Confined to Their Room In a Manner That Prevents That Person From Leaving" (Except for the Purpose of Sleeping), They are Secluded Under the Law".

The definition of seclusion and restrictions on its use are clearly expressed in C.G.S. Sections 46a-150 to 46a-154. DCF regulation Section 17a-16-7 defines seclusion as "isolation from the general population of an institution of the Commissioner *enforced by locked door." (Emphasis added)* The Department's definition of seclusion allows children to be confined to their room in a manner that prevents them from leaving and as long as the door is not locked, the child is not considered "secluded."

This contradiction between the state statute and DCF policy was brought to the attention of Deputy Commissioner Gerber in a letter dated July 12, 2002 from Supervisory Assistant Public Defender James Connolly. Connolly is a member of the CJTS Restraint and Seclusion Committee. He noted to Gerber the "*disparity between the reported use of seclusion by DCF and the reported use of seclusion by*" his clients. He was further concerned that children were being *"routinely secluded at CJTS in violation of DCF regulations simply for discipline and convenience of staff*." Specifically, there is disparity between the law and DCF regulations in regards to the locking of doors. Boys at CJTS were being sent to their rooms and told not to leave. Although the doors were not locked, the boys were told not to leave the rooms at threat of sanctions. OCA witnessed and was informed about this practice as well.

Deputy Commissioner Gerber responded to Attorney Connolly in a letter dated August 7, 2002. She referenced DCF regulation 17a-16-7 that defines seclusion. She admitted, *"You are accurate in your statement that this definition is inconsistent with C.G.S. § 46a-150*." She indicated that relevant parties had been instructed to bring the regulations into compliance with the law. Gerber essentially acknowledged that CJTS had been breaking Connecticut law. Although she indicated that the regulations would be brought into compliance with that law, as this investigation came to a close in early September 2002, OCA was still observing boys secluded in their rooms during shift changes and other periods for the convenience of the staff.

Beyond the definition of seclusion, Long Lane Policy 89-19-4 is clear on how it should be used. Seclusion is allowed as an emergency intervention to prevent immediate or imminent injury to the resident or to others, to prevent escape or as specifically provided for in an individual treatment plan. The use of seclusion for discipline or convenience or as a substitute for a less restrictive setting is strictly prohibited. Seclusion is authorized for up to eight hours when: a resident is dangerous to himself or others and there is reasonable cause to believe that he/she may inflict physical injury on another person, or to prevent escape.

According to LLS 82-19-4, in every case, staff must notify a supervisor immediately upon placement of a resident in seclusion, and the supervisor must review the reason for the placement. After the review of the appropriateness of the action, the resident and staff are informed and the action as authorized should be documented in the duty officer's and unit supervisor's logbook.

Early in this investigation, OCA received several complaints regarding the blanket use of seclusion for the benefit of staff taking time to give each other report at shift change. While visiting the units in January, OCA staff observed this practice to last over an hour at times. The policy clearly states that seclusion is not to be utilized for administrative convenience. OCA observed and received confirmation from interviews with staff and resident boys that CJTS regularly locks youth in their rooms after school, during shift change, during treatment team meetings, and during morning and evening hygiene and shower periods.

A review of incident reports revealed that youth have been placed in seclusion while awaiting disciplinary hearings and for incidents occurring the prior shift or prior day. There is also a practice of sanctioning for breaking houserules with "five hours out", meaning a boy may only spend five hours out of his room in a day. This sanction may lasts up to ten days. Incident reports indicate that violations can result in additional time. Staff do not consider this time seclusion and therefore do not regularly record or report it, although five hours out appeared on some incident reports, the seclusion section was checked "no" on some reports and "yes" on others.

During the period when there were problems with tampering with the sprinkler system, seclusion was used as a means to stop the pranks. In a November 15, 2001 directive from Superintendent Mara the following pertains to seclusion:

> *"As an interim measure and in an attempt to limit the number of occasions when our youth are able to set off the sprinkler in their rooms, the following is in place immediately: … Actual tampering/setting off the sprinkler system should result in a youth being transferred to the padded room. Release from the padded room should be reviewed beforeh and with either the Program Supervisor or on-call Administrator."*

On more than one occasion the Child Advocate has voiced concerns, to both the Commissioner and the Superintendent, that youth in every unit of this facility are serving "room confinement[38]" during shift changes for staff convenience and treatment team meetings. In a letter to Commissioner Ragaglia dated January 9, 2002, the Child Advocate wrote, "*our investigation has revealed that all children are routinely locked in their rooms each afternoon as part of the daily schedule. This is not done for the purpose of sleeping. This use of seclusion also clearly violates agency policy."* The Child Advocate also noted that Superintendent Mara had directed staff to use seclusion as a further response to attempts to activate the sprinkler system. "*Her directive of November 15, 2001… once again, violates the policy requirement of an imminent danger of physical harm to self or others."*

Superintendent Mara response was attached to letter from the Commissioner on January 22, 2002 stating,

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[38] Room confinement: Periods in which a resident is confined for over 15 minutes for cause or punishment in the room or room in which he or she sleeps, rather than being confined in an isolation room or room.

> *"Our policy since opening the facility is that youth rooms are not to be locked unless a youth is formally in seclusion status… I met with all unit leaders, program supervisors and assistant superintendents today to review this policy and they in turn will review it again with staff. In addition, I will be issuing a written alert as a reminder."*

Commissioner Ragaglia further commented in her January 22nd letter to the Child Advocate that,

> *"The practice of youth remaining in their rooms at shift change between first and second shifts will cease effective the submission of a corrective action plan by February 28, 2002. This practice had been in place to allow staff from one shift to the other the opportunity to communicate regarding the needs of the youth."*

On June 5, 2002 the Commissioner wrote the Child Advocate again, and noted, among other things, that

> *"It also appears that there are too many occasions when youth are locked in their rooms during the after school hours. I have taken steps to ensure that this inappropriate use of seclusion is immediately stopped."*

When the Commissioner addressed the use of shift change seclusion in her January letter, she did not acknowledge the related violation of state law and agency policy the practice presented. Rather she provided an excuse or explanation that translated to the use of seclusion for the convenience of the staff. Still, she did indicate that the practice would cease by a specific date. When Commissioner Ragaglia again addressed the issue of shift change seclusion five months later, she did not do so in a manner that suggested she had already been aware of the problem and in fact, had indicated that action was taken to cease the practice. Commissioner Ragaglia's communications to the Child Advocate indicate, a lack of appreciation for the state law and the policy of her agency and a lack of attention to serious details in activities at her facility taking place around children for whom she is guardian.

Over time, OCA noted no change in enforcement of the policy or the boys' rights. Where some units maintained that the boys' doors were not "locked" but on "Group Access." Group access refers to whether a door of a boy's room is locked. Technically, a door on group access is not locked and can be "popped" open, however, standard protocol requires the boy to use a call button and request permission to leave the room. Boys who "pop" their doors and leave without permission typically receive charges and sanctions. Many of the units continue to have the doors secured as they have done since the facility opened. Reports of residents and staff indicate that the use of room confinement is at the discretion of direct care staff and varies by unit and staff member.

1. AT CJTS there are conflicting perspectives of what seclusion is and how it should be used.

Secure room confinement time imposed for administrative convenience does not appear in the logs or other documents provided by CJTS. Therefore it is notpossible to determine overall frequency and duration. Direct care staff appear to view room confinement in these situations as routine and do not consider it to be seclusion. For

example, one incident report indicates no seclusion time but states that the youth remained in his room "due to shift change".

There is an absence of structured programming and activities to occupy the boys during afternoon hours and times of shift change. CJTS programming does not provide enough structure and activities all through the day in order to effectively manage the boy's movement and staff needs. Opportunities for recreation are limited. There are limited after-school activities and no structured arrangement for supervision of the boys during shift change time when the off-going shift must report to the oncoming shift about the boys and issues on the units. Staff members reported that they see no alternative than to keep the boys in their rooms during report, meetings, and while monitoring hygiene activities.

E. OCA Observations, Interviews and Record Review Revealed the Practice of Restraining and Secluding Boys at CJTS is Contrary to Agency Policy and State Law.

During the course of this investigation, OCA noted several areas of concern regarding restraint and seclusion. Specifically,

1. There was evidence that boys were being restrained and secluded in ways that violated policy and state law.
2. Documentation of incidents of restraints and seclusions were neither complete nor reflective of actual practice.
3. CJTS reporting of restraint and seclusion use has been inaccurate.
4. Training and educating staff regarding techniques to avoid employment of restraints and seclusion is inadequate.

1. Boys were being restrained and secluded in ways that violated CJTS policy and state law

Use of restraints as punishment or convenience of the staff

One of the early problems with the physical plant of CJTS was the ready access of the sprinkler system to boys for tampering. There was no structural device to the design of the building to protect the sprinklers from that tampering. There were several incidences in which boys set off the sprinklers. On November 15, 2001, Superintendent Mara took action to prevent the boys from further pranks.

The superintendent authorized Assistant Superintendent John LaChapelle to send out a written directive to staff stating,

> "*When a youth verbally threatens or actually attempts to set off the sprinkler system, he shall immediately be placed in a Posey Ambulatory belt with a locking mechanism. This procedure supercedes prior instruction regarding ankle restraints. This should limit a youth's ability to access the ceiling/sprinkler system. The youth shall be periodically checked during the shift and released if in control and no longer*

threatening. The Building Program Supervisor or the on-call Administrator must approve this restraint beyond eight hours."

The directive was a direct contradiction to LLS Policy 82-19-1 stating no physical behavior intervention or course of treatment for any resident shall: Be used for punishment or as a punitive measure or be used for the convenience of staff. It also broke the Connecticut law, specifically Conn. Gen. Stat. §§ 46a-150(3), 46a-152(a) in relevant part, children at CJTS … subject to involuntary restraint… . provided the restraint is not used for discipline or convenience and is not used as a substitute for a less restrictive alternative… "

On December 4, 2001, three weeks later, the Department of Children and Families Child Abuse and Neglect Hotline received a report of abuse and neglect on a boy at CJTS who had been placed in mechanical restraints on November 16, 2001 for setting off the sprinkler system in his room. At the time, CJTS staff had invoked an Individual Behavior Plan, which required him to wear shackles for five days. He was in shackles at all times including sleeping hours and bathing times. He was subsequently handcuffed when he was let out of his room. The boy reported bleeding where his skin wore due to the rubbing of the shackles. The boy's clinician, the unit leader and the treatment team signed and approved the IBP. In addition staff reported that a copy was sent to Administration via e-mail. The Hotline investigation of the abuse and neglect allegations did not begin until March 6, 2002, over three months later.

The DCF Hotline investigation substantiated "physical neglect as defined in DCF policy manual 33-6-14, being denied proper care and attention physically, educationally, emotionally, or morally" against the Connecticut Juvenile Training School for reasons as listed:

1. The boy "was secluded in his room for three days and kept in shackles for 5 full days without relief."
2. The boy "was not afforded any educational opportunity while completing his Individual Behavior Plan."
3. "The Individual Behavior Plan implanted by CJTS was overly harsh given" the boy's "mental health status."
4. "The Individual Behavior Plan was written for 6 full days." The boy," could not be removed from the plan until the entire 6 days were over, despite any positive behaviors he showed during this period of time; however, had the boy violated the plan, he faced the potential of being held at status, dropped a day, or being dropped to Day 1 (of the plan)."[39]

Long before the Hotline investigated CJTS on this issue, the Child Advocate informed DCF Commissioner Ragaglia of her concern regarding the practice of placing children in mechanical restraints when they attempted to activate the buildings fire sprinklers in a letter dated December 21, 2001. Responding in a letter on December

[39] Department of Children and Families Special Investigations Unit Report Re: Connecticut Juvenile Training School. Confidential. Submitted to June Wiehn, Bureau Chief of Child Welfare Services, May 9, 2002, by MC Gregory, Special Investigation Unit Supervisor and K. Mysolgand, Director of the DCF Hotline, page 9.

31, 2001 Superintendent Mara told the Child Advocate that she issued a directive authorizing the use of a Posey Ambulatory belt to prevent tampering with the sprinkler system. Superintendent Mara further stated that when a sprinkler is activated, unit life is disrupted because the children must be relocated to another unit. Finally she stated that there is an unnecessary burden to the fire personnel who must respond. She did not allege that activation of the sprinkler system resulted in a serious threat of injury to any person.

The Child Advocate followed up with a second letter to Commissioner Ragaglia expressing safety concerns within the facility. She wrote,

> *"The use of mechanical restraints in response to a threat or attempt to activate a sprinkler violates your own policy and is an inappropriate use of physical restraint. I am deeply concerned by the decision of your highest level administrator to authorize such improper use of physical force against children who do not present a threat of imminent danger."*

Commissioner Ragaglia responded on January 22, 2002, writing,

> *"Superintendent Mara and I have discussed your allegations regarding the use of restraint and seclusion. Because the behavior modification program is far enough along, we can continue our progress in reducing staff's use of restraint and seclusion. Accordingly, Superintendent Mara has rescinded her "blanket" directive regarding the use of restraints and seclusion in connection with youth setting off the sprinkler system."*

The Commissioner also addressed the Child Advocate's concern that youth were

> "*Being locked unrestrained and alone in the rooms with restraint beds. These rooms do not have cameras as any youth in these rooms is to be supervised 1:1 at all times."*

Attached to the Commissioner's letter was a memo from Superintendent Mara in which she responded to the Child Advocate's concerns, stating, "*there is no practice of using restraint rooms for anything other than restraints."*

The concerns about boys being left unattended in mechanical restraint rooms arose from OCA staff touring those rooms on units at CJTS. On three separate occasions in different buildings, windows and doors of restraint rooms were observed to have scratches and writing on the inside panel. On one occasion the building manager was asked about the language that was carved into the window of the door and how it could have gotten there. Although, there was no direct response, there was the suggestion that boys had broken loose from the restraint mechanism and carved the words into the window. This clearly should not be possible as, according to CJTS draft policy 82-19-3 all youth, while in mechanical restraints, are to be supervised on a 1:1 status. In a separate building in May of 2002, another restraint room inside window had evidence of tampering, including significant scrape marks.

The evidence of unattended children in the mechanical restraint room contradicts the superintendent's claim that the rooms are used for anything other than restraints. If that is the case, there may be inadequate supervision of children restrained in the rooms; however, it is difficult to believe that the leather restraints on the beds are that easily broken.

Facedown positioning during restraint

In the Spring of 2002 OCA became aware that at least one boy was being restrained in a facedown position. Positioning "facedown" or "chest down" during restraint may place the restrained individual at serious risk of injury. Positioning may affect the airway through a positional obstruction, or, more likely, it may inhibit the chest wall from expanding to allow for breathing and heart function. Compression of the chest, as in the case of Andrew M., can result in an individual not being able to breath and interrupt heart function. Andrew M. died very quickly in that restrained position. In June of 2002 an OCA Staff member interviewed CJTS Staff trainer Walt Piszchala on the subject. Despite the number of reports OCA had received from staff and boys in residence, Mr. Piszchala reported that it was not the practice at CJTS to restrain boys face down. He also noted that he did not conduct any training on such positioning during restraint and that the Handle With Care Program did not include any training on the practice either.

OCA contacted a representative of the Handle With Care Program. They reported that the training and training materials provided to CJTS did, in fact, include instruction for a facedown restraint technique. The technique has very specific positioning of the restrainer and requires the use of an apparatus to protect against chest compression in lengthy restraint incidences. They also indicated that once a facility has received training for the entire Handle With Care Program, not all aspects of the program are incorporated into the facility's practice.

Following the conversation with the Handle With Care representative, on 8/19/02 Bruce Chapman, the founder of the program, contacted OCA via E-mail commenting,

> *"With regard to the use of mechanical restraints, it has always been my policy that they be applied as soft restraints in either a supine (face-up) or seated configuration exclusively and only on "one-to-one" continuous supervision. Every agency we train is given absolutely clear direction from us on this subject, including each Connecticut facility that uses Handle With Care. I have also made it clear that I consider the use of conventional handcuffs and leg shackles to attach someone to a stationary object or to use them for anything other than a short-term intervention abusive."*

In April of 2002 DCF received a Hotline report alleging a CJTS staff member elbowed and tried to choke a boy during a restraint. While the Hotline Special Investigations Unit (SIU) did not substantiate the allegation, a "Program Concern" was noted in their report that was sent to the DCF administration. Specifically, the SIU noted that the boy *"was placed on a Posey bed face down. Due to the possibility of a resident*

having his chest compressed or having difficulty breathing during a restraint procedure, a resident should always be placed face up regardless of his behaviors."

OCA staff members reviewed a sample of thirteen boys' records collected on restraint occurrences (See Table 4). Of thirteen records, three boys were documented as being restrained in a chest down position, one for one hour and thirty minutes and the other for fifty-five minutes. Information on positioning was not completed for three of the thirteen incidents. A notation on a nurses' flow sheet for one incident indicated that advice was given to the direct care staff to monitor the boy's breathing since he was in a facedown position. There was no documentation of attempting to change the boys' position or of getting special permission for that position or even a reason for it.

After reviewing the SIU report and the sample of restraint records, OCA staff communicated concerns regarding the practice of restraining face down via an E-mail inquiry dated August 13, 2002 to the CJTS and DCF administrations

> *"After reviewing the training manual and policy, it appears as if only face-up restraints are to be utilized by staff. Please advise as to who has authorized the utilization of facedown restraints? Who provides training for the technique? And if the actions are indeed contrary to policy and being carried out without authorization or training, what actions will be taken to address this practice at the facility?"*

OCA received a response to the August 13th inquiry on August 14th from Assistant Superintendent John LaChapelle. He included a copy of the current LLS Policy 82-19-1 Physical Behavior Intervention, and *"a directive previously approved through the Juvenile Justice Bureau Chief in March 2000 that has remained in effect*." He stated in relevant part:

> *"… A youngster may be positioned chest-down during a restraint under certain limited and exceptional circumstances and on a temporary basis if necessary to protect immediate health and safety of staff and youth. Such extraordinary action requires supervisory approval and documentation of efforts to re-position the youth as soon as possible… Our training of staff includes training on this critical area of behavior management."*

Assistant Superintendent LaChapelle then referred OCA to discuss training with the CJTS training staff. The policy that LaChapelle included in his response to OCA is the same heretofore described, LLS 82-19-2, that includes a list of prohibited uses including, in relevant part:

- Life-threatening physical restraint, which restricts the flow of air into a resident's lungs, whether by chest compression or other means
- Restraints or holds in which the resident experiences chest or back compression or in which the resident is held face down with arms crossed in front or behind the body with or without chest compression

There is no mention within the policy that facedown restraint is acceptable. The effective date of the policy is noted on the lower right hand corner of the document as "July 14, 2000 (New)". The March 2000 directive that Assistant Superintendent LaChapelle included for OCA is a memo from him to "all departments" and copied to R. Brooks (then Juvenile Justice Bureau Chief). The directive referred to a February 14, 2000 memo that "*specified all restraints to the bed are chest up unless otherwise indicated for clinical or medical reasons*." He then stated that the Behavior Management Committee is said to have "*acknowledged that in certain situations the chest down restraint position presents less risk of injury*." The directive concludes,

> *"Therefore, in situations where the youth's size, strength, level of agitation and/or available number of staff could present significant risk in repositioning a youth from the initial takedown, the resident may remain in a chest down position. This decision is made on an individual case basis, as authorized by the YSRSI at the scene, and documented on the Long Lane Incident Report. These situations should be the exception rather than the rule and will be closely reviewed to ensure that the typical restraint continues to be in the chest up position.*

The directive dated March 2, 2000 was circulated four and a half months before LLS Policy 82-19-2 Physical Behavior Intervention was updated and effective. A thorough review of the policy found no indication that the content of the directive on chest down restraint was incorporated into the updated policy. The "exceptional circumstances" warranting chest-down are not articulated clearly. If this is indeed the official policy of the facility, it allows a great deal of staff discretion to determine positioning in restraint. Staff trainer Piszchala had already indicated to OCA staff in a previous discussion that he was not conducting any training specific to facedown positioning during restraints.

The rationale for facedown restraint in the April 2002 SUI report was that the boy was spitting at staff. LLS Policy 82-19-2 allows for involuntary physical restraint only to:

- Prevent immediate or imminent injury to the residents or to others
- Prevent escapes
- As necessary and appropriate, determined on an individual basis by the resident's treatment team, to protect the safety of the resident and others.

Spitting, although unpleasant for any person who is spat upon, does not, by definition, present persons with immediate or imminent injury. It is not known whether protective facemasks and eye guards are available to staff for restraint procedures.

Despite the likelihood that facedown or chest-down restraint may be a violation of policy, its use appears to be overlooked as a serious concern. In response to OCA's August 13, 2002 E-mail inquiry about the report, Hotline Director Kenneth Mysogland stated in an August 15th E-mail, "*The SIU will continue to document in the Program Concerns section if we see any face down restraints. If the incident rises to the level of abuse or neglect in addition to the face down restraint, we will certainly substantiate."* It appears that the misconception about the appropriate use of facedown positioning during restraints goes all the way to the director of the Abuse–Neglect Hotline. On August 20, 2002 OCA sent a follow-up inquiry by e-mail to Assistant Superintendent LaChapelle requesting clarification on the facedown restraint procedure and related training. He responded on September 3rd stating he

would, "raise the issue of a response to your further inquiry." OCA has received no further explanation of whether facedown restraints are acceptable procedure at CJTS and if so who trains the staff to employ the procedure.

Minimal clinical involvement

OCA found that clinical staff is not regularly consulted as part of the initial decision to use restraints or seclusion, leaving the initial decision to direct care staff. According to staff interviewed, in addition to a lack of involvement in initiating restraints on a boy, clinicians typically do not speak with youth placed in restraints.

Thirteen Days of Restraints

"Dan"(not his real name) has been at CJTS since the transition from Long Lane School with the exception of two months at Riverview Hospital. In late may and early June of 2002, Dan was suicidal, depressed, paranoid, irritable, withdrawn, sometimes aggressive, sometimes hearing things and sometimes appearing to respond to internal stimuli. Dan made five overt, observed suicide attempts during those days by tying things around his neck and attempting to drink a cleaning agent. These symptoms intensified as the 13 days from May 22 to June 3 passed. On May 22nd he tied a shirt around his neck in an apparent suicide attempt after being taken to a padded room. He was placed in two-point restraints with a 1to1 suicide watch.

Dan proceeded to be restrained in two or four point restraints every day, all day until June 3rd. On May 24th a directive was written in the CJTS Duty Officer's Log Book per Program Supervisor Irma Bradford. The directive demanded,

"Youth (Dan) is to be in a Texas 2 point restraint at all times 1st-2nd and 3rd shift. He can have one hand unlocked for showers. He is to be checked by a nurse every 4 hours, including 3rd shift. Program Supervisor will call in to check his status with the D.O.s daily. The D.O.s should report Dan's status to back-up every shift. This is to remain in effect until Tuesday morning and Dan is again reviewed by Program Supervisor."

Also on May 24 an Individual Behavior Plan was developed for Dan. The "Objective/Intent" of the plan was to, *"limit Dan's access to the community until he becomes psychiatrically stable and demonstrates full treatment compliance… "* The procedures for the plan included 2-point restraints for all shifts, his room was to be stripped of everything except a pillow, mattress and sheet. And he would be on 1to1 suicide watch on 1st and 2nd shifts as well as 3rd shift if a clinician were to assess the need.

On June 1st Dan was again escorted to a padded room and restrained. His clothing was cut off after he attempted to tie a sweatshirt around his neck. When he covered the window of the room, he was mechanically restrained to the restraint bed. An on-call clinician called an on-call psychiatrist to request an assessment of the boy. According to the clinical notes, the psychiatrist refused to come to see the boy, stating, "I know this boy from Riverview (hospital), what good would it do to send him to the ER? They would just send him right back." Left on his own, the clinician made a contract with Dan that he would remain in restraints until he calmed down. Dan was periodically in mechanical restraints throughout that day and the next.

In the early hours of June 3rd, Dan tied a sheet around his neck in another suicide attempt. He was restrained at four points for approximately one and a half hours. Shortly after being unrestrained he tore a pillowcase apart and tied that around his neck in another attempt to kill himself. Dan's fifth attempt was

interrupted and he was placed in four point restraints for the next five hours until the on-call psychiatrist had him sent to an emergency room for psychosis and suicidal ideations with a plan to hang or choke himself.

ANALYSIS

After 13 days of despair, depression, psychosis, hopelessness and anxiety, it is a wonder Dan did not succeed in killing himself. The response to his acute illness was to mechanically restrain him rather than seek treatment. The use of restraints over a period of 13 days was contrary to facility policy, as well as state and federal law. He should have been evaluated and actively treated much sooner given his display of imminent self-harm. In addition to neglecting to treat "Dan", the overuse of restraints and seclusion instead of treatment was an unfortunate maltreatment of the boy.

2. Documentation of incidents of restraints and seclusions were neither complete nor reflective of actual practice.

Reports from CJTS staff and the boys in residence about the use of restraints at the facility differed dramatically from reports by CJTS administration. Actual incidence of use of restraints at CJTS is unclear. Anecdotal reports from CJTS staff and the boys in residence about the use of restraints at the facility differed dramatically from the CJTS administration reports and findings of OCA record review.

The CJTS documentation does not provide a complete picture of the frequency with which restraints are used. Monthly summaries reviewed by OCA for two units reflected totals that differed from the data recorded in individual incident reports and nurses' flow sheets. Notations in the duty officer logbook are not consistent with the unit logbooks, flow sheets or incident reports.

Information on incident reports and nurses' flow sheets was found to beinconsistent, and items such as the length of time a boy was restrained are not consistently recorded. Table #3 highlights the inconsistencies of documentation regarding restraint use on a Nurses Flow Sheet. Most notably, certain information has not been recorded. Of twelve files reviewed, only half had completed documentation. There is no record of what time two of the boys became restrained. The incident on 4/21/02 does not indicate when the boy was released from restraints; however, it does indicate that he was in a facedown or chest down position. Table # also exhibits the infrequency with which clinicians are called when mechanical restraints are employed. In only three instances of twelve was it documented that a clinician was called. It was impossible for OCA to determine the average duration that boys are restrained due to incomplete documentation. OCA reviewed many incident reports, restraint reports and flow sheets and found documentation on all to be consistently incomplete and unclear throughout the course of this investigation.

RESTRAINT DOCUMENTATION REVIEW **Table #3**

Date	Time Applied	Nurse Notified	Nurse Arrived	Time Restraints removed	Chest Up? Y/N	1:1 staff Y/N	RN Called Y/N	Clinician Called Y/N
3/3/02	12:35p	___	1p	3:25p	__	Y	Y	Y
4/21/02	___	___	___	___	N	Y	Y	N
5/2/02	___	___	5:00pm	5:35pm	Y	Y	Y	N
5/22/02	5:18p	____	5:39p	6:05p	Y	Y	Y	Y
6/1/02	2p	On unit	On unit	3:10pm	__	Y	Y	Y
6/2/02	5:00p	4:50P	4:52P	6:20	Y	Y	Y	N
6/9/02	5 :12p	6 :20pm	------	6 :47pm	----	Y	Y	Y
7/27/02	11:00am	10:55am	10:55am	12:19pm	Y	Y	Y	N
7/29/02	11:50	12p	12:10p	1pm	Y	Y	Y	N
10/13/01	9:40p	On unit	On unit	10:25p	Y	Y	Y	N
11/12/01	7:30pm	7:30pm	7:30pm	_____	Y	Y	Y	N
11/14/01	5:50p	6pm	6:05p	6:45p	N	Y	Y	N
11/15/01	6:20p	On unit	On unit	7:50p	N	Y	Y	N

3. CJTS Administrative reporting of restraint and seclusion use has been inaccurate.

CJTS participates in a Performance-based Standards (PbS) Project for Office of Juvenile Corrections and Detention Facilities (OJJDP). Funded by OJJDP, the PbSwas established as a result of a 1994 national Conditions of Confinement study that surveyed conditions in juvenile facilities throughout the nation. In 1996, the PbS project convened a group of experts who developed twenty-two performance-based standards in six areas of facility operations: safety, order, security, programming, health, mental health and justice. As part of the implementation of the standards, each participating facility periodically reports the to the project on performance data. The data is collected and analyzed, and each facility can compare its performance with national averages. In comparisons, DCF has reported that CJTS performs better than the national average on several key indicators, including the use of restraints and seclusion.

The OCA/AG investigation has revealed that CJTS has not been reporting accurate data on the actual use of restraints and seclusion. In January 2002 monthly data on restraint use since the opening of the facility was collected from CJTS administration. (According to CJTS administration, no data was recorded for the months of August and September 2001, as those were transition months). The administrative data reported to OJJDP was compared to data discovered by OCA[40].

[40] OCA reviewed samples of records for October, November, and January from Units 5-c, 5-d and Building 2 including boy's files, incident reports, logbooks, duty officer logbooks, staff flow

Findings indicated that the numbers did not match. OCA found a much greater incidence of restraint use than reported by CJTS administration to their funders. In May and June, CJTS-reported incidences of restraints rose but still varied from the number of recorded restraint use in the Duty Officer's logbook where all restraint use is required to be reported and recorded. (See Table 4 below). CJTS also reported average duration of restraints and seclusion to OJJDP. Restraint duration in the months of January, May and June 2002 ranged from 31.7 to 49.9 minutes. Seclusion in those same months ranged from 106.2 minutes to 147 minutes. OCA was not able to review the average duration of boys being mechanically restrained or secluded because the information was not consistently recorded. Given the lack of record keeping on duration of restraint and seclusion use, it is strange that CJTS was able to provide OJJDP with data indicating those lengths of restriction on the boys' movement.

Incidence of Restraint and Seclusion **Table 4.**

Month/ Year	OCA-identified Mechanical Restraint use[41]	CJTS-reported Mechanical Restraint use	CJTS Reported Seclusion
10/01	23	8	97
11/01	67	25	107
1/02	32	5	57
5/02	24	36	95
6/02	33	19	130

CJTS has been citing decreases in the use of mechanical restraints as a success for the move to CJTS. Contrary to OCA's findings, Commissioner Ragaglia stated in a March 8, 2002 letter to parents/guardians of youth at CJTS:

> *"that this programs ranks in the upper tier in comparison to about 100 similar programs across the country, according to an independent review project funded by the Federal Office of Juvenile Justice and Delinquency Prevention…we have made strides in reducing the use of restraints (down 80 percent compared to 1998) and isolation and seclusion (down 61 percent since 1998).*"

After comparing the statistics reported to OJJDP with the OCA record review, it appears that CJTS is actually above the national average for use of mechanical restraints and seclusion on boys in their care. Even with questionable reporting, the use of mechanical restraints and seclusion has continued to rise. (Note CJTS reported

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sheets, nurse flow sheets and monthly restraint and seclusion reporting forms. For the period of May and June OCA reviewed only the CJTS Duty Officer's Log Book. Incidences of restraint are required by policy to be reported to the Duty Office on shift.

[41] See footnote 35.

130 incidences of seclusion during the month of June.) The numbers are likely higher as OCA found that not all room restrictions were being recorded, as discussed elsewhere in this section. According to Connecticut law and CJTS policy, boys should only be physically restrained or secluded as a last resort. The consistency in the use of restrictive measures suggests a lack of alternative interventions to maintain boys with dangerous behaviors safely. The alternatives should include a fully operating behavior management system. As cited previously, Commissioner Ragaglia sent a letter to the Child Advocate on January 22, 2002, stating, "*Because the behavior modification program is far enough along, we can continue our progress in reducing staff's use of restraint and seclusion.*" If the behavior modification program was truly progressing in January, the statistics of restraint and seclusion in May and June indicate that progress is not towards an effective program.

4. Training and educating staff regarding techniques to avoid employment of restraints and seclusion is inadequate and inconsistent.

It is in the nature of adolescent development to challenge authority, whether youth are in CJTS or in their homes and communities. Young people frequently engage in confrontations, provocative behavior, and refusal to obey rules in juvenile facilities, as they do in many other situations. In a institutional setting like CJTS, the stakes of such confrontations may be much higher than of those that occur in homes or other settings. Beyond developmental characteristics of this age group, the high occurrence of behavioral disorders among the population further intensifies confrontations. Staff persons working with this population require skills in managing behaviors as well as preventing escalating confrontations. Sensitivity and understanding of a child's diagnosis and personal perspective is key to managing and improving problem behaviors. Where facility staff are not adequately trained, incidents, which start small, can quickly escalate into major confrontations and use of last-resort interventions such as restraints or seclusion.

Staff working with adolescent boys at CJTS are not trained to deal with problem behaviors for crisis intervention as well as promoting positive behavioral change.

It is evident from interviews with youth and staff, and review of records at CJTS that there has not been sufficient training of staff at CJTS on deescalation techniques. De-escalation techniques are verbal methods of interacting with young people in order to prevent the situation from getting to the point where physical control is needed. If staff are not able to de-escalate a boy's behavior, physical intervention may be necessary. Even as a last resort, staff must be trained in specialized technique in order to get control of a situation while maintaining safety for staff, the boy and others around him. OCA found inconsistencies in the training and reported training for restraint use. Training covering positioning during restraint use is a case-in-point. Not only were the perceptions of training taking place contradictory among staff, a trainer and CJTS administration, the policy and applicable procedure to be taught were unclear.

ANAYLSIS OF RESTRAINT AND SECLUSION USE AT CJTS

The key to safety in an institutional setting is clear policy, informed and educated staff, and consistent oversight and supervision. The use of restraints and seclusion, as observed at CJTS, is not consistent with policy or law. Rather it is arbitrary and without guidance from clinical professionals. The arbitrariness with which restraints and seclusion are used on the boys at CJTS violates the boys' basic civil and human rights, in addition to breaking Connecticut law. In at least one case, room restrictions, DCF administrators have admitted the contradiction of practice with law. The inappropriate use of these restrictive measures also causes harm both physically and emotionally to the boys as a form of maltreatment.

Furthermore, there is no oversight or even awareness of practice throughout the facility. Because the concepts of restraint and seclusion are interpreted arbitrarily, there is no consistent record of occurrence. Perhaps most concerning, what records have been produced and made public in claims of good practice are not reflective of actual practice. Staff members themselves report a lack of training in managing the difficult behaviors of resident boys. CJTS and DCF administrators have failed to acknowledge the void in staff training and supports.

III. MANDATED REPORTING AT CJTS OF SUSPICIONS OF ABUSE OR NEGLECT OF CHILDREN NEEDS TO BE IMPROVED

THE STAFF AT THE CONNECTICUT JUVENILE TRAINING SCHOOL RRE NOT TRAINED OR FULLY AWARE OF THEIR BBLIGATIONS AS MANDATED REPORTERS.

Many direct care staff at the Connecticut juvenile training school do not understand their obligations as "mandatory reporters" under Connecticut law. All persons with concerns about the safety and well-being of a child can alert DCF, the child protection agency, of their concerns. However, given the expertise and special opportunity to assess a child's situation that certain professionals and caregivers have, they are required by law to note and report suspected child abuse or neglect. Described in the in Connecticut law as "mandatory reporters," (See Appendix D., Conn. Gen. Stat. §17a-101), these reporters are required to make their reports to the DCF Child Abuse and Neglect "Hotline," established specifically for the receipt of such reports.

As mandated reporters, any CJTS staff member has an obligation as well as a mechanism to ensure that children are safe and properly cared for (See Appendix E). Examples of the need for a direct care staff in an institution like CJTS to make a report to the Hotline include witness of any form of abuse or neglect[42], such as: witnessing

[42] DCF 34-2-7
Neglect – The failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education. A "neglected" child is one who among other things, is being denied proper care and attention physically, educationally, emotionally or morally, or is being permitted to live under conditions, circumstances or

children being restrained improperly, being left unsupervised, being emotionally abused through public humiliation, and so forth

During the course of this investigation, OCA staff concluded that, while all of the CJTS clinicians had received mandated reporter training, direct care staff had not. OCA staff found that the staff did not understand their obligations as mandatory reporters from two perspectives. First, they were generally not informed on what constitutes abuse or neglect and second, the majority of staff members interviewed were not aware that each member of the staff has a legal obligation to personally report suspected abuse or neglect to the DCF Hotline or ensure that a report is made.

The DCF BQM report reported that among staff surveyed, " sixty-four percent reported that CJTS does not consistently and effectively train staff in their responsibilities as mandated reporters of abuse and neglect." Ironically, *"The facility administration responses disagreed with all other staff group response"… in the area mandated reporter training. The BQM report noted that among facility administrators surveyed, "one hundred percent reported that staff are trained in their responsibilities to report abuse and neglect."*

As a consequence of direct care staff not understanding their mandated reporter obligations they are failing to make reports. During the course of this investigation OCA staff were obligated (as mandatory reporters) to make file three separate reports to the DCF Child Abuse/Neglect Hotline concerning suspected incidents that were not previously reported by anyone at CJTS. Two more reports would have been filed but CJTS administration told OCA staff that facility nurses had filed reports on those cases. However, those reports were not filed until after OCA requested and reviewed videotapes of the incidents. Some staff may have had knowledge of situations that warranted the concern, but they did not grasp their responsibility to report themselves. OCA staff learned from a number of staff that their practice was to report concerns or suspicions to their immediate supervisors rather than call the DCF Hotline.[43]

ANALYSIS OF STAFF MANDATED REPORTER OBLIGATIONS

Without reports, abuse and neglect of children will persist. A significant contributing factor to the deficit in reporting at CJTS is the sheer lack of training.The fundamental key to keeping children safe is to recognize when they are not safe and to act upon

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associations injurious to his/her well being, or has been abused and has physical injury inflicted by other than accidental means, injuries that are at variance with the history given them, or a condition that is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.
Abuse – A non-accidental injury to a child which, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care. Abuse includes any injury which is at variance with the history given; maltreatment, such as, but not limited to, malnutrition, sexual molestations, deprivation of necessities, emotional maltreatment or cruel punishment.

[43] This could also result in a failure to report where the supervisor through lack of training or otherwise also fails to recognize the matter as one requiring a Hotline report.

that knowledge. Training staff to recognize abuse and neglect and report it is a primary responsibility of both CJTS the facility and DCF the parent agency. Failure to properly train and support staff directly translates to failure to ensure the boys placed in DCF care are safe and cared for properly.

IV. CJTS PROGRAMMING AND SERVICES

The Behavior Management Program

ACTING OUT
A defense mechanism whereby an individual expresses feelings through behavior rather than word.

The expression is used to describe any situation where an individual's behavior seems to reflect the expression of unconscious feelings or conflicts in actions rather than words. Acting out behavior may range from mildly disruptive in preschool or home settings, to dangerous, such as self-harm or suicidal gestures. In children, acting out may result in social isolation and limit his or her ability to engage in and learn from new experiences.

Children may act out as a way to express powerful, painful, and/or confusing feelings that they are unable to verbalize. Dealing with acting out behavior requires, minimally, a two-pronged approach. The first strategy is aimed at managing the behavior itself: the adult helps the child learn to substitute an acceptable behavior as an expression of his or her feelings. Secondly, the adult supports the child in investigating and dealing with the feelings he or she is expressing in acting out behavior. This investigation generally requires the guidance of a trained child psychologist or psychotherapist[44].

Acting out or disruptive behaviors may be symptoms of underlying illness. They may be learned behaviors from aggressive role models or responses to aversive relationships or events such as abuse and neglect. For example, a child runs away form an abusive adult in order to be safe. Consequently, running away may become habitual behavior when the child feels threatened or unsafe. The complexities of the root cause of a child's behavior may not be readily apparent to persons without expertise in child and adolescent psychology. Therefore, the response to a child's problem behaviors can easily be imprudent if not guided by a trained professional with specific strategies to address the behavior.

The purpose of a juvenile training school is to address and "train" behaviors in individuals at a point in their development when they are still susceptible to changing behaviors before escalating to those more serious. A behavior management program, therefore, is the basic foundation upon which any modification can be accomplished. The purpose of the behavior management program is to modify individual behaviors and maintain the behavior of the whole group in order to accomplish a safe, secure and therapeutic environment in which all the children will be able to progress toward their individual goals with individual supports.

[44] Kagan, J (Ex. Ed), (1998). The Gale Encyclopedia of Childhood & Adolescence. Gale: Detroit.

When CJTS opened in late August of 2001, there was no functioning behavior management program in place.

In fact, this was one of the chief concerns made to the OCA that prompted the initial visit in November. Historically, the behavior program used at LLS was the Guided Group Interaction Program (GGI). GGI was a peer pressure model in which the youth were encouraged to use peer pressure to enforce appropriate behaviors. Superintendent Mara ended the use of GGI in a memo dated July 13th, 2001, stating, "*a new set of procedures is needed to allow staff to intervene consistently and proactively in responding to conflicts and concerns of the youth in their living areas*." Until a permanent behavior management program could be developed and implemented, an "Interim Program" was presented to staff that was referred to as, "Informal/On the Spot Counseling." The core intervention for this approach was a problem solving strategy that required staff to intervene on the spot by attempting to help a boy recognize what the problem was that caused the behavior and choose a solution to the problem[45]. No staff interviewed for this investigation indicated that the so-called interim program was useful or effective. The majority of persons indicated that it was, for the most part, ignored. In the meantime, individuals in various areas of CJTS including residential units and school classrooms instituted different behavior management strategies.

Six months after the GGI program was discontinued, Superintendent Mara released a memo to all staff on January 7, 2002 launching the new CJTS behavior management program that day. The program was described as having three components, a Point Level System, Aggression Replacement Training and Cognitive Behavioral Therapy Relapse Prevention (see Table 5).

1/7/02 CJTS Behavior Management Program **Table 5.**

1) Point Level System. A tracking system, which can provide data on how well youth are behaving during their school day, recreation activities, mealtimes, weekends and holidays. It is an incentive system designed to motivate positive behaviors with sanctions for misbehaviors.

2) Aggression Replacement Training. An educational program to be given during the school day which gives youth training in three modalities: a) social skill building, b) moral development, c) anger management. These modalities are taught through a multi-disciplinary approach with teachers, clinicians, residential care staff, nurses and rehabilitation therapists trained in this approach.

3). Cognitive Behavioral Therapy-Relapse Prevention. A substance abuse treatment component of the program. While youth are residing at CJTS illegal substances are inaccessible, which allows for this particular form of therapy designed to prevent relapse[46].

The plan was to roll out the program in pieces. The first piece to be implemented was the Point Level System and the rest in subsequent weeks. All staff were to be trained in the Point Level System prior to January 7, 2002. However, due to staffing issues,

[45] Connecticut Juvenile Training School: Interim Program Procedures. Undated, unsourced document.

[46] Mara, L. (2002) Superintendent's memo to CJTS Staff dated January 7th.

holidays and other factors, not all staff received the two-day training. The DCF BQM Program Evaluation Report noted on page 52 of 74,

> "both observation and reports indicate that the direct care staff at CJTS do not adequately support or implement the point/level system as it is currently designed. The behavior management system is still in the beginning stages of development and appears to be overshadowed by the use of 'sanctions and charges' that conflict with the immediate reinforcement schedule the program is based upon."

Direct care and professional staff reported to OCA that as the sole means of behavior management the point level system was not effective.

1. Aggression Replacement Training

The second part of the behavior management program to be implemented at CJTS was Aggression Replacement Training (ART) program. Long Lane School Clinical staff had committed several years to developing ART as what they viewed to be an effective therapeutic program to decrease aggressive behaviors. There was a consensus among staff of concern regarding further delay before such a critical component of the overall program would be implemented at the facility. The ART training began in mid-April 2002. Only 12 staff were trained to provide the classroom interventions for ART, including several clinicians and teachers but no direct care staff. Half of the youth in residence, approximately 70, were oriented to the program. In September 2002 – a full year after the facility opened, Director of Psychology Patrick Russolillo reported to OCA that ART training is in the process of being provided to all staff.

2. Cognitive Behavioral Therapy (CBT)

The third component of the behavioral management system was also delayed in implementation; only 30 youth were participating in CBT in July of 2002. In addition to problems with the timeliness of CBT being made available, there have been significant problems with its design. Dr. Yifrah Kaminer designed the original CBT curriculum.[47] It was modified at the direction of the Superintendent and Assistant Superintendent Flower-Murphy. In sworn testimony before the Office oft her Attorney General Flower-Murphy stated, *"We modified it using … some of the curriculum from the training academy into more sessions ad longer sessions and have it be more culturally competent to the kids at CJTS."*

CJTS administration shared their revisions with Dr. Kaminer. In a May 21, 2002 letter to Assistant Superintendent Flower-Murphy and John Callas from the DCF Training Academy, Dr. Kaminer pointed out significant problems in the credibility of the

[47] Dr. Yifrah Kaminer, M.D., M.B.A, Associate Professor of Psychiatry, Alcohol Research Center at UCONN Health Center and consultant to DCF on the Byrne Grant Program, a four-year substance abuse treatment services grant awarded to Long Lane School in 1999. Dr. Kaminer was funded as trainer and consultant through the grant.

proposed alterations of his original, evidence-based model of therapeutic intervention. He expressed specific concerns with content in the program training manual; time allotted for treatment sessions; and the use of Hip-Hop culture to engage the boys.

Regarding the manual, in addition to typos and unclear details, he noted that the, "*explanation of several important topics as well as suggestions for interactions are not always evidenced-based and therefore inaccurate or could be misleading (e.g., depression and negative moods).*" Dr. Kaminer was also concerned that the time allotment for CBT-relapse prevention was reduced to an "*unsatisfactory level.*" He also noted that the "*structure and content of sessions successfully utilized in the pilot study… . has been changed and not for the better (why, and how?)".*

Dr. Kaminer's concerns regarding the use of Hip-Hop culture and rap music from an "*African American ethnocentric and inner city perspective*" to engage the boys appeared to be "*intuitive*" with "*several serious shortcomings*." In addition to the possibility that the approach would be inappropriate for boys who are not from an African American, inner city culture, Dr. Kaminer outlined five other areas of shortcomings.

> 2. "The adolescents exposed to this technique are being stimulated to a level that is not constructive to CBT process. These youths, many of whom have learning disabilities, attention difficulties, problem(s) in managing impulsive and irritable urges need to be calm and focused to benefit from the challenging curriculum of CBT.
> 3. There is a cue exposure potential to reminiscing on drug use while being exposed to music that could have been played when adolescents with substance abuse problems used drugs.
> 4. Although the songs chosen generally advocate for positive goals, I question the means by which our youths will choose to meet these goals if they will not be wisely guided. Some of the lyrics are very disturbing and tend to enhance (the) perception of victimization, isolation, aggression, and nihilistic anti societal, church or government sentiments. See the song Why on session 5 'the radio station they help with the slaughter'?!, 'the senators governors break the law?!, on session 7: What Kinda World – 'there is no such thing as a government'?!, 'Churches are run like corporations'?!, and more.

Dr. Kaminer concluded on the issue of Hip-Hop culture used to engage boys in cognitive behavioral training by clarifying, "*aggressive ethnocentric sentiments and isolationism do not contribute to rehabilitation in general and to a successful treatment for substance abuse in particular.*"

Assistant Superintendent Flower-Murphy was questioned by the Attorney General's office regarding the changes to the CBT Curriculum and Dr. Kaminer's response. When asked whether she recalled if his views towards the curriculum changes expressed in his May 21, 2002 letter were favorable or unfavorable, Flower-Murphy testified, "*I think it was favorable. It was only two pages and the curriculum is about two hundred.*" (p.124) Flower-Murphy was presented with a copy of the letter and

asked to review it. When asked to clarify whether the letter was actually supportive of the changes, she testified, "*Knowing what I know about the curriculum, I don't agree with everything that he wrote here, so yes, I didn't see it as a really bad thing." (p. 125).*[48]

The assistant superintendent indicated during her July 2002 testimony that the first group of boys to receive CBT had conduded and two reviews were underway. One review was a revisiting of the curriculum and the other was an evaluation by an outside person. OCA requested copies of both reviews. At the time of this report's release, nothing had been made available.

3. The behavior management program at CJTS is just not functioning as it should.

Staff satisfaction and buy-in with the CJTS behavior management program was and continues to be poor. DCF's own BQM evaluation of the program found strong evidence of this. Of direct care staff surveyed and interviewed regarding the program the BQM report indicated that, *"Both observations and reports indicate that the new behavior management system and group program has yet to be fully implemented and internalized by most of the direct care staff."* (p 49).[49] The report further states on page 53, *"both observation and reports indicate that adequate rewards and incentives are not built into the foundation of the point/level system at this time."*

The findings of that DCF-conducted report identified a no-confidence vote among staff for the Point Level System. *"The point/level system recently implemented at CJTS has not been routinely supported or internalized by the majority of the CJTS interdisciplinary staff. Overall, it is the belief of a number of staff that the CJTS behavior management and treatment services do not effect improvements in youth behavior functioning."*[50]

The staff opinion, according to the BQM evaluation report, directly contradicted that of administrative personnel who reported, "*that the behavior management and treatment services at CJTS were effective in improving youth functioning.*"

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[48] In fact, it was obvious from Dr. Kaminer's letter that he was highly critical of the changes to the CBT program. We are concerned that Assistant Superintendent Lisa Flower-Murphy did not provide a candid response in her sworn testimony when first asked about the letter. If she did not agree with Dr. Kaminer she should have said so up front rather than testifying under oath that his letter was favorable, when it clearly was not, and clarifying her statement only after being confronted with the letter.

[49] DCF Bureau of Quality Management, (2002). Connecticut Juvenile Training School: Program Evaluation Report. June 10. p. 52 of 74

[50] Ibid, p. 10 of 74.

Analysis of Behavior Management Program

Changing human behavior is no easy task in the best of situations. Given the complicated histories and root cause behind the behaviors of resident boys at CJTS, the challenge is intensified. CJTS chose a three-pronged approach to manage and modify the boys' behaviors. OCA never had the opportunity to find any one person who could thoroughly describe the way the three approaches would work individually and as a program whole. The source of the combination of programs was also difficult to grasp if that source was indeed credible, research-based, professionally supported methodology.

When dealing with children's lives, innovation and new development is certainly to be encouraged, but only from persons who have the expertise and experience to make credible hypotheses and to know enough to evaluate for positive and negative outcomes. Lisa Flower-Murphy and Lesley Mara are not licensed psychologists or social workers. Yet they facilitated profound curriculum change to a clinically-based behavior program that had been developed by a psychiatrist with specific expertise. This interference in clinical programming, as Dr. Kaminer's letter seemed to express, can alter a program and therefore its therapeutic effect dramatically. Such alterations that are not clinically and research-based may be useless and even dangerous. It is this kind of disregard for the value of professional expertise that has contributed to the failure of CJTS and DCF to provide appropriate care and protection of the boys in their custody.

The delayed and fragmented implementation of the three components of the behavioral management system has contributed to the ineffectiveness of the overall program. Each of the three components was chosen as a complement to the other. Without asking the question about how it is determined that the three in fact do complement each other, the very fact they were not implemented as complements threatens effectiveness.

Consequently, there is a complete lack of staff and administration agreement on programming for the boys. Even DCF's own evaluation identified a significantlack, or even an absence of, buy-in from direct care staff for the behavioral management program. Repeated attempts to address the deficiencies in programming by direct care and professional staff have been ignored by the administration. As it stands, staff members are inadequately trained to implement what fracture of a full program exists. The rogue programs that have popped up and set behavioral expectations in individual classrooms and residential units at the facility contribute to the overall inconsistency of programming throughout CJTS.

The failure of the implementation process is that most of the youth who were transitioned into CJTS from August 27, 2001 to the present time, will not receive the benefits of a comprehensive behavioral management program. The programs are scattered at best with sporadic involvement from staff and youth.

V. CLINICAL SERVICES AT CJTS ARE POOR OR NON-EXISTENT

"The results are overwhelmingly convergent and compelling, however, in indicating that there is a significant lack of clinical and therapeutic services being provided at CJTS". DCF BQM Report, 2002

A. Background

Behavior may be what lands a child in an institution like CJTS. And behavior management may be what maintains order and reinforces appropriate behavior for returning to community living. But behavior is only a symptom. It may be a symptom of pathology, or disorder. It may be a learned response or a defense mechanism. And behavior management is generally not the solution to the underlying problem. Behavior management may maintain order and safety, just like suicide watches are meant to maintain safety, and restraint and seclusion maintain safety. Watching, restraining, secluding and managing are not therapeutic interventions. They are compliments to therapeutic interventions. Clinical services make up the therapeutic interventions that, together with behavior management, will begin to address the conditions children are experiencing that cause unwanted behaviors. They include comprehensive health care, psychiatric care, behavioral care, dental care and any other therapy that applies to the problem. In an institution where treatment is a primary goal, therapeutic interventions are the key interventions for lasting change.

The crucial role played by clinical staff in a juvenile training school derives from the high incidence of mental health problems among committed youth. Children's involvement in the juvenile justice system is highly correlated with incidence of mental health problems. Among the general population, an estimated 20 percent of children and adolescents experience some degree of mental illness. By contrast, history of sexual and physical abuse, neglect and trauma and related mental health conditions are common denominators in the equation for a child's entry into the Juvenile Justice system. Among the incarcerated population, between 50 and 75 percent of youth have diagnosable mental health disorders, with 1 in 5 having a serious emotional disturbance. Youth in the juvenile justice system also have a significantly higher rate of psychotic disorders than the general population. Estimates of the most common disorders among incarcerated youth indicate that 55% have clinical depression, up to 80% conduct disorder, and up to 45% Attention Deficit Hyperactivity Disorder (ADHD). Many adjudicated youth have multiple diagnoses. At least half have a co-occurring substance abuse disorder,[51] and incidence of learning disabilities ranges anywhere from 20 to 60 percent, depending upon the study.

The youth at CJTS reflect national trends. OCA sampled eighty (representing approximately half the population) Psychosocial Assessments from CJTS Intake department. The review revealed that approximately 40% of the eighty boys are on psychotropic medications, 80-90% are classified as conduct disordered. Mood

[51] Coalition for Juvenile Justice, (2000). Annual Report

disorders (including depression), attention deficit hyperactivity disorder, emotional disorders, and posttraumatic stress disorder, are also serious concerns. OCA noted 80-90% of the boys in the sample to have substance abuse problems. In an application for program funding[52] CJTS cited a 1999 Alcohol and Drug Policy Council study that identified CJTS youth as having the highest need for substance abuse treatment services among all Connecticut youth in high risk categories. Given the focus on "rehabilitation" at the training school, the expectations for clinical assessment, treatment and follow-up should be extensive.

B. Clinical Services at CJTS – Initial Intake Assessment and Treatment Planning

Upon a youth's admission to CJTS a comprehensive psychosocial assessment is conducted. This assessment includes a review of the boy's clinical background, previous diagnostic impressions, a clinical intake interview, substance abuse history, preliminary DSM-IV Diagnosis[53], intake screening results, a summary of all findings and recommendations for treatment. Additionally, a comprehensive family assessment, a psychosocial evaluation and substance abuse assessment are required to be conducted. Each youth should receive a complete medical and dental examination and educational evaluation. In addition, recreational interests are to be assessed and pastoral services offered.

The intake assessment should be the foundation upon which the "Plan of Service" is developed. The Plan of Service acts as the boy's treatment plan. It should be a detailed outline of his identified needs and recommended treatment. Two clinicians[54] are assigned to conduct the intake assessment including the psychosocial evaluation, the family assessment and the substance abuse assessment. They are also expected to provide ongoing services to the youth placed in Building 4, the intake unit.

OCA staff reviewed a sample of seventy individual comprehensive intake assessments that were conducted between September 2001 and January 2002. Substance abuse was targeted as an example of a frequently occurring concern. OCA staff found that 43 of 63 boys in the sample assessed for substance abuse were diagnosed with some form of substance abuse or dependence and were recommended for treatment. Clearly the need for substance abuse treatment programs is high at CJTS

Clinical and direct care staff members who were interviewed all expressed a concern for the lack of substance abuse education and treatment programs. Some boys require more intensive treatment. Currently, neither is fully provided.
OCA staff also reviewed a sample of Individual Plans of Service. All of the Plans of Service reviewed followed a generic format. Each consisted of a list of goals and interventions. Regardless of the findings in the related psychosocial assessments or

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[52] Grant application: Byrne Grant Program, Connecticut Office of Policy and Management: Policy Development and Planning Division, 3/01.
[53] Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. A reference work developed by the American Psychiatric Association and designed to provide guidelines for the diagnosis and classification of mental disorders.
[54] Clinicians: Licensed psychologists and/or Licensed Clinical Social Workers.

the recommendations, the corresponding prescribed interventions for each boy did not correspond to individual needs. Each boy, regardless of his need, had essentially the same interventions outlined in his Plan of Service (see table 6).

Plan of Service Interventions: **Table 6.**

1.	Youth will attend Cognitive Behavioral Training in the form of relapse prevention, refusal skills building and harm reduction techniques 2-times per week.
2.	Youth will attend Aggression Replacement Training in the form of skills streaming, anger management and moral reasoning 3-times per week.
3.	Youth will participate in the behaviors modification point/level system of the unit on a daily basis to increase his positive behaviors and deter impulsive behaviors.
4.	Clinician will work with the youth's family on establishing clearly defined rules, boundaries and consequences for misbehavior.
5.	Clinician will encourage Youth's involvement in extracurricular social, athletic, or artistic activities with a positive peer group that expands interests beyond hanging out.

The lack of individualized planning and interventions is even more disturbing given that the prescribed interventions have not been fully available. The three components of the behavior management program are not fully in place. The Point Level System, was not rolled out until 1/7/02; the CBT program was just recently implemented for half of the CJTS population in 4/02 without supportive staff training; and the ART has yet to be implemented as of this writing. Furthermore, work with families is sporadic and only occurs at the lead of individual clinicians. Several obstacles to work with family were identified by clinical and support staff members. They include decreasing assistance to families to facilitate family visits such as bus passes and other transportation assistance. Families are not able to meet with the boys in "normalized" settings but only in the visitors' room of the main administration building.

"Currently, there are virtually no interventions employed by the program that are likely to have much effect on offender behavior… Although the risk level of participating offenders is known when they enter the program, it does not appear that the intensity and duration of treatment is appropriately matched to the offender's level of risk and need… . Once in the program everyone essentially receives the same treatment regardless of his risk level or characteristics."[55]

The majority of the staff interviewed on all levels expressed a desire to provide services to these youth. Many have made attempts at developing programs or initiating activities that were not assigned to them in order to help the boys. Clinical staff members reported feeling they had been deterred from organizing their own substance abuse groups, AA/NA participation or other creative methods of servicing the youth. A general complaint of many staff members was the lack of support to be creative with services for the boys.

[55] Latessa, EJ., Pealer, J., (2002). *Correctional Program Assessment Inventory: Conducted on the Connecticut Juvenile Training School*. Center for Criminal Justice research, Division of Criminal Justice, University of Cincinnati, Cincinnati, Ohio. April.

C. CJTS Administration of Clinical Services

As noted earlier, the primary therapeutic technique at Long Lane was Guided Group Interaction (GGI). The interim behavioral program required clinical staff to meet with youth on their caseload once each week. The many vacancies in clinical positions made individual meetings virtually impossible. Clinicians reported being stressed with caseloads that were simply too large. Some youth have been seen once a week, some biweekly, and some monthly. Frequency of clinical meetings has been crisis-driven, dependant more on the boys' behavior in the units – with clinicians providing crisis intervention -- than on their needs as diagnosed in the clinical assessment.

There are those boys who have educational disabilities and applicable Individual Education Plans (IEP) that include weekly counseling. Services prescribed in an IEP must be provided according to state and federal law.[56] Boys with IEPs are given priority for receiving weekly therapy sessions, while other youth must fit into the remaining time that clinicians have available. Another complication is that Superintendent Mara directed that clinicians are not to see youth during school hours unless the youth are in crisis. The attempt to avoid interrupting the school day on a regular basis has resulted in limited opportunities for counseling. Teachers and YSOs reported their impression that some youth provoke a crisis in school as a means of accessing time with their clinician. The clinical staff interviewed for this report consistently reported that the boys at CJTS need more treatment that they are currently getting, more individual attention and more organized therapeutic activities.

In an effort to provide more clinical coverage, the Superintendent Mara re-assigned the two clinical directors to work on the units with full caseloads. This action was widely viewed as a demotion, and one clinical director resigned. The intention to reduce the caseloads with two clinicians was seen by staff to limit the availability of senior clinicians for supervision, planning, development of new therapeutic programs, training, or other functions. Open clinical positions listed for CJTS on September 13, 2002 included one full time psychologist and five part time (20 hours per week) psychiatrists. There were no positions listed for licensed clinical social workers.[57] Over the summer of 2002 it appeared as though some of the workload was being lightened with the presence of MSW candidates (student interns) on site for internships. In August of 2002 OCA received a copy of a CJTS internal e-mail in which Assistant Superintendent Flower-Murphy made a request of two clinicians regarding MSW-candidates at the facility. Flower Murphy wrote, "*Would you agree to be on paper supervisor for a student that I would place in building 2? I have a lot of requests and cannot fill them…* " Clinical staff expressed concern to Assistant Superintendent Flower-Murphy and DCF administrators regarding professional supervision and liability

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[56] CT Gen Stat Sect 10-76a to 10-76h, inclusive and the federal Individuals with Disabilities Education Act (IDEA) are laws that require the provision of special education services to eligible children with disabilities.

[57] Employment Opportunities at DCF, http://eww.dcf.state.ct.us/HumanRes/emplyop.htm , 9/13/02

for the students. OCA was told that the students were on units seeing boys independent of supervision. OCA is continuing to address this concern with DCF.

The DCF BQM evaluation report (p. 59) states,

> *" It is the strong belief of the Program Evaluation Team that one of the missions of CJTS is to provide individualized rehabilitative treatment that is effective in facilitating the transition and long-term maintenance of youth in the community or in a less restrictive environment. The results are overwhelmingly convergent and compelling, however, in indicating that there is a significant lack of clinical and therapeutic services being provided at CJTS. This includes substance abuse treatment as well as individual, group and family services. CJTS staff at all levels, youth and external observers concur that CJTS is currently not meeting the treatment needs of youth." (p59)*

Analysis of Clinical Services

Despite efforts to conduct comprehensive psychosocial and physical assessments on each boy, recommendations for treatment or intervention are not individualized and they are predominantly for interventions that do not yet fully exist at CJTS. The DCF BQM report indicated that, *"Both observations and reports indicate that the CJTS Intake and Assessment Unit does not adequately differentiate security and treatment factors, or match youth with an appropriate service structure based on their level of security risk and therapeutic need."* The problem with a standardized format is that it is not individualized to meet a youth's specific needs, all youth receive the standard plan, and specific treatment factors are not appropriately addressed.

Given the lack of services available, boys may be moving through CJTS without any intervention at all. Although the argument may be that the CBT and ART will incorporate such therapeutic services as substance abuse treatment, they are not and have not been for some time. This lack of appropriate programming and treatment is a failure by DCF to ensure that youth placed in the department's care have services that they need. The inadequate assessment and lack of appropriate services represents medical and psychological neglect of the boys.

CJTS has been described as a "treatment setting" versus a "correctional institution". Yet the facility is not staffed adequately to provide treatment or facilitate a therapeutic culture. Deficiencies in staffing are the primary obstacle to ensuring that boys get the treatment that has been prescribed them. The lengthy duration of seclusion, suicide "watching", and restraint use discussed in previous herein is evidence that clinical treatment is not being provided any where near appropriate therapeutic levels. The boys at CJTS are not being treated, they are being "contained."

In fact, it appears the only way to assure seeing a clinician on a regular basis is to have an IEP or to be in frequent crisis. Crisis intervention or fear of penalty of law seems to be the only means of assuring counseling services. Although one could

argue that the majority of the boys at CJTS would qualify for special educational services, including counseling under those same laws.[58]

The lack of adequate clinical staffing, supervision and support has generated an inability to provide appropriate therapeutic services across the board to the population. Scheduling of clinical services should also be flexible. If CJTS is a treatment setting, then treatment, including counseling should be incorporated into the school day daily schedule, as should tutoring, athletics, etc. The absence of physical space to accommodate treatment sessions is a sad comment on the commitment to a treatment model at CJTS. Either the provision of treatment was never truly intended or the planning for the physical plant was entirely deficient.

The strengths of CJTS clinical programming rests with the commitment of the clinical staff. The majority of the clinical staff expressed dedication to the youth to provide whatever they can offer. However, the current programming does not allow for flexibility, interactive treatment, group dynamics or therapeutic supports. The limitations rest in the failure to implement a behavior management system. The clinical staff has been operating with numerous limitations since this program began, and they continue to struggle to meet the expectations of their daily caseloads. In the meantime, CJTS and DCF are failing to provide proper care and attention to the boys placed in their custody.

VI. CJTS MAY BE OUT OF COMPLIANCE WITH STATE AND FEDERAL LAW REGARDING EDUCATIONAL PROGRAMMING

A. A SLOW START

At the new Cady School[59] the CJTS vision was to establish a "typical" high school with a centralized school building. Youth would be placed by grade level, and there would be movement between classes (e.g., science, math, history, etc.). The "typical" school was designed to include general educational services, special educational services, vocational programs, and a Student Assistance Center. The departure from the Long Lane School design in which boys were educated within residential units according to placement versus grade level was a transition for both the staff and boys.

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[58] Connecticut schools are required to refer promptly any child to a Planning and Placement Team meeting who has been "suspended repeatedly or whose behavior, attendance or progress in school is considered unsatisfactory or at a marginal level of acceptance (CT Agency Reg. 10-76d-7). The Federal Individuals with Disabilities Education Act also requires early testing and referral of special education children, under the "child find" section of that law [20 U.S.C. sec. 1412(a) (3)]. For a child experiencing academic trouble or behavioral problems (multiple suspensions, expulsions, truancy etc.) the school is required to convene a PPT, evaluate the child in any area of suspected disability [20 USC 1414 (b) (3) (c)] and develop an Individual Education Plan for any child with a disability who by reason thereof needs special education and related services. (20 USC 1401). Children with emotional disturbance are eligible for special education.

[59] Cady School is the name of the original school at Long Lane School.

The new model had the support of educational staff. However, educational professionals who were interviewed for this report identified several factors that interfered with the success of the plan, including 1) a short time frame for planning and starting a dramatically different educational program, 2) the lack of follow-through on plans, 3) repeated changes in institutional and school policy, 4) delayed delivery of furniture and supplies, 5) a prison like nature of the facility, and 6) significant behavior management issues during school hours. Education staff also expressed concern that the school management was making decisions about school curricula that they were not qualified to make. Further concern was expressed that security and behavior management issues outweighed academic programming.

Initially, the start up at the CJTS facility was stalled by delay in delivery of basic items like desks and chairs. Books and supplies did not begin to become available until December 2001. Only a portion of the library books and five of twelve computers for student use in the library had arrived by February 2002. The library media specialist noted that new computer equipment was distributed among administrative staff while second hand computers were set up in the new library for the students. Some equipment that is on hand cannot be used. For example, the lack of security-filtering software prohibits students from accessing the Internet themselves. Students are not allowed to handle microscopes because they came equipped with regular glass lenses, presenting safety and security risks. In both cases, the teacher must demonstrate to a group of students how to search the Internet or use a microscope, but cannot allow any hands on experience.

B. SPECIAL EDUCATION SUPPORTS

Performance in school is one of several strongly related factors to a youth's involvement in the juvenile justice system. Behavior problems among these youth are common and may be a manifestation of an underlying disability, including a learning disability. As noted in Table 7 at the very least, a behavior disorder can interfere with the educational process. State and federal laws are designed to protect and ensure a child's access to an education (see Table 7). Given that 80 to 90 percent of the boys at CJTS are diagnosed conduct disorders and other problems it is highly likely that the majority of them are eligible for some special education and/or reasonable accommodation.

Relevant Educational Laws **Table 7**

Connecticut schools are required to refer promptly any child to a Planning and Placement Team meeting who has been "suspended repeatedly or whose behavior, attendance or progress in school is considered unsatisfactory or at a marginal level of acceptance (CT Agency Reg. 10-76d-7). The Federal Individuals with Disabilities Education Act also requires early testing and referral of special education children, under the "child find" section of that law [20 U.S.C. sec. 1412(a) (3)]. For a child experiencing academic trouble or behavioral problems (multiple suspensions, expulsions, truancy etc.) the school is required to convene a PPT, evaluate the child in any area of suspected disability [20 USC 1414 (b) (3) (c)] and develop an Individual Education Plan for any child with a disability who by reason thereof needs special education and related services. (20 USC 1401). Children with emotional disturbance are eligible for special education.

Section 504 of the Rehabilitation Act.

C. A 1998 SETTLEMENT OF A FEDERAL COURT CASE REQUIRES DCF TO PROVIDE APPROPRIATE EDUCATION AND EDUCATIONAL SUPPORTS TO CHILDREN RECEIVING EDUCATION FROM THE UNIFIED SCHOOL DISTRICT II.

Unified School District

The Unified School District II is a school district established by Connecticut General Statute 17a-37 and which operates within the Department of Children and Families under the supervision of the Superintendent of Schools. It provides educational services to students who reside in DCF facilities and whose treatment needs require that they receive their education within the facility. It also provides educational services to students who are no-nexus an who have been placed by DCF in a private residential facility, psychiatric hospital or in the residential component of a Regional Educational Services Center (RESC).[60]

The Cady School at CJTS opened with a very recent history of having to review educational and related services to resident children in a class action suit. The school is under the Unified School District II, which is subject to the same Connecticut educational statutes as other public school districts[61]. The district is also subject to all relevant Federal Law. A court settlement in the case of *Smith, et al., Plaintiffs v. Wheaton, et al., Defendants*[62] (1998), recognizes that the Cady School is mandated under the Individuals with Disabilities Education Act (IDEA) and § 504 of the Rehabilitation Act to provide educational and related services, to address the socially inappropriate behaviors that inhibit student's ability to learn, tobe educated in a less restrictive setting, and to live in a community setting.[63]

D. DESPITE CHILDREN AT CJTS BEING AT HIGH RISK, ONLY HALF OF THE CJTS POPULATION HAVE IDENTIFIED SPECIAL EDUCATIONAL NEEDS

The January 30, 2002 census revealed that 55 percent of the boys at CJTS were receiving special educational services. At the beginning of the school year in fall of

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[60] Department of Children and Families, Unified School District II: Frequently Asked Questions. http://eww.dcf.state.ct.us/education/Education_FAQ.htm

[61] Department of Children and Families Unified School District II Homepage, http://eww.dcf.state.ct.us/education/usd2, 9/16/02

[62] An action under the IDEA, 20 USC §§1401-1485, and § 504 of the Rehabilitation Act of 1973, 29 USC § 794. The plaintiffs were the mentally disabled, adjudicated delinquent individuals who made up the population of the Long Lane School, a residential facility run by the State of CT for adjudicated youth. The defendants were the State Board of Education, the State Department of Education, the State DCF, the Long Lane School, Unified District II, and its superintendent and the Cady School.

[63] US District Court, Connecticut. (1998). Norman Smith, et al., Plaintiffs v. Amy Wheaton, et al., Defendants. No. H-87-190 (TPS) Summary. September 30.

2002, ninety boys of approximately 150 to 160 total were enrolled in special education. Teachers and pupil services staff indicated that a majority of students lacked basic skills. Teachers reported that the variation in skill level and low level of basic reading skills make it difficult to teach grade level classes. Materials, such as grade level books in substantive areas, are ineffective because a significant number of students are not able to read them. For example, many of the students in Grade Ten are at the first or second grade reading level.

Educational staff reported that the lack of therapy and counseling services contributes to school–related difficulties. The teachers reported that many of the students are unable to concentrate or stay focused on their work. Those boys who have been unsuccessful in school often appear to just give up on simple tasks. The teachers feel that individual and group counseling is sorely needed. They explained that while some youth need therapy, others just need to be able to sit down and talk to someone about their day. The teachers said that they get good support from clinical staff when they are available. Staffing shortages, however, have made it difficult to get clinical assistance. Pupil services staff reported that their communication with clinical staff is now done mostly by email, because there is not enough time for face-to-face conversations.

E. SUSPENSIONS AND EXPULSIONS

The latest school management policy formulated by the Superintendent In April 2002, indicates that a:

> "*Youth can be removed from school and sent back to his unit for any behavior that may be potentially health threatening. This includes actual assault, property damage, and persistent and repetitive threats of harm. The student will be sent back to his living unit any time staff has to with physical force of any magnitude. A youth can also be removed from school if he requires more than 3 time-outs for any class period. When a youth is removed he is required to miss the remainder of the class from which he was removed and the entire next period before he can be assessed for appropriateness to return to school…* " [64]

Some aspects of this policy may be in direct conflict with state and federal law protecting the rights of children to an appropriate education. At the very least, a PPT and any relevant evaluation are indicated if a boy is removed from school consistently. Federal law precludes the use of school removal as punishment. Instead, the law requires that schools provide services and related supports in the areas of socially inappropriate behaviors that inhibit student's ability to learn, to be educated in a less restrictive setting, and to live in a community setting[65].

[64] CJTS Behavior Management System Program Manual
[65] IDEA (20 USC § 1401 (17)

F. BOYS ON THE SPECIAL NEEDS UNIT ARE NOT RECEIVING FULL EDUCATIONAL SERVICES AND ARE NOT BEING INTEGRATED INTO THE GENERAL POPULATION.

Due to security risks and severe behavioral disorders, the boys who reside in Building 2 do not attend classes in the educational building. Instead, they receive educational services in their unit. Interviews among staff and boys in Building 2 revealed general dissatisfaction with the educational services.

The boys who were interviewed reported that classes often start late and end early. During designated class time, boys were observed lounging about either watching TV or playing cards. Several boys complained that they did not feel challenged, "we just basically play games." They expressed that school for students in the general population was better and more challenging. One teacher reported that certain classes scheduled on Tuesday and Thursday were only 20 minutes long. The teacher expressed frustration with so short a class period citing the time inevitably taken up by managing behavior issues instead of teaching.

Youth in Building 2 also complained that they had no vocational opportunities by virtue of their being on that particular unit. Within the new educational schedule some of the building 2 populations must be "integrated" into the school building for certain blocks of time each day. Some boys go to the educational building for 2-3 periods a day, either in the morning or the afternoon, depending on the schedule. However, the boys from Building 2 are not actually integrated with the general population. When they go to the educational building, Building 2 boys go only to the library to have class, or obtain books. They are not actually mixed into the population with other classes. Participation in visit to the educational building is based on the boys' behavior and staffing availability. This does not happen for every youth or every day.

G. STUDENTS WITHOUT SPECIAL EDUCATIONAL NEEDS ARE OFTEN OVERLOOKED.

Students whose academic performance is average or above average get little to no attention at the CJTS School. One teacher reported assigning some of the more skilled students to work with those who needed additional help. There were no special programs described as being for the more advanced students. Of the education staff interviewed for this report, none reported any focused effort to support youth who have the potential for high school graduation or post secondary education.

H. ENVIRONMENT, SETTING AND ATMOSPHERE

During the course of the investigation, several staff members expressed concern regarding the difficulty in implementing an education and treatment-oriented program in a facility that looks and feels like a prison. Some staff suggested that the facility was not designed to implement the educational program or accommodate

the number of students planned. One staff person noted that the Ohio facility, upon which CJTS was modeled, was designed for older individuals and did not have a school. That person referred to the school as "an afterthought" to the CJTS design.

School staff reported that the school building would not accommodate the expected CJTS population at full census. Office space and private consultation space are already inadequate. For example nine pupil services staff share five offices, and there is no space for clinical staff to meet with students privately at the school. Many of the classrooms are now in use, with a current total facility population ranging between 140 to 160 boys. Educational staff estimated that the building could accommodate up to 175 students but that it will not be able to serve the facility capacity of 240.

I. BEHAVIOR MANAGEMENT AND SUPPORT

Behavior management is key to providing a calm, secure environment in which children learn. Discussion with educational staff regarding behavior management in school was dominated by disappointment and frustration with the lack of a comprehensive behavior management program for the boys. The abandonment of the LLS behavior management system and the delay in implementing a replacement program at CJTS created significant challenges in controlling student behavior and keeping classrooms on task during the school day. Even once the new point system started, a majority of the staff interviewed reported problems with student discipline and concern for teacher safety. One teacher implemented her own point system in addition to the new CJTS point system to better manage her students' classroom behavior. A majority of staff expressed frustration at the amount of time they had to spend on behavior management and security issues rather than education and treatment. With a focus on managing behaviors, one YSO stated that boys attempting to do well are falling through the cracks. They are not getting the attention they need because they are not acting out.

In general, staff expressed frustration with a lack of alternatives for addressing disruptive behavior. One teacher stated, "Although staff recommended changes in student management, we didn't recommend giving up student discipline". In late Spring of 2002, teachers still lamented elements of the proposed behavior management system, such as aggression replacement training (ART) that were still not in place.

Due to the distractions of boys' behavioral problems, teachers reported that the challenge to educate is heightened. They cited that the shortage of staff across the board, including teachers, youth service officers, rehabilitation therapists, clinical social workers and psychologists impedes the focus of education with the distraction of safety and discipline. All of the vacant positions are fully funded positions. In May 2002 as the school year came to an end, there were thirteen vacant teacher and substitute teacher positions in the school. On September 13, 2002 positions listed for

CJTS included four teachers, one pupil services specialist, one principal and one school department head.[66]

J. SUPERVISION DURING THE SCHOOL DAY AND THE ROLE OF THE YOUTH SERVICE OFFICERS

Concerns about the ability to maintain order and allow for the boys to benefit optimally from school programs came from other staff as well. The new system of distributing boys in classrooms according to grade level caused changes in the responsibilities of direct care staff from the residential units during school hours. The job of the Youth Service Officers (YSO) is essentially to accompany boys throughout their day providing supervision, redirection and safety within the school community. At LLS, when the boys remained in their units for schooling, the YSOs remained with them. At CJTS, YSOs accompany boys to the educational building where the boys all split up to their respective classrooms. YSOs from the different units are then stationed outside the classrooms in designated chairs where they are responsible for managing student movement and assisting teachers with behavior problems. They more or less "share" monitoring of the boys but may be called to respond to one of the boys from their own unit who is having behavioral problems in class. A consequence of this is the loss of supervision from a familiar adult as well as the opportunity for that adult to facilitate a connection between the boys' unit activities and school achievements or difficulties.

The consistency of following up on youth behavior, collaboration between disciplines, and relationship developing is compromised as a result of the new limits in oversight. CJTS is still exploring the most appropriate use of YSOs during the school day. For example, considerable discussion has addressed whether YSOs should be inside or outside the classroom. To date, the YSO's are stationed in the hallways outside the classrooms.

K. SCHOOL TRANSITIONS AND DISMISSAL

Direct care staff and teachers reported significant difficulties in student management during class transitions and especially at the end of the day when school is dismissed. Despite the level of staffing to control student behavior, several staff indicated a need to get a handle on youth who just wander around during school hours.

One teacher noted that the behavior problems at CJTS were not significantly worse than those she encountered in public schools. She suggested that assumptions about CJTS youth might contribute to the tensions in the school. Several school staff mentioned the potential for danger because youth had been committed to CJTS for serious offenses. It was not clear whether the staff were provided any accurate information about the background of the boys that concerned them.

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[66] Employment Opportunities at DCF, http://eww.dcf.state.ct.us/HumanRes/emplyop.htm , 9/13/02

L. THE STUDENT ASSISTANCE CENTER (SAC) AS IT IS CURRENTLY OPERATING DOES NOT APPEAR TO OFFER THE SUPPORT TO STUDENTS AND TEACHERS THAT WERE INTENDED IN THE DESIGN OF THIS SUPPORT SERVICE.

Established to provide support for the boys at school, the SAC is described in a CJTS draft document dated 01/16/02 as being located in the school building to allow "easy access to intervention and support during the school day." The Center was described as being able to provide youth the following services and supports:

- "Crisis intervention and on the spot counseling services provided by certified and licensed personnel to increase the likelihood that the youth will remain in school and profit from the school day
- Routine advisement and guidance during the school day
- Access to the facility's Ombudsman, School Nurse and Chaplain"

Students can be referred to the SAC for time out from class as a response to disruptive behavior. A student may also be referred to the SAC for planned proactive intervention before behavior disrupts. Students may also be referred to the SAC for reasons of personal distress or crisis. The SAC should be staffed with one counselor, the school nurse, and the ombudsman.

Education staff indicated that the Student Assistance Center (SAC) has not been successful in helping students or avoiding disruption. Teachers and pupil services staff expressed the desire for the SAC to be used in a more proactive manner to avoid problems rather than just to address them after they happen. Some staff suggested that students were using time out or a trip to the SAC to avoid the classroom. Others reported that students actually make appointments to meet their friends at the SAC. Because several students are in the time out room or the SAC at a time, they see it as a social occasion, and fights have been known to break out.

Changing directives and directions of the SAC was reported to be causing tension and frustration between the administration and direct care staff on all levels. The educators, clinicians and YSOs view the use of the SAC as ineffective. Limited time, large caseloads of boys needing individual treatment, and staff vacancies and re-assignments have interfered with clinical effectiveness of the center. Clinicians report that their time is wasted because they are only seeing boys who are acting up or in crisis. Often times they see boys who are not on their caseload. That burdens them with the obligation of following up with the boy's clinician and documenting the whole interaction.

M. VOCATIONAL PROGRAMS ARE NOT AVAILABLE FOR EVERYONE.

Youth and staff spoke enthusiastically about the vocational skills program, particularly the culinary arts and media production classes, although the number of students who participate in these activities is limited. Lack of equipment delayed start up of these programs. The administration reports that the rollout of vocational classes is now on target. But enrollment information provided to OCA indicated that participation in

vocational educational programs is limited to a small number of boys and classes are only offered for 45 minutes of a school day.

ANALYSIS of EDUCATIONAL PROGRAMS

Although educational staff expressed concerns about behavior programs, supplies and equipment and lack of support for the educational programs, it was largely apparent to OCA that educational services and related supports were wholly inadequate. Students are exhibiting symptoms of learning disabilities and disorders that interfere with their ability to learn. Nearly all the boys have social, emotional and behavioral histories that place them at risk for learning disabilities and disabilities in general that interfere with the learning process. Their characteristics and behaviors also place them within the realm of educational supports and related services to achieve the goals of IDEA and Section 504. The school may easily be in violation of state and federal law by not addressing these problems.

Most compelling is the state of educational services for the boys in Building 2. They do not appear to be receiving equal opportunity to educational services and accommodation. Integration and least restrictive environment are the minimal standards of the relevant laws. Those standards are not being met. If there is a mandate to integrate these boys then they must be fully integrated (within safe parameters) and given equal opportunities to all academic programming, including vocational programming.

The educational system in general at CJTS has experienced numerous challenges including insufficiencies in programming, limited staff available to educate, ineffective and inconsistent behavior management systems available to maintain youth behavior, and vacant administrator positions charged with supporting staff and maintaining educational integrity. All of these deficiencies have negatively impacted the educational support the boys have received over the past eleven months.

The educational staff appears to have attempted to adapt to the changes and implementation of different programs. However, this is a difficult population to educate without adequate supports and resources. In order to create the best atmosphere in which the boys can learn, a facility-wide behavior management system must be fully implemented. It should include appropriate consequences and sanctions for inappropriate behavior, as well as positive rewards that provide incentives for appropriate and exceptional behavior. A balance between education and behavior support needs to be incorporated into the school and carried back to residential units. This has not occurred to date.

Staffing shortages have a direct effect on safety, class size, and attention to the educational needs of individual boys. Any school with similar staff vacancies would be pressed to function adequately.

The most recent policy on the use of YSO in the school requires them to be stationed around the hallways. Their presence in the hallways gives the impression of a building

under siege and it does not support consistency in response to individuals in classrooms. It is not apparent whether outcomes in classroom behavior have been affected by the location of YSO. Data indicating improved behavior according to whether YSO are outside of or inside the classrooms would be useful to determine the best use of these direct care staff.

Those students who are able to perform academic work on or above expectations must be provided with the appropriate level of challenge in their work. Opportunities to excel and be rewarded for academic performance are opportunities for enhancing self-esteem and positive motivation.

Beyond inadequacies in school staffing and a functioning behavior management plan, the school supplies and equipment that were missing at the opening of the school, much of which is still not available, underscores the ineptness of planning for this facility. In a "treatment-focused" facility serving developing adolescents, education should have been and continue to be a priority. The result, in addition to a frustrated, ineffective staff, is students who are given the impression that their education is not important. The chronic insufficiencies of programming undermine the intentions of professional educators to meet the educational needs of the boys at CJTS. CJTS and DCF are neglecting to provide adequate and appropriate educational services as required by state and federal law.

VII. REHABILITATION THERAPY AND RECREATION

A. BACKGROUND

"Adolescence is a period of transition between childhood and adulthood – a time of rapid physical, cognitive, social, and emotional maturing… "[67] Rest and exercise are two of the most important factors in healthy development of the adolescent. While the boys at CJTS may be described as youthful offenders, ultimately they are adolescents with normally developing bodies and normal needs for rapid growth. Recreation may be thought of as "play" or "free time", however, "the practice of sports, games and even dancing contributes significantly to growth and development, the education process, and better health."[68] Exercise has been associated with intellectual and spiritual development, improvements in gross and fine motor skills, psychological disposition and decrease in aggressiveness[69]. Therefore, recreational programs, especially in a setting where confinement and limitations on movement and socialization occur, should be a critical component of the overall programming to ensure the health and development of the adolescent residents.

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[67] Wong, D. L., (1997). Essentials of Pediatric Nursing, 5th Edition., p466. Mosby: St. Louis.
[68] Ibid, p. 481.
[69] Kagan, J., (1998). The Gale Encyclopedia of Childhood Adolescence, Gale: Detroit.

B. REHABILITATION THERAPISTS ARE RESPONSIBLE TO PROVIDE RECREATIONAL ACTIVITIES FOR THE BOYS AT CJTS.

Based on the program structure each residential unit is supposed to have a dedicated rehabilitation therapist assigned to provide and organize services or activities for the boys. That would translate to twelve (12) therapists. There are currently five full-time and one part time rehabilitation therapists at CJTS. Despite reports from CJTS administration to the contrary, few activities werefound to be going on. Staff members attributed the lack of programming to vacant positions, staffing problems, and program issues. What was observed was that rehabilitation therapy and recreational programs are available in the form of Art and Music therapy (rehabilitation therapy) or basketball, football, weight room exercise and card playing (recreation).

Cancellations of recreation classes were noted to be chronic due to limits in staff supervision, according to monthly scheduling documents. Periodic recreation time with the unit YSO staff has overwhelmingly consisted of playing basketball on the half court within the resident building.

In addition to staff shortages, obstacles to the provision of recreational and rehabilitation activities that staff reported included conflicting policies and administrative directives concerning the operating of programs. Access to supplies and appropriate staff supervision to support rehabilitation staff have been issues of contention.

Participation in the rehabilitation therapy/recreation classes is incorporated in the Point/Level System. If youth do not participate they lose points. This is problematic for therapists teaching specialized classes. In music for example, some boys may not participate due to interests or attitudes. The program does not allow therapists to develop different activities or classes to meet the varying individualized needs and interests of the boys. The administrative directive has been to provide art and music therapy only to all of the boys, leaving no options for individualized therapeutic activities. The staff reported they have had little input in program development.

The most organized recreational activity that was observed through most of the year was a basketball league that occurred between different units. Although this is a good opportunity for the youth to interact appropriately with each other, basketball was the most common and only outlet available to them. Non-organized recreation also involves primarily basketball in the half-court, or going to the weight-room, depending on staffing levels and youth behavior. Over the summer of 2002 softball became a frequently offered activity for the boys and staff. There are no opportunities for field trips, special recreational functions or family-inclusive activities. These activities occurred on a regular basis at the old facility at Long Lane.

There were many complaints about recreation programming and opportunities on Unit 2, by both youth and staff. Boys reported that recreation is often cancelled and they often do not get sufficient amount of time. Though we observed one organized

recreation class, where a gym teacher led the boys in stretching exercise before playing half court basketball, both youth and staff reported that recreation is generally not organized in Building 2 due to staffing shortages and behavior problems among the boys.

ANALYSIS OF RECREATION AND REHABILITATIVE THERAPY

Activities and exercise are critical to all levels of development for adolescents. The very nature of a daily routine in an incarcerated population heightens physical, emotional and behavioral needs for organized physical exertion and play. In fact, these activities should be recognized and included as vital components in the therapeutic milieu of the institution. Extracurricular activities present valuable opportunities for enhancing self-esteem and promoting healthy development and motivation to succeed.

There must be more staff in order to meet even the minimum requirements of daily structured activities for all the boys at CJTS. In addition, a meaningful program that is appropriate to meet the needs of the boys as a group and individually must be developed. The boys should have options that are favorable to meet their individual interests, as opposed to limited standard recreation (basketball/football) and Art.

There is no equity in recreational and exercise options for the youth in Building 2 compared to the rest of the population. The boys from Building 2 are being unfairly denied access to activities that are just as important for their growth and development as to other boys at CJTS. There are has been limited staffing and facility resources to adequately provide a therapeutic recreation schedule to these youth.

There is no evidence that the staff and boys have any input into changes, or development of new programs. CJTS and DCF are failing to provide appropriate exercise or recreational activities for healthy development of the boys in their custody.

VIII. CJTS INFRASTRUCTURE

A. CJTS HAS NO MISSION STATEMENT TO GUIDE THE STAFF AND SERVICES

The expectation and responsibilities of staff translate to needs of staff in the context of operating a 'rehabilitative' facility such as CJTS. The range of services required by the boys in residence drives the burden of work that the staff is presented with. From admission to discharge, there are expectations of service, including daily care, clinical support and intervention, education and special education support services, recreational and interpersonal activities, and safety for all residents and staff.

A mission and vision of any facility drives the range of services provided. No vision or mission statement exists at CJTS. Without common goals, planning and staffing may

be poorly guided and ineffective. The expectations would be a strong vision and staff fully prepared and supported to accomplish that vision. A management structure and supporting policy would be the framework upon which the vision would be carried out. Superintendent Mara recognized the concept early in her administration. In a memorandum authored by heron May 14, 2001, she explained her assessment of the Long Lane School staff and their *"appropriateness"* to assume responsibilities at the new Connecticut Juvenile Training School. The superintendent's first operating assumption was that, "*The greatest weakness at LLS is the lack of a clear, efficient management structure bolstered by policy and procedures that are consistently and uniformly enforced*."

A lack of a mission statement for the facility was noted as a deficiency in the DCF BQM evaluation report. In response to that report, the CJTS Action Plan that was developed included plans for identifying the mission (See Appendix A). Superintendent Mara sent an e-mail to the Child Advocate on July 22, 2002 with minutes from the first meeting of the CJTS Quality Council on July 18th (established by the Action Plan.) Item number six of the minutes recorded that,

> *"There was some discussion of the mission of CJTS, as the development of such is one of the areas of focus of the action plan. While it is clear that the Commissioner has a primary role in determining the philosophy of CJTS, the Council and the staff as a whole determine the way in which we demonstrate that philosophy and accomplish our mission on a day -to-day basis."*

One year after the CJTS was opened and boys were placed there in the custody of DCF there had yet to be a mission statement established to guide the work of the staff and the care of the boys. Seemingly unaware of the void in her agency that she was describing, DCF Commissioner Kristine Ragaglia was quoted by the Hartford Courant on September 9, 2002 stating, "*One of the challenges that we've had at Connecticut Juvenile Training School is having an understanding of what kind of philosophy that we want to achieve...*"[70] Without a mission, it is not clear what outcomes are expected or what they would be measured against. Without a mission, how would staffing needs be determined?

Despite having no clear vision and therefore guidance by which staffing and program goals would be developed and carried out, the facility has been operating for the past year. The void in guidance has translated to the staff's essential inability to provide safe and appropriate care to the boys placed there. Contributing factors include staff vacancies and absences, staff overtime, staff training and profoundly low staff morale. The majority of staff members interviewed by OCA investigators expressed a commitment to working with and helping the boys at CJTS. They frequently expressed frustration with the overwhelming obstacles that prevented them from doing their jobs.

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[70] Herbst, M., (2002). Ragaglia Says Goal is Improved DCF. Hartford Courant, Sunday September 9, page 2.

B. STAFFING CJTS

1. Introduction

Delivery of the full compliment of services to meet the unique needs of the boys placed at CJTS demands a full range of professionals, line staff and administrators. The immediate concern identified during this investigation was a profound staff shortage with a resulting overworked staff. Training in specific techniques to care for the boys was also noted to be lacking. These are issues of crisis, issues of immediacy, but they must not deter from the importance of the qualifications of individuals working with the boys at CJTS. Although some youth placed at CJTS may be adjudicated for criminal activities, may be aggressive, oppositional and possibly even dangerous at times, they are also a very vulnerable population of boys who have experienced a very high rate of abuse and neglect. Many carry the complications of dysfunctional families and the side effects of maltreatment. Many are substance abusers and suffer other mental and behavioral health problems. Therefore, the issues of concern around staffing are not just the availability of staff, but the availability of qualified, credentialed, prepared, supervised and supported staff.

In previous sections of this report, the needs of the boys at CJTS have been outlined. They have psychiatric or clinical needs. They need assistance with managing their behaviors. Many of the boys have learning disabilities and some are likely to have undiagnosed learning disabilities. There are boys who suffer addictions; some require treatment to recover from past abuse and neglect. Some of the boys at CJTS have very basic needs. They may not have lived in a structured environment before. Those boys must be socialized to function as members of a community. And even more basic, some have never experienced a trusting relationship with another person before. They need to learn to trust others, to establish relationships and live up to their potential. Consistency in the way adults interact with youth is a key factor for the development of trusting relationships.

The expectation of the staff should be to identify the needs of each individual child admitted to CJTS and develop a plan to best meet those needs. There should be a synchrony between disciplines with understanding and respect for the role that each plays. The child's progress should be communicated across all settings at the facility in order to complete his experience and accomplishments. Staff in residential areas should be able to interact with the boys in a way that compliments the work of educational and clinical staff.

2. Vacancies and Extended Absences

During a visit to the Connecticut Juvenile Training School ("CJTS") in March 2002, OCA found widespread difficulties caused by staff shortages. This was a particular problem with respect to the education department where educating the boys depends entirely on the availability of teachers, program directors, school rehabilitation therapists and youth services officers. The following information was provided by CJTS concerning staff vacancies and extended absences. From the time

the school opened until May 28, 2002, there had been 39 vacancies that had a direct and immediate impact on the ability of the school to educate and develop programs to constructively occupy the students. These vacancies include the following: 10 teacher vacancies (27% of all teacher positions); 2 department heads in the education department (66% of all department heads) 2 school principal vacancies which are currently filled in a durational capacity (100% of all principal positions); 2 pupil services specialists (18% of all pupil services specialists); 5 rehabilitation therapist vacancies (42% of all rehabilitation therapists); 4 clinical social worker vacancies (36% of all clinical social workers); 4 psychologist vacancies (57% of all psychologist positions); 13 youth service officer vacancies (9% of all youth services officers); and 8 security officers (36% of all security officers). These vacancies are funded positions that were or became vacant since the school opened in August of 2001. The records provided indicate that 36 of the 39 positions became vacant after the new facility was opened.

All disciplines and staffing levels were affected by shortages. In early June 2002 Diane Gadow, an independent consultant for DCF, submitted a revised draft of a staffing report that outlined recommendations for staffing patterns. OCA found no evidence that such a report had been sought or generated prior to the summer of 2002. In addition to problematic vacant positions, numerous teachers and clinicians have been out on extended medical leave or workers' compensation leave since the opening of the facility. Extended leave for workers' comp have ranged from successive 2 week periods to a full 10 months.

There has been a consistent high turnover rate (36 departures between August 2001and May 2002) particularly among teachers, rehabilitation therapists and clinical social workers. Prolonged periods with substitute teachers and a shortage of clinical and rehabilitation staff severely impairs the difficult task of educating troubled youth. Given the proper structure and staff, the state has an opportunity to teach students to read, master basic math skills, provide vocational incentives, and provide more advanced learning opportunities once the basics are mastered. Due to behavioral problems, education is difficult to achieve. Due to the shortage of teachers, youth services officers, rehabilitation therapists and clinical social workers and psychologists; the school cannot get beyond discipline to the much needed education and rehabilitation. This is not a matter of a lack of funding. This problem concerns turnover in established funded positions.

3. The shortage of staff members leads to the burden of excessive amounts of overtime on the staff.

High incidence of overtime work was noted in several categories of staff positions. Youth service officers' (YSO) work schedules were examined as a sample of staff workload. The YSOs have the challenging and essential job of maintaining order and security in the entire facility that includes the education building, the residence halls, the cafeteria, and recreation areas. These are the front line custodial caregivers who are responsible for care and custody of the residents. OCA found that overtime among youth services officers was extraordinarily high.

Youth Services Officers' Overtime Hours **Table 8**

Pay date	Overtime hours	Number of YSO's paid 40 or more OT hours
8/24/01	624	11
9/7/01	765.75	14
9/21/01	700.56	13
10/5/01	299	5
10/19/01	656.75	12
11/2/01	662	12
11/16/01	779.89	15
11/30/01	1,436.42	24
12/14/01	1,767	29
12/28/01	1,843	31
1/11/02	2,038.54	34
1/25/02	1,997.50	31
2/8/02	1,723.40	30
2/22/02	1,897.50	32
3/8/02	1,615.03	26
3/22/02	1,603	29
4/5/02	1,333.75	23

The regular full-time workweek for a youth services officer is approximately 40 hours. Overtime reports during the 17 pay periods from August 24, 2001 to April 5, 2002 were reviewed and categorized to show the frequency of overtime hours paid in each two week pay period in excess of 40 hours, 60 hours, 80 hours and 100 hours. On 371 occasions, youth services officers were paid for more than 40 hours of overtime during two week pay periods. A youth services officer who was paid 40 hours of overtime during a pay period was paid for approximately 5 extra eight-hour shifts in addition to his or her regular 10 shifts over two weeks. On 140 of these 371 occasions, youth services officers were paid for 60 or more hours of overtime, which is 7.5 extra eight-hour shifts (beyond the regular 10 shifts) over two weeks. There had been 37 occasions in which youth services officers were paid over 80 hours of overtime during a single pay period. A youth services officer who was paid 80 hours of overtime during a pay period, was paid for approximately 10 eight-hour shifts in addition to his or her regular 10 shifts. In 19 of those 37 occasions, the youth services officers were paid for over 100 hours of overtime, which translates into approximately 16 extra eight-hour shifts (beyond the regular 10 shifts) over two weeks.

A review was also conducted of the total number of overtime hours paid to youth services officers per pay period (See Table 8). A significant increase occurred approximately three months after the new facility opened, and this increase was sustained throughout the last pay period reviewed which ended on April 5, 2002 (see table 8).

These extraordinary overtime hours lead to significant stress and strain on staff that inevitably has a detrimental and widespread effect on conditions at the facility. Any person who is responsible between 60 and 90 hours in a single week for resident care, custody, order and security at the Connecticut Juvenile Training School is being stretched beyond appropriate limits.

4. The DCF BQM CJTS Program Evaluation Report found that staff reported being inadequately trained to do their jobs.

The Report noted,

> *"Regarding staff training, sixty-two percent of all staff surveyed reported that CJTS does not consistently and effectively train staff in crisis intervention, behavior management and the use of restraints before assuming duty. Seventy-six percent of staff surveyed reported that they are not trained in maintaining appropriate interpersonal boundaries and eighty-six percent reported a lack of consistent training in the appropriate use of authority and control in a secure setting." Page 61*

As discussed previously in this report, staff training is paramount to safety and appropriate care of the boys in residence. In regards to the management of aggressive behaviors alone, repeated training is necessary to develop the high degree of competence the work requires. Good training promotes the retention of qualified staff.[71]

It is unclear what policy and procedures staff are being oriented to at the point of entry, as the policy manual is not yet complete. Staff consistently reported to OCA that policy and procedures are not implemented within the program structure, so even if appropriate training on policy is provided there is no on-the-spot training, supervision, implementation and oversight to complement the initial information.

Because the organization, presentation and oversight of staff training has not been strictly applied, policy and procedure is not being implemented consistently. A case in point is the practice of strip-searching. Strip-searching is one of the techniques used to preserve security at CJTS (largely to prevent weapons or other contraband from entering the facility). The circumstances in which strip searches are conducted are guided by Policy 82-23-3 and are very limited due to obvious privacy implications.

Strip searches are to be conducted only by staff trained in proper search techniques. Staff members of the same gender as the youth being searched must carry them out in a nonpublic, designated area. In general, all Youth Services Officers (YSO) should receive training on proper search techniques.

Interviews were conducted among several resident boys regarding their experience with strip searches. Some boys reported that they had been searched, but not every time they returned to the facility. They also reported that being searched depends on what staff person is on duty. The boys stated that some staff are there to conduct searches and other staff are, "cool and they just let you go back to the unit". Some youth also reported that they were allowed back to the unit and were searched

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[71] American Academy of Child & Adolescent Psychiatry, (2002). Practice parameters for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions, with special reference to seclusion and restraint. Journal of the American Academy of Child & Adolescent Psychiatry, 41:2 Supplement, February.

there. Other youth reported that they were not strip searched but only asked to strip to their underclothes and then patted down.

The inconsistencies of carrying out strip search practice and policy has not been unnoticed by the boys at CJTS. Some complained that they are targeted by staff as a form of harassment. That particular inconsistency may be in violation of the boys right to privacy and freedom from maltreatment. As concerning is the risk of contraband being smuggled onto the units that may be used in harming self or others. Training of the staff regarding practices such asstrip-searching is evidently not complete and there does not appear to be any oversight as to the practice when carried out.

After reviewing training logs provided by CJTS administration, it was not clear that all administrators and managers have themselves gone through the training program to fully understand what is expected, taught and, in fact, implemented of their staff. The result is a thoroughly unprepared staff who are expected to work with very complex adolescent boys in sometimes hazardous situations.

5. Arbitrary changes of clinical staff scheduling undermined staff-administration relationship and overall morale.

A flashpoint came over Superintendent Mara's decision to assign clinical staff to the second shift. Soon after CJTS opened, Superintendent Mara notified clinical staff that she wanted clinical coverage during the second shift (3:00 pm to 11:00 pm). Clinical personnel recognized the desirability of providing coverage during second shift and offered to provide some coverage, but Superintendent Mara deemed the offer insufficient. She then arbitrarily assigned certain clinical staff to the second shift. This represented a major change in work schedules for those affected. Ten clinicians resigned.

Clinical staff members that belonged to the union filed a grievance over Superintendent Mara's assignment of staff to the second shift. The arbitrator ruled in favor of the union and sustained the grievance. These events powerfully polarized Superintendent Mara and the clinical staff. However, Superintendent Mara replaced the clinical staff that resigned with clinicians specifically hired for the second shift, thus eliminating the grievance issue. She excluded clinical staff from the hiring process for new clinicians. She re-assigned the two clinical supervisors to work in the residential units providing individual counseling, moving them out of their administrative offices and into the cramped and shared spaces in the residential buildings, in an action that was widely viewed as retaliatory and a significant demotion. As noted earlier, one of the supervisors resigned.

Superintendent Mara and Assistant Superintendent Lisa Flower-Murphy set clinical policy. Until the end of February, Superintendent Mara and Assistant Superintendent Flower did not meet regularly with the clinicians as a group to discuss clinical policies, staffing, and changes at the facility. Superintendent Mara has no clinical background and Assistant Superintendent Flowers has a master's degree in social work, but has no clinical experience in an institution. The earlier discussion on the development of the

CJTS behavior management program is a case-in-point. Where the two administrators interfered with clinical programming the neither had the expertise or credentials to be doing. Clinical staff reported overwhelmingly that the interference in their professional areas caused a great deal of stress as well as concern for the boys.

6. Morale

The Bureau of Quality Management Evaluation Report of CJTS June 10, 2001, stated that,

> ***"the results of the program evaluation bring to light an important issue regarding the perceptions of CJTS staff and youth regarding safety and security. The results clearly highlight that the majority of staff perceive CJTS as an environment of "instability and insecurity. Ninety-six percent of all staff surveyed, including sixty percent of administrators surveyed, reported that CJTS is neither a safe nor positive environment for its staff.*** **(p 56)"**

In May 2002 a ballot for no-confidence vote in the administration of Lesley Mara, Superintendent of CJTS, was submitted to the Commissioner of DCF. On the behalf of the CSEA, 1199 and AFSCME union members the following was submitted: 182, responses, 8 suggested confidences, 20 abstained and 174 agreed with the no-confidence ballot. The 5/14/02 memo to the Commissioner highlighted the following:

> *Superintendent Mara ignored staff and safety concerns. Superintendent Mara has been unresponsive for 8 months to repeated calls for restoration of effective behavioral consequences.*
> *Against professional advice from the Department of Corrections, Superintendent Mara decided to house residents according by geographical region.*
> *Superintendent Mara has taken control of educational administrative functions that by statute are supposed to be the responsibility of Unified School District II.*

The difficulties that staff members experienced appear to have gone way beyond routine problems typical of a transition period. Members of staff form all disciplines reported ongoing struggles occurring between administrative staff and all other levels of facility professionals. The lack of perceived administrative support and oversight was a consistently reported focus of concern among staff. Each division of staffing has a particular discipline that they excel in and feel their input is valuable; however, they frequently reported feeling their expertise and experience was not valued by the administration. The result is palpably low staff morale from a subjective point of view that is supported by the laments of all staff members who took part in interviews for this investigation. The superintendent subsequently resigned her position in early September 2002.

7. Analysis of Staffing Issues

The move from Long Lane to CJTS would have presented challenges under the best of circumstances. Failure to include staff at all levels of the facility in the decision-making process resulted in a number of conflicts and prevented the staff from taking responsibility for, and committing to, the new policies. Worse, failure to acknowledge

the expertise and credentialed judgment of professional staff has resulted in programming that is invalid and ineffectual.

With a move to a very large, secure setting and limited training and staff supports, transition problems are anticipated. However, the problems that began to surface in September 2001 increased over the months to come instead of leveling off. According to the Center for Criminal Justice Research Report (4/11/01), *"[T]he problems experienced by the CJTS appear to be more than transitional in nature"* and *"conflict between the program staff and the executive staff, a lack of strategic program planning, and a lack of support from stakeholders and the community … have had a significant impact on program integrity."*

The pervasive conflicts between staff and management at CJTS have led to a state of virtual open warfare. The level of conflict severely undermines operation of the facility and jeopardizes the treatment of confined youth. Youth Law Center staff who assisted OCA with the initial investigation of CJTS reported that staff morale at CJTS was the worst ever observed in 25 years of visiting juvenile facilities.

The staff shortages and overtime, likely a result partially due to the lack of a mission, low morale, inadequate training and ineffective programming has placed the staff of the facility in danger. They are not feeling as if they are working in a safe and secure environment and indeed, they are not. Staff members are at risk for injuries related to exhaustion as well as from boys whose behavior may be out of control for lack of appropriate behavior management programming and clinical supports. An overworked staff is also at risk of making serious mistakes, both in action and judgment that may place the boys at risk. The Office of the Child Advocate continues to receive reports, including copies of DCF Abuse-Neglect Hotline reports that indicate a high incidence of injuries to both boys and staff during restraint procedures, there have been complaints of name calling and ethnic slurs by staff on boys, and as recently as September 6, 2002 there were findings on facility videotape that showed five different staff members asleep on the third shift. That sort of blatant breach of duty leaves the boys unsupervised and is evidence that the staff are not supervised either.

The oversight and supervision of all staff, including new hires, is not adequately addressed. Unless on-sight supervision and monitoring is occurring, it is difficult to address what the staff is actually implementing in an effective manner. Without clear expectations and follow through from all levels, program integrity and safety remain compromised. This speaks to the contradiction in the BQM findings regarding staff and administration perceptions that training is adequate. This disconnect suggests an astonishing level of denial that threatens the very safety of the children CJTS means to care for. Undermining professional standards and obligations by interfering with clinical programming and refusing support to clinicians and other professional staff places the boys at CJTS at considerable risk that translates to further risk for the staff.

The morale within the facility is of great concern that affects the safety and security of the boys at CJTS. Without a supportive relationship with common goals and mission

amongst staff and administration, there will continue to be inconsistencies in the way policies are carried out. Likewise,

As the mother agency of CJTS, DCF cannot stand silent to the problems that develop in a situation where the agency has sole responsibility for the facility and children cared for there.

In early September 2002, a year after the institution was opened and occupied, an interim superintendent was appointed to replace Superintendent Lesley Mara. This one new person will be not able to effect the needed changes at CJTS alone. A large focus of the new superintendent's work will have to focus on bringing the staff together with a common mission and respectful inclusion. Supportive and proactive leadership from the Department of Children and Families will be critical to any degree of improvement.

C. CJTS, A DCF Owned and Operated Facility, Failed to Establish Any Quality Assurance or Risk Management Structure to Ensure the Safety and Well Being of the Boys Placed There.

DCF's own BQM report identified considerable deficiencies in quality assurance mechanisms at CJTS.

> "*Policies and procedures for most departments at CJTS are not formulated and do not appear to be clearly understood by most CJTS staff. This appears to contribute to high levels of service implementation variability and inconsistency. The numerous critical incidents and sentinel events that have resulted in investigations by the DCF Hotline and State Police during the past several years have not been adequately tracked within the facility. No particular mechanism exists at the current time to follow-up on corrective actions, or to develop formal systems to prevent or minimize the risk of similar critical incidents from taking place again. Members of the professional community outside of DCF expressed concern regarding treatment, discharge and aftercare planning, and the quality of services delivered within the facility.*"[72]

The DCF Bureau of Quality Management made a total of ten recommendations addressing quality assurance at CJTS. In September of 2002, over one year after opening, CJTS received approval from DCF to fill a risk management position. Development of a risk management structure for the facility began in early September 2002 as well. In response to OCA requests for critical incidents data recording the trends and incidence of critical events such as injuries and suicide attempts, on September 4, 2002 Ron Brone of CJTS provided a packet of documents and a memo. He wrote in the memo that "*We are currently in the process of refining our definition of and processes for gathering data on critical incidents*." The packet of documents included a collection of copies of individual critical incident reports. As

[72] Department of Children and Families, Bureau of Quality Management, (2002). Department of Children and Families Connecticut Juvenile Training School: Program Evaluation. June 10, page62.

he explained in the memo, "*In order to gather this information in as comprehensive a manner as possible, staff on each unit were asked to audit the records of all current residents as well as residents who had resided here since March 1 but had since been discharged*." This illustrates that there is no mechanism for tracking and oversight of critical incidents at CJTS. In other words, there is no mechanism for CJTS administrators to be aware of, or track how many boys attempt suicide, or are injured in the institution. There is no way to identify trends in serious or even dangerous events on the units or in school. There is also no way of knowing whether incidents of those kinds are on the rise, when they occur, or how they are responded to.

On August 29, 2002, the Child Advocate received a letter from Dr. Lou Ando, Bureau Chief of Behavioral Health, Medicine and Education. In it he reported that Dr. Arnold Trasente serves as the representative of the Bureau of Quality Management who will oversee the implementation of the CJTS action plan. The action plan, as noted earlier in this report, is in response to the BQM program evaluation of the facility. More recently, Dan Panchura, also of BQM, was temporarily assigned (90 days) to develop and implement a risk management program. There were apparently no plans from the conception of the Connecticut Juvenile Training School for a risk management system to operate.

IX. DCF FAILED TO PROVIDE PROPER LEADERSHIP, GUIDANCE AND OVERSIGHT TO CJTS

A. THE PROBLEMS AT CJTS SHOULD HAVE BEEN OBVIOUS TO DCF ADMINISTRATION.

If anything is clear from this investigation, as well as DCF's own June 10, 2002 BQM Program Evaluation Report concerning CJTS, it is that CJTS, only a year old, is a troubled facility falling far short of the expectations assigned to it after Tabatha B died. The problems at CJTS should have been obvious to DCF management. The concerns that were surfacing very early on in the life of CJTS were largely a carbon copy to the problems so recently experienced at Haddam Hills Academy. DCF management did not take the concerns seriously until significant public attention and this investigation of the Child Advocate and Attorney General flagged the alarming conditions at the training school. This highlights the fact that DCF has not taken sufficient steps on it s own to assure the safety of the boys placed in their care.

Early concerns in this investigation led both the Child Advocate and Attorney General to write to Commissioner Ragaglia in order to raise her awareness of the threats to the safety and well being of children at CJTS. The Child Advocate sent letters to Ragaglia on January 9, 2002 and the Attorney General did so on January 18, 2002. Issues that the two raised included the absence of a behavior management program, inappropriate restraint and seclusion of children, excessive use of overtime while staffing was shrinking, absence of clinical services due to staffing vacancies, lack of

appropriate education and vocational programs, and major safety breaches threatening both residents and DCF staff.

Commissioner Ragaglia's January 22, 2002 response to the Child Advocate claimed that

> *"[T]he move into CJTS has gone well.... This evolutionary improvement process is well-documented in a national study funded by OJJDP [Office of Juvenile Justice Delinquency Prevention]. CJTS' outcomes stack up well when compared to, and often exceed, the majority of facilities in the study across the country.*"

Attached to that letter was a January 18, 2002 memorandum from CJTS Superintendent Lesley Mara to Commissioner Ragaglia purporting to address some of the issues raised by the Child Advocate.

Similarly, Commissioner Ragaglia responded to the Attorney General on January 28, 2002 asserting: "*Our improvements are well-documented and put us in the upper tier in terms of program quality and safety of youth and staff*." The Commissioner's letter went on to attribute concerns about CJTS to many staff who were finding the transition difficult. Her letter stated "*... I would not be surprised to hear that those staff who do not support our program changes ... have come to your office with 'concerns.'*" During this same time period significant public attention was drawn to what was going on at CJTS. In response, to the Child Advocate, the Attorney General, and the public DCF persisted in touting CJTS as a national leader, explaining away the concerns or attributing them to a disgruntled staff having difficulty with the transition.

B. AT THE BEGINNING OF MARCH 2002 COMMISSIONER RAGAGLIA FINALLY ASKED HER QUALITY MANAGEMENT DIVISION TO DO A PROGRAM REVIEW OF CJTS.

In a March 8, 2002 letter the Commissioner promised the Child Advocate, "*We will use the same approach in evaluating [CJTS] as we would use in evaluating a privately operated program*." In the same letter Commissioner Ragaglia once again touted CJTS as ranking in the upper tiers when compared to similar programs. The Child Advocate and Attorney General raised more concerns about CJTS with Commissioner Ragaglia in letters dated March 14, 2002 and March 25, 2002, respectively. Public attention continued to be drawn to issues at CJTS. DCF continued with its program review.

The DCF BQM issued its program review report on CJTS on June 10, 2002. In the report numerous serious shortcomings at CJTS were identified.

Among other things the DCF report flagged:

- an unstable environment at CJTS;
- breakdowns in safety;
- difficulty with behavior management;
- excessive use of restraints and seclusion;
- staff injuries;
- over utilization of overtime;
- insufficient clinical services due to staffing shortages,
- difficulty in delivering educational services to youth.

In other words, DCF's program review validated the numerous concerns that the Child Advocate, Attorney General, and others had been bringing to DCF's attention. All of the deficiencies of the Haddam Hills program and the old Long Lane program persisted at the new training school. Commissioner Ragaglia required CJTS to develop a corrective action plan within 30 days.

In apparent anticipation of the issuance of the report of DCF's program review, on June 5, 2002 the Commissioner sent substantially similar letters to the Child Advocate and the Attorney General clarifying her earlier correspondence. In the June 5 letters Commissioner Ragaglia admitted, based on DCF's program review, that *"the transition to CJTS has been and continues to be problematic and has not proceeded as well as I had hoped or believed*."

ANALYSIS OF DCF LEADERSHIP, GUIDANCE AND OVERSIGHT AT CJTS

In 1998 the Long Lane School was unsafe, had substandard facilities and staff that were ill-prepared to keep a suicidal teenager safe. Physical restraints of the youth there were overused and the staff was not aware of what their responsibilities were as mandated reporters of abuse and neglect within their facility. In 2001 Haddam Hills Academy was shut down after chronic deficiencies in programming and unsafe conditions for the resident boys were finally acknowledged. Haddam Hills Academy had no established program. It was woefully understaffed, the boys were maltreated to the point of physical abuse and their clinical needs were neglected.

What is especially troubling about the Connecticut Juvenile Training School is that the Department of Children and Families was not on top of the issues at all until the Child Advocate, the Attorney General the media and others focused a great deal of attention on them. Commissioner Ragaglia and her administration clearly did not learn from DCF's recent history with troubled facilities serving adjudicated youth. CJTS is a brand new facility that was supposed to be state of the art. DCF was touting its supposed success and discounting concerns, rather than looking at what was going on with a critical eye and providing truly independent oversight to assure the boys placed there would be safe and well cared for. DCF is the owner and operator of the training school. The agency is also the legal parent of most of those boys. As a parent, the agency has failed to provide proper care and protection to its children.

While DCF's BQM program review did a commendable job of discussing what the problems are at CJTS, there is no apparent strategy to ensure that the findings of that review will be addressed. The various committees designed in the facility's Action Plan show no evidence of productivity. Commissioner Ragaglia herself stated publicly that determining the mission for the facility has been difficult – this said fully one year after troubled young boys were placed in the care of the school.

The BQM report does not answer the questions of how DCF got into this situation in the first instance and why DCF itself did not begin the process of analyzing and addressing the very serious issues at CJTS sooner. The fact that DCF management had to clarify early statements that the move into CJTS had gone well strongly suggests that senior managers at DCF did not have timely and accurate information concerning CJTS. The leadership at DCF has to have been aware, however, that the training school has been without a mission or vision since inception. In a way, it may have been presumptuous to expect DCF to evaluate the school when they had yet to define what the school should be accomplishing and how.

The joint investigation by the Office of the Child Advocate and the Attorney General has not been restricted to investigations only but has spurred multiple communications and reports of concerns to both the DCF and CJTS administrations throughout its course. OCA staff generated four reports of suspected abuse and neglect upon the institution. There have been multiple letters and personal meetings between OCA and administrative personnel from both the agency and the institution.

In early 2002 discussions, Commissioner Ragaglia agreed to a recommendation from the Child Advocate that a program monitor be hired and assigned to CJTS under the auspices of the Office of the Child Advocate. A monitor has been identified and will be taking up responsibility imminently for a period of one year. The monitor will replace the independent presence that OCA staff have established at the facility throughout this investigation. However, this position will not replace a quality assurance program. It is only meant to be a short term eye on the progress of the facility in the coming year with the ability for quick response should the boys at any time be assessed unsafe.

X. RECOMMENDATIONS WITH DISCUSSION

SUMMARY

Throughout this investigation the Office of the Child Advocate has repeatedly notified the Commissioner of DCF of ongoing concerns within CJTS. The Child Advocate also provided information to the Department's Bureau of Quality Management program evaluation of CJTS. Areas of concern that were communicated consistently included the internal functioning of the facility that continued to be in crisis; restraint and seclusion utilization as behavior management; increased staff injuries, data collection inaccuracies; lack of clinical presence and services for the youth; inadequate monitoring of the Point Level System implemented January 7, 2002; and continued

concerns with the appropriateness of the educational and vocational services provided.

Safety and security, effective treatment interventions, program oversight and accountability are all necessary within CJTS structure to obtain the goal of youth rehabilitation and integration back to the community. All of these areas are in need of vast improvements and direction in order to effectively motivate the culture that has been created at CJTS in order to foster positive change.

From the outset of the transition into the new facility a barrier between Administration and staff was apparent. The barrier has increased over the past year and has impacted every aspect of functioning of the facility. A disconnect has heightened the "identity crisis" the facility and staff continue to experience. Crisis is inherent when the mission of an organization and vision for facility programming is not clear.

Organizational style and structure adds to the overall ability of a facility to function efficiently and effectively. The presence of management and supervision on site is key to that equation. There is no management presence routinely at CJTS for all shifts. The duty officer that runs the facility in the absence of the Superintendent and Assistant Superintendent is not a manager – this person holds a union position of Assistant Unit Leader, one class above Youth Services Officer. Given the size of CJTS and the risk factors that present themselves, especially during unscheduled activity time, managerial oversight at CJTS must be a priority.

All of the issues that have been addressed throughout this investigation and in documented contact with the Department remain in effect at the writing of this report. This analysis documents serious, deeply entrenched problems at the Connecticut Juvenile Training School. The mission of the Department of Children and Families is to protect children, strengthen families and help young people reach their potential. To achieve these goals DCF must intervene to protect youth who are abused and neglected. DCF is charged by law with providing child protection services, juvenile justice services, mental health services, substance abuse related services, prevention and educational services for children. The juvenile justice system is mandated to assure the provision of treatment for juvenile offenders whose rehabilitation is a priority.

This report demonstrates DCF's abject failure to assure that the needs of youth at the Connecticut Juvenile Training School were met or even that such youth were safe. While the impetus to create the Connecticut Juvenile Training School was the Tabatha B suicide, there is still a substantial risk of a successful suicide at CJTS. There are also numerous other fundamental problems at CJTS.

Several themes emerge from our investigation and analysis of the situation at the Connecticut Juvenile Training School. Significantly, many of the themes are substantially the same as those that were reported in great depth in our May 30, 2002 report concerning DCF oversight of Haddam Hills Academy. Accordingly, we make the following recommendations:

1. Proper protocols should be put in place for the assessment of risk of suicide and for suicide prevention in order to ensure that no child at the Connecticut Juvenile Training School is at risk for attempting or committing suicide.

The most significant finding of this report is that children in DCF's care who are placed at the Connecticut Juvenile Training School continue to be at significant risk for succeeding in committing suicide. The situation at CJTS in this regard is not very different from the situation that existed in the past at Long Lane School as reported following the Tabatha B suicide, except that CJTS is a brand new facility developed and operated at a cost of approximately $90 million. The protocols for assessing risk of suicide and preventing suicide should be immediately reviewed and revised to ensure that proper steps are taken every step of the way.

The most fundamental part of this is review and implementation of a proper policy. The policy should be clarified to specify when children should be seen by clinicians, what the clinical indicators are for the various types of safety watches or other interventions, how much time may pass between safety watch status and follow-up assessment, and when a referral for psychiatric evaluation should be made.

Clinical staff must be held accountable for applying consistent and appropriate criteria to determine risk of suicide and the forms of safety watches or other interventions that are appropriate. Direct care staff should in fact implement the safety watches or other interventions as ordered.

All staff should receive appropriate training, and periodic refresher training, in order to understand the relevant policy and protocols and to be able to effectively implement necessary safety watches and other interventions. This should also include protocols for clinical supervisors and direct care supervisors to directly monitor all aspects of the system in order to ensure that the clinicians and direct care staff are doing their jobs effectively, including accurate and timely completion of all necessary documentation in a timely fashion.

Because so little progress has been made since the Tabatha B report, the DCF administration must take a fresh look at all of the recommendations of the Tabatha B. report to ensure that they are implemented at CJTS. This includes evaluation of availability of appropriate clinical services to all children, prompt and immediate assessment of all new admissions, development and implementation of needed treatment groups, timeliness of psychological and psychiatric evaluations and caseloads that allow for full case management including relevant documentation and consultation.

2. Connecticut Juvenile Training School policy and practice regarding the use of restraint and seclusion must immediately be brought into compliance with Connecticut law.

This investigation revealed extremely troubling practices within CJTS regarding restraint and seclusion of youth. It was found that staff were relying on restraint and seclusion for behavior management because of the lack of an effective behavior management program. In addition, staff have not received effective training on behavior de-escalation techniques resulting in excessive use of physical interventions. Licensed mental health professionals have developed individual behavior plans

authorizing extended periods of mechanical restraint for behavior control. Mechanical restraints are being over utilized. Restraint techniques employed by some staff have the potential for severe, possibly life-threatening, harm. Children were found to spend extraordinary amounts of time in mechanical restraint, not receiving clinically appropriate, as well as legally required, observation, assessment and care.

CJTS practices regarding seclusion were also found to be in violation of both Connecticut law and their own policy. Room confinement for staff convenience continues to occur today. As with restraint practices, some children were found to have spent extraordinary amounts of time secluded without the required observation, assessment and care.

3. All staff at all levels at the Connecticut Juvenile Training School should immediately receive training in their "mandatory reporter" obligations under Connecticut law.

It is clear from our investigation that numerous staff at the Connecticut Juvenile Training School fail to understand their obligations as "mandatory reporters" under Connecticut law. This is really not surprising since most of them have not received mandatory reporter training. Mandatory reporter training should be provided immediately to all staff at CJTS. There should also be periodic refresher training.

One important dimension of mandated reporter training is understanding what actually constitutes abuse and neglect. Having a proper understanding of this should greatly assist staff in ensuring that their own conduct is appropriate. It should also assist them in knowing when the conduct of other staff is inappropriate.

The obligatory responsibility to make an abuse/neglect Hotline report or cause a report to be made is a concept that must be fully addressed with each staff member. At present, numerous matters that should be reported to the DCF Hotline go unreported. The typical reason for this would be that staff does not know that a matter is reportable to the Hotline or passes a matter on to an immediate supervisor who in turn is not fully cognizant of mandatory reporting obligations.

The DCF Hotline serves an important role as a mechanism external to the facility itself to review allegations of suspected abuse or neglect in order to ensure that the children are protected. It goes without saying that the Hotline needs to apply the same standard to CJTS that it does to the rest of the state in order the ensure that children are protected.

4. The leadership of the Department of Children and Families should articulate a clear vision and mission for the Connecticut Juvenile Training School, and then enforce their expectations and rules.

The Connecticut Juvenile Training School must have a clear vision and mission that is understood and embraced by all. That is clearly not the case at CJTS. The process of articulating a vision and mission for CJTS should be comprehensive and address all aspects of the facility.

At the very least it should encompass what the purpose of placing boys at CJTS is and how associated goals will be achieved. Related policy must be developed clearly, with written expectations of staff duties and responsibilities in all areas, including the expectations and responsibilities of all disciplines All policies and

procedures governing the facility should be developed and implemented, within the confines of the law, in order to guide facility personnel in consistently providing a safe and nurturing environment for children.

The vision and infrastructure for operations at CJTS must then be implemented with comprehensive training for all managers, supervisors and line staff. Aside from the obvious importance of ensuring that all levels are trained in the same thing such training should address the conceptual framework of the facility's mission and the value each employee has within the vision.

5. The Connecticut Juvenile Training School leadership must take immediate steps to provide for the individualized needs of the children in their care. This will include the provision of appropriate treatment and education.

The needs of the children were lost in all of the problems of getting the Connecticut Juvenile Training School up and running. The children at CJTS have diverse and often highly specialized health, mental health, educational and social needs. Individualized treatment plans for each child must reflect the individual needs of each child through treatment goals, interventions and responsibilities of all disciplines serving the youth. In developing such plans CJTS should apply clearly understood criteria for assigning youth to living areas and programs. All disciplines should have meaningful input into such plans. It should also be clear which personnel in particular are responsible for developing these plans and for ensuring that they are properly implemented.

In addition, CJTS needs to engage in a comprehensive evaluation of the educational services at the facility in order to ensure that all educational and educational support services necessary for the individualized needs of the children are provided. This evaluation should also encompass assessing and providing for the special education needs as required by law.

6. DCF administration must ensure that management at CJTS is on site and accessible to all staff at all times and that such management fully understands all aspects of the facility and its programs.

During the course of this investigation the Child Advocate and Attorney General were struck by the division between management at CJTS and other staff. There was evidence of total disregard for professional clinical expertise. Members of the administration were essentially usurping clinical responsibilities with unfounded interventions and direction to clinical and direct care staff.

All managers at CJTS who have responsibility for clinical staff, direct care staff and/or quality assurance staff must experience the facility on a day to day basis in order to develop an accurate understanding of life on the unit from the perspective of staff and the children.

Management must be accessible to staff at all times. Management presence will ensure the availability of supervision as well as a resource for staff when important decisions need to be made.

Managers would also benefit from enhanced staff development specifically including leadership training. Managing CJTS properly is a great responsibility.

Leadership and team building skills are especially important in working with and motivating staff at CJTS.

7. The Connecticut Juvenile Training School administration must define, develop and implement protocols for tracking and following up on "critical incidents."

The term "critical incident" is a term that is supposed to encompass serious adverse events affecting youth that require immediate intervention and follow up (i.e. suicide attempt, incidents of abuse, assault of or by youth, etc.). While the term is widely used there is no clear understanding at CJTS of what matters constitute critical incidents and what is supposed to happen when a critical incident occurs.

First, a clear definition of what constitutes a "critical incident" at CJTS needs to be developed and articulated. This definition needs to be accompanied by clear directives as to how the existence of the critical incident is to be documented and communicated (in addition to any Hotline report), who is responsible for developing an action plan responding to the critical incident, how follow through is tracked, and who is responsible for follow through.

8. The Connecticut Juvenile Training School administration must improve the process of imposing and reviewing sanctions on children at the facility.

An essential component of a behavior management system for a facility such as the Connecticut Juvenile Training School is a mechanism for imposing and reviewing sanctions on children. A properly implemented system will support the children to develop improved coping skills and behavior control in addition to appreciating consequences for bad choices. An improperly implemented system could breed anger and resentment and even injury.

Interviews with staff and youth at CJTS leads us to be concerned about inconsistent sanctions for similar behavior as well as a lack of a clear understanding by staff and children as to what all of the rules are. The CJTS administration and clinical staff must reexamine the issue of sanctions within the facility in order to ensure that all policies and procedures are appropriate, that all staff and children understand the rules, and that all rules are applied consistently and fairly.

9. The actions of officials and employees of the Department of Children and Families should be reviewed to determine whether or not disciplinary action is warranted.

The failure of DCF officials and employees, and personnel at the Connecticut Juvenile Training School to take timely and appropriate action to protect the children in their care suggests incompetence, mismanagement or misconduct. In light of the findings of this report, the actions of officials and employees of the Department of Children and Families should be reviewed to determine whether disciplinary action against them is warranted.

10. Oversight of state operated facilities serving children, such as the Connecticut Juvenile Training School, should be truly independent from DCF functions associated with program development and program administration in order to ensure that DCF decision making is objective.

DCF had divided interests and loyalties in overseeing the Connecticut Juvenile Training School. DCF was under great pressure to get CJTS up and running. Unfortunately, the Bureau of Quality Management, which should have been performing the program oversight functions, did not play a substantial oversight role until the Spring of 2002, following substantial public attention being given to issues at CJTS as well as communication from the Attorney General and the Child Advocate to the DCF Commissioner. While the action ultimately taken by the Bureau of Quality Management to document extremely serious shortcomings at CJTS is commendable, it came much too late and does not explain why the Bureau of Quality Management was not monitoring what was going on at CJTS from the facility's opening in August 2001. Furthermore, the response to the DCF BQM report has been sluggish and the action plan developed as required has not been fully implemented.

The DCF Commissioner was initially very defensive about CJTS and tended to laud it as a national model, rather than initiating action to take a critical look at substantial concerns. In fact, following the Bureau of Quality Management review of CJTS, the Commissioner later sent letters to the Attorney General and Child Advocate retracting her previous favorable representations to them about CJTS. The Commissioner commented publicly that if CJTS were a private facility it would probably not have been licensed.

It is simply unacceptable to have a situation where a state operated facility is unable to meet the licensing standards that are applied to privately operated facilities. This is also a significant indicator of the failure to provide proper oversight at CJTS.

At this point, steps should be taken to immediately put in place an independent oversight structure for CJTS. This goal should be a priority.

11. An effective internal quality assurance program is necessary at the Connecticut Juvenile Training School.

An effective internal quality assurance mechanism is a necessary management tool for any facility serving children like the Connecticut Juvenile Training School. DCF expects this of all DCF licensed facilities and should certainly expect it from a facility such as CJTS.

The internal quality assurance mechanism at CJTS should be the first line of accountability outside of the direct supervisory chain of command. It should not be necessary for personnel from the Office of the Child Advocate to be reviewing videotapes of what is happening at CJTS in order to assure that staff at CJTS are doing what they are supposed to do. No one at CJTS is performing those functions.

Until March 2002 there was no Quality Assurance Director at CJTS. Prior to this there was little oversight of reporting systems, data collection, Hotline reports, reviews of video tapes recording activities at the facility, restraint and seclusion practices, strip search practices, program operations and other CJTS functions. There is no formal process to oversee the abuse and neglect reports and other CJTS functions. There is no review of training for staff for restraint, seclusion and other interventions. There is no training for reviewing videotapes of incidents.

While the new Quality Assurance Director has been assigned the responsibility for reviewing all individual behavior plans of youth, monitoring programs and information systems, this director is not responsible for analyzing data, inconsistent implementation of behavior management systems, or restraint, seclusion and strip search practices.

Internal quality assurance at CJTS can be summed up as "too little, too late." At this point in time internal quality assurance at CJTS needs to be strengthened a great deal. The internal quality assurance program at CJTS should be no less than what DCF expects of private facilities for internal quality assurance, and should certainly encompass all critical areas of safety and programming for the children there.

Internal quality assurance can also be enhanced through better supporting the Ombudsman position at CJTS. The role of an institutional ombudsman is to investigate complaints involving possible breech of relevant law or policy and to communicate findings and recommendations to the facility leadership. A properly supported Ombudsman position would enhance a sense of fairness in the complaint process available to resident boys as well as alleviate some of the abuse and neglect reports being filed.

12. The management structure and protocols for internal communication at the Department of Children and Families must be revamped so timely and accurate information is presented to responsible managers.

The experience of the Department of Children and Families with the Connecticut Juvenile Training School reflects a serious management failure: managers simply did not interact with each other properly. There are numerous examples of internal communication issues at CJTS itself. There are also numerous examples of DCF administration, including the Commissioner herself, conveying inaccurate information about CJTS to other state officials, ultimately leading the Commissioner to retract in writing some of her prior representations. This simply should not be the case.

In addition, the current process of documenting and communicating with respect to incident reports, treatment plans, suicide precautions and other areas is poor. Documentation is often missing or misfiled. There are concerns about the completeness and accuracy of some information. Review of documentation by supervisors and managers is inconsistent and often lacking. All levels of staff at CJTS must be assisted to understand the importance of proper documentation.

In short, various components of DCF interacted very poorly or not at all. Critical information did not always reach the right place. Even when information did reach the right place, it was not always taken seriously or was ignored. Senior managers and DCF executive staff either knew or should have known that there were serious problems at the Connecticut Juvenile Training School. Changes must be made to ensure that timely and accurate information is presented to responsible managers in order for appropriate action to be taken.

13. The Department of Children and Families should develop a long term planning unit that operates separately from program administration.

The numerous problems encountered at CJTS reflect a wholesale failure to properly plan for the opening of the facility. This specifically includes understanding the needs of the target population to be served by the program, preparing the staff and boys for change, having an appropriate suicide prevention system in place, having an appropriate behavior management system in place, and assuring that all equipment and supplies – especially those for the educational programs – were in place by the time that the facility was to open.

DCF should have undertaken a comprehensive analysis, on an ongoing basis, of the needs of youth under its supervision at this facility – and all others – as well as future trends with respect to such needs. This exercise should be part of a systematic long-term planning effort, integral to anticipating and meeting the needs of young people at risk.

A meaningful planning function should be separate and independent from those divisions of DCF responsible for program administration. DCF's experience with Connecticut Juvenile Training School demonstrates that decision-making suffers when the pressures of the day drive functions that should be independent. Proper long term planning involves careful assessment of future needs, matching those needs to existing programs and ascertaining what change is needed in order to serve the needs of children.

CONCLUSION

For all of the foregoing reasons we conclude that the Department of Children and Families failed in its obligations to the children at the Connecticut Juvenile Training School. The Department of Children and Families failed to properly plan for the opening of the Connecticut Juvenile Training School and failed to meet the needs of the children there. This is all the more problematic since the facility is a brand new facility that was supposed to be a state of the art "model" facility which has already cost nearly $90 million to develop and operate. Appropriate steps, such as those outlined in our recommendations, should be taken immediately to ensure that the needs of the children at the Connecticut Juvenile Training School are met in the future.

Dated at Hartford, Connecticut, this the 19th day of September 19, 2002.

_____	_____
Jeanne Milstein	Richard Blumenthal
Child Advocate	Attorney General

APPENDIX A

CJTS Action Plan Summary

- An Advisory Board was proposed to review ongoing development of services at CJTS -- Completion date 7/31/02
- A Consultation Team was proposed to provide external program and systems reviews and evaluations and to recommend ongoing quality improvement ideas – Completion date 7/15/02
- A Quality Council was proposed for developing, monitoring, and reporting on a facility-wide quality improvement plan and process – Completion date 7/12/02
- Facility-wide and unit-based forums were proposed to solicit staff input in formally defining the philosophy, mission, and model of the facility – Completion date 7/22/02
- A Health and Safety Committee was to be established to monitor and evaluate facility safety issues, make recommendations, address problems, and assess effectiveness of the actions-- Completion date 7/1/02
- All staff positions were proposed to be filled in order to optimize safety and security and ensure a full delivery of services to the boys -- Completion date 9/30/02 (6/30/02 – 25%, 7/31/02 – 50%, 8/31/02 – 75%, 9/30/02 – 100%)
- Positive working relationships and resolution of labor-management issues are to be facilitated through ongoing forums, dialogues, meetings and picnics -- Completion date 7/15/02
- A subcommittee was proposed to establish building-based administrative oversight to support the CJTS mission, increase accountability and ensure consistent staff training and support– 7/15/02
- A subcommittee was proposed to establish and implement an educational program and environment that effectively meets the individual educational needs of each boy in a safe and secure way – Completion date: 9/1/02
- A Youth Council was proposed to develop youth involvement and get their feedback regarding facility services and operations 7/31/02

APPENDIX B

Policy 82-21-1 – Suicide Assessment and Prevention

The Connecticut Juvenile Training School (CJTS) will ensure youth safety by procedures for the screening, assessment and supervision of youth at risk for suicidality.

Screening: Admissions

All admissions, whether new or return youth, will be screened for suicidality within one hour of admission/readmission to the facility. Screening for suicidality will be carried out by a clinical staff member.

Youth Risk Status

When clinical staff carry out a mental health assessment to determine youth risk, the assessment will include an interview of the youth and a thorough review of the youth's mental health history including diagnosis, medications, hospitalizations, previous history of suicidality (ideations, verbalizations gestures, attempts), intake screening results, staff observations, recent life stressors, loss of program privileges, disciplinary actions, court dispositions. The level of security and supervision determined clinically necessary would be based upon the risk status of the youth.

Intervention for Suicidality: Staff Responses

Any staff member who has reason to believe a youth is potentially suicidal, through gesture, words, or behavior will put the youth under direct observation and then:

Immediately phone Clinical Services for a clinician to assess the youth; or, in the absence of an on site clinician phone Medical Services for the nurse on duty to respond.

Follow the instruction of the clinician/nurse as the level of observation needed until they arrive to assess the situation. The Unit Leader/Duty Officer will be notified and will assist with any staff coverage issues.

As the staff member observing the youth, fill out the Safety Watch Form documenting the youth's status as directed.

Complete a CJTS Incident Report.

Intervention for Suicidality: Clinician Response

Once the clinician has assess the youth, the clinician shall:

Complete the Alert Report and assign safety watch status. (2) In the event of a suicide gesture/attempt, notify the psychiatrist for consultation and evaluation, if necessary. (3) Enter a note in the youth's file.

Intervention for Suicidality: Nurse Response

When a nurse responds in the absence of an on site clinician and screens the youth for suicidality, he/she shall consult with the on-call clinician. If a safety watch is indicated, the nurse shall issue the Alert Report. In the event of a suicide gesture/attempt or significant risk of self-harm, the on-call clinician shall come in to complete an on site evaluation of the youth. Consultation shall then occur between the clinician and on-call psychiatrist to review the level of watch necessary, the need for immediate psychiatric hospitalization or follow-up psychiatric evaluation within twenty-four (24) hours.

Safety Watch Status: Authorization

A youth may be placed on any of the following watches by the clinician based on screening/mental health assessment of youth risk:

Ten (10) Minute Safety Watch - The ten (10) minute safety watch is for those youths who have some risk for suicidal behavior. Staff should observe these youths and document behavior at staggered intervals not to exceed every ten (10) minutes (e.g., 4, 7, 10 minutes, etc.).

5 Minute Safety Watch - The five (5) minute safety watch is for those youths whose risk for suicidal behavior is seen as being significant. Staff should observe these youths and document behavior at five (5) minute intervals.

One to One Safety Watch - The One to One (1:1) safety watch is for those youths whose risk for suicidal behavior is seen as being imminent. The staff's exclusive duty is to directly observe and protect the youth at all times. The behavior of youths on 1:1 safety watch status will be described every fifteen(15) minutes on the safety watch sheet.

Special conditions of supervision apply to youths on 1:1 safety watch status:

Staff must supervise youths within two arms' length at all times and in all areas when they are in the general population

When youths are in their rooms, the door must be open with supervising staff positioned in the doorway, facing and with full view of the youth

When youths need to use the bathroom or otherwise require some measure of privacy, supervising staff

of the same gender will accompany the youth and maintain visual observation
If a youth needs to be secluded, staff will follow the procedures for Use of Seclusion (82-19-6) but must maintain eyesight of the youth at all times through the room door window.
Safety Watch Status: Supervisory Responsibilities
Supervisory staff have the responsibility for periodic checks to ensure that the safety watchprocedures and any special conditions noted on the Alert Reports are being properly carried out.

APPENDIX C

POLICY 82-21-1 - STAFF TRAINING TABLE 3.
All staff with direct care, medical or mental health responsibility for youth shall receive suicide prevention training as part of their Preservice Orientation program as well as annual refresher training. All staff with responsibility to screen youths for suicidality shall receive training on a written screening instrument for suicide risk and will demonstrate knowledge in its use prior to assuming this duty.
Initial Training Curriculum The initial training curriculum will include the following components: Review of suicide risk related to the juvenile correctional facility environment. Predisposing factors for suicide risk. High risk periods for suicide attempts. Warning signs and symptoms of suicidality. Comprehensive review of the facility's Suicide Assessment and Prevention policy and procedure. Liability issues related to suicides in juvenile correctional facilities.
Annual Refresher Training The annual refresher training will include a review of: Predisposing factors for suicide risk. Warning signs and symptoms of suicidality. Any changes in the facility's Suicide Assessment and Prevention policy and procedure which result of any Critical Incident Reviews.

APPENDIX D

Conn. Gen. Stat. §§ 46a-150(3), 46a-152(a)

Children at CJTS shall not be subject to involuntary physical restraint on a person at risk except (1) 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… "
LLS Policy 82-19-1 Physical Behavior Intervention
Unless emergency circumstances dictate otherwise, physical restraint and seclusion shall be used only after less restrictive strategies have been exhausted. The use of any physical behavior intervention, physical restraint or seclusion shall not be considered treatment. Physical Behavior Interventions shall take into consideration the individual treatment plan and factors such as developmental level, gender, age, weight, existing health conditions, medications, and history of victimization of each person. Even in an emergency situation, when immediate physical intervention is required, verbal directives to stop the behavior should be utilized.
Prohibited Uses
No physical behavior intervention or course of treatment for any resident shall:
Be used for punishment or as a punitive measure
Be used for the convenience of staff
Be used for the intentional infliction of pain or discomfort
Legal Reference: PUBLIC ACT 99-210.

APPENDIX E CJTS 85-3-2 Mandated reporting by staff

Statutory Reference	Connecticut General Statute § 17a-101 et seq
ACA Standard Reference	
Policy	The abuse of any youth placed in the care of the Connecticut Juvenile Training School (CJTS) shall not be tolerated. Any complaints or suspected cases of child abuse shall be reported immediately.
Definition	Child Abuse means physical injuries to any child or youth under the age of eighteen other than by accidental means, or injuries which are at variance with the history given of them, or a condition which is the result of maltreatment including but, not necessarily limited to, malnutrition, sexual molestation, deprivation of necessities or cruel punishment.
Staff Required to Report Abuse	Any staff member who observes or receives a complaint that child abuse has occurred to a CJTS youth shall: • Report this immediately to their supervisor. In the event that the immediate supervisor is not available, the verbal report should be made to the next administrative level. • Make a verbal report to the DCF Child Abuse and Neglect Hotline (1-800-842-2288). • Prepare a detailed CJTS Incident Report before the end of his/her shift, which shall be submitted to the supervisor and then forwarded to the Superintendent.
Supervisor's Responsibilities	The Supervisor, upon receipt of the initial verbal report, shall: • Ensure that the Medical Services Department is notified and that the youth is taken for a physical examination. • Notify the Superintendent and, if after hours, the on-call administrator of the alleged child abuse incident. • Verbally notify the Superintendent and, if after hours, the on-call administrator that a DCF-136 has been submitted.
Report of Suspected Child Abuse Form (DCF-136)	The staff member who received the initial report of alleged child abuse, as well as the nurse who examined the youth, shall jointly complete a Report of Suspected Child Abuse form (DCF-136) if such appears warranted. When the DCF-136 has been complete, it shall be forwarded to the Superintendent. The DCF-136 shall be forwarded to the DCF Hotline within 48 hours of the oral report. On weekends, the original shall be sent to the Hotline after the call has been made, and a copy of the DCF-136 shall be sent to the Superintendent.
Nurses' Responsibilities	When feasible, at the direction of the nurse, snapshots should be taken of physical injuries. Any such photographs shall be labeled in ink by the nurse and placed in the medical record.
Superintendent's Responsibilities	The Superintendent, or designee, shall notify the Program Supervisor who shall then have the parent/guardian notified. If the youth has been injured, the parent/guardian shall be referred to Medical Services for further information. The Superintendent shall also ensure that an immediate internal investigation of the parties involved is undertaken, to determine if there is a necessity for disciplinary action, program adjustments, staff training, policy and procedure changes, and the necessity for police involvement.
Child/Youth and Alleged Abuser to be Separated	While an incident of alleged child abuse is under internal investigation, the staff member(s) involved shall not work directly with the resident involved. At the time of the report, the supervisor on duty shall consult with the Superintendent or on-call administrator and make arrangements to keep apart the resident and staff member(s) involved.
Union or Legal Representation	All staff members questioned during the course of investigation are entitled to have union or legal representation, should they request the same, at no cost to the State.
Disciplinary Action	Any staff member, who is found to be in violation of the Child Abuse Policy and Procedures, shall be dealt with through the progressive discipline process.