Woodside Juvenile Rehabilitation Center Detention Unit: Time is Running Out

A VP&A Report on Threats to the Health and Safety of Youth With Disabilities Detained in D-Wing

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VP&A is the Protection & Advocacy System for the state of Vermont

EXECUTIVE SUMMARY

Vermont Protection and Advocacy, Inc. (VP&A), Vermont's federally mandated protection and advocacy system, has produced this report about youth with disabilities detained at the detention wing (D-Wing) of the Woodside Juvenile Rehabilitation Center in response to allegations that youth with disabilities detained in D-Wing were subject to neglect and rights violations. On average about 345 youth are detained annually in D-Wing and many of these are youth with disabilities. After over a year of interviews, site visits, record reviews and additional research, we found that there have been relatively few serious injuries to residents over the last twenty years. However, the reporting of incidents involving harm to residents has been inadequate by any professional standard. We also found that for years D-Wing has not been provided with the resources or leadership necessary to maintain an adequate and comprehensive detention program, despite repeated warnings to the officials responsible for maintaining D-Wing. Beside serious failings that impact all D-Wing residents, such as the lack of necessary air conditioning, sprinkler systems and cleaning services, we found that there are serious failings in the ability and, in some cases, willingness of D-Wing staff and administrators to adequately accommodate the large numbers of youth with disabilities who are detained in D-Wing for weeks and months at a time. These problems, including lack of appropriate assessment and training on providing accommodations to youth with disabilities detained in D-Wing, the failure to provide adequate special educational services, and to abide by the best practices when responding to situations that often result in the use of force, have serious and detrimental impacts on youth with disabilities and

unnecessarily deprive them of the ability to fully participate and benefit from the positive aspects of the D-Wing program.

Youth detained in D-Wing are placed there because they either have been adjudicated as a delinquent child, have been formally alleged to be a delinquent child before a Vermont Family Court, or are in the custody of the adult Department of Corrections, but are too young to be held in an Adult Correctional Facility. These youth, with or without disabilities, are placed in D-Wing when the State believes there is no other, less restrictive environment that can assure the youth's safety. Sometimes youth are in D-Wing because they have or are alleged to have committed a serious crime, but many youth are detained in D-Wing because they ran away from placements, acted out self-destructively, or are simply awaiting placement in a more appropriate program. These youth are often individuals who have withstood years of neglect or abuse in their prior placements and have histories of surviving various forms of trauma.

After a detailed review of various parts of the D-Wing experience and consultation with a variety of national and regional experts on juvenile justice and the needs of youth with disabilities in detention units, VP&A is able to provide several recommendations in this report that will result in remedying the problems that currently exist while strengthening the positive aspects of the program. One important and overarching recommendation is that D-Wing administration continue their recent efforts to adopt the Performance based Standards (PbS) system, a self-improvement and accountability system used in twenty-six states and the District of Columbia to improve the quality of life and treatment services for youth in custody. Another recommendation requiring immediate attention is the authorization of an outside, independent regulatory

body to oversee the treatment and services being provided to youth in D-Wing. Recently the Department of Children and Family's Residential Licensing Unit, which had been providing regular evaluations of D-Wing, was removed from its role of regulatory oversight by the Department, leaving D-Wing effectively free from any qualified outside review of its program or environment. We make additional specific recommendations in the areas of intake and screening, mental health treatment, restraint and confinement, education, discharge planning, mixed gender placement, staffing patterns and dynamics, physical plant and quality assurance.

VP&A hopes that by identifying areas of serious concern that threaten the health, safety and legal rights of youth with disabilities in D-Wing in this report, decision-makers at all levels of state government and the juvenile justice system will be informed, motivated and supported in acting quickly and effectively to remedy the problems, while preserving the aspects of D-Wing that should make it a model in many ways for progressive, relationship-based detention facilities around the nation. However, time is running out. Each day these longstanding problems exist, the likelihood of detrimental or even tragic consequences grows.

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I. INTRODUCTION

> ***"Dear Commissioner, I am writing to you in reguards (sic) to my room [in D-Wing] and how hot it gets during the night. With the door closed [and locked] at night, I often have to sleep on the floor because the floor is colder at night....in my room in the morning I wake up and all my sheets are sticking to me...I know we are not the best kids in the world but I think at least we deserve cold air in the rooms that we sleep in." D-Wing resident June 2005.***

> ***"Dear Commissioner, It is so hot in my room! So hot that...I throw up. If you're hot you sweat so it makes the room smell. So then in a hot, smelly room with nothing to do so you get lonely so you start think[ing] of your family and friends and you get sad ...I hope you can help me." D-Wing resident, June 2005.***

Vermont Protection & Advocacy, Inc. (VP&A) is a private, independent, not-for profit agency mandated by federal law to provide advocacy services on behalf of people with disabilities to ensure their rights are protected. See Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 et seq, 45 C.F.R. Part 1385 et seq; Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 et seq; 42 C.F.R. Part 51 et seq; Protection and Advocacy of Individual Rights, 29 U.S.C. § 794(e) et seq, 34 C.F.R. Part 381 et seq. Under our federal mandates, VP&A has the duty and authority to investigate allegations of abuse and/or neglect involving people with disabilities, if the incident is reported to VP&A or if VP&A determines there is probable cause that an incident of abuse and/or neglect occurred. Id. VP&A is Vermont's designated protection and advocacy system and is a member of the National Disability Rights Network.

VP&A initiated its monitoring of the detention unit (D-Wing) at the Woodside Juvenile Rehabilitation Center (Woodside)[1] after receiving reports from a variety of sources that the needs of children with disabilities detained in the facility were not being addressed. We, of course, were aware that since D-Wing's creation twenty years ago it has maintained a detention environment that has avoided more than a handful of serious physical injuries to juveniles detained there. We also knew from experience that D-Wing staff, most of whom have been there for well over five years and many since the inception of the program, have consistently maintained a detention environment that is objectively and subjectively fairly categorized as safe and relationship based. Such a track record and underlying philosophy is all too rare in juvenile detention facilities nationwide. Nevertheless, we took the reports seriously and decided that monitoring was both appropriate and necessary. VP&A is very grateful for the access and forthrightness of the staff and administrators that cooperated with our monitoring leading up to this report. The openness to outside review demonstrated by everyone associated with D-Wing is positive evidence of a program willing and able to benefit from experience and input, both internal and external. As indicated by Dr. David Roush, a nationally known juvenile justice consultant hired by the Department of Children and Families (DCF) to review D-Wing, first in 1988 and then again in 2006, the strengths of the D-Wing program must be nourished and nurtured to provide this resource for our youth and as a model for jurisdictions across the nation.

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[1] Woodside was established by the Vermont Legislature as a secure detention and treatment facility for juvenile offenders in 1983 in response to a homicide carried out by two juveniles. At the time, Vermont did not have a secure facility for violent juveniles. See 33 V.S.A. § 5801. An average of 345 youth are detained in D-Wing annually. VERMONT CRIMINAL JUSTICE COUNCIL, DETERMINATION OF LENGTH OF STAY AT WOODSIDE JUVENILE DETENTION CENTER, p. 31 (2004).

Despite some real strengths, VP&A has found there are aspects of the D-Wing program that are not adequate, appropriate, or safe. There is a strong likelihood that youth with disabilities in D-Wing will be subject to harm and their civil rights violated if the problems we identify herein and those noted by Dr. Roush, by the Agency for Human Services, Department for Children and Families (DCF), Residential Licensing Unit (RLU),[2] and by others, are not addressed and remedied.

This report and its recommendations are based on approximately a year of interviews, document reviews, site visits and analysis, and are offered to highlight areas of the D-Wing program that Woodside leadership, DCF and the Legislature must address to realize the most effective, safest and legally adequate detention environment for Vermont youth with disabilities who become subject to such detention.

Unfortunately, many of the serious problems and hazards we identified have been noted in the past, many over and over again, without the Department acting to remedy the problems. Dr. Roush, and the Agency of Human Services' own Residential Licensing Unit, alerted the Agency to serious concerns, some of which date back to the inception of the program in 1986.[3] Some of the problems related to the facility's physical structure. For example, the lack of air conditioning in the detention unit has been a serious problem from the first day of Woodside's existence. More recently, staff from the Juvenile Defenders office notified D-Wing administrators about letters from detained youth during

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[2] We rely on the Residential Licensing Unit's (RLU) reports, even though RLU, which had been providing regular regulatory reviews identifying serious failures on the part of D-Wing, is no longer authorized to regulate or monitor D-Wing. We are concerned that the absence of the RLU creates a vacuum of regular, independent oversight at Woodside.

[3] DR. DAVID ROUSH, PROGRAM EVALUATION, D-WING SECURE DETENTION UNIT, WOODSIDE JUVENILE REHABILITATION FACILITY, DIVISION OF SOCIAL SERVICES, DEPT. OF SOCIAL AND REHABILITATIVE SERVICES (1988)(hereafter *Roush 1988*).

the hot summer months in 2005, begging for relief from the heat. Likewise, the unit's own pediatrician made a similar complaint that summer. Yet effective efforts to provide air conditioning only began in 2006 with actual air conditioning not being ready until *after* the summer of 2006. Similarly, it took twenty years for the Agency to install a sprinkler system in all of D-Wing and come into compliance with the fire code. There is no adequate explanation for the lack of compliance for all these years.

The problems are not only structural. Many of the important programs that VP&A believes are required for youth with disabilities are not being provided. This is so, in significant part, because D-Wing staff and administrators cling to the theory that they are a short-term detention facility and that providing programs and services will only increase the number of youth and length of stay at the facility. The "if we build it they will come" mentality was strongly presented to us in the course of our monitoring. However, VP&A found that this identification as a short-term facility is contradicted by the average length of stay throughout D-Wing's existence consistently exceeding two weeks with many youth currently remaining in D-Wing for weeks and at times months. D-Wing must be prepared to respond with the services, programs and protections legally required and clinically recommended when housing youth with disabilities for such lengthy periods.

Furthermore, our review uncovered what might be called a certain "slippage" in the quality of services generally in D-Wing. We agree with Dr. Roush's observation that "[f]or reasons that elude clear explanation, small bits of evidence are surfacing that WJRC is not doing some of the things that other institutional practitioners would consider obvious (e.g. same sex supervision, cleanliness, room checks, paperwork). These are the

cracks in the foundation of programs and reputations, and they are the precursor of greater problems. They need immediate attention."[4]

VP&A suggests that the history of failing to remedy these and other serious concerns in D-Wing and the most recent "cracks in the foundation" should compel all Vermonters and advocates for children to refocus our efforts on procuring the funding, training and quality assurance necessary to remedy the problems and to nurture the strengths that so clearly exist in D-Wing today. The facility has begun to undertake some efforts that bode well for the future. We are encouraged, for example, that recently DCF has committed to instituting Performance-based Standards (PbS). PbS is a self-improvement and accountability system used in twenty-six states and the District of Columbia to improve the quality of life and treatment services for youth in custody. PbS sets national standards for the safety, education, health/mental health services, security, justice and order within facilities. In addition, it gives agencies the tools to collect data, analyze performance results, design improvements and measure effectiveness with subsequent data collections and performance outcome reports. PbS' cycle of activities follows data collection and reporting with helping facilities develop an improvement plan that targets specific outcomes for change and implements activities to create the change.[5]

VP&A considers PbS a good program and a sign of an increased rate of positive change as compared to years past. The challenge laid out by this report is to what extent D-Wing staff and administration, DCF and the Agency of Human Services will maintain

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[4] DR. DAVID ROUSH, NATIONAL PARTNERSHIP FOR JUVENILE SERVICES, ASSESSMENTS OF THE SECURE DETENTION AND RESIDENTIAL PLACEMENT PROGRAMS OF THE VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES AT THE WOODSIDE JUVENILE REHABILITATION CENTER, p. 36 (2006)(hereafter *Roush 2006*).

[5] COUNCIL OF JUVENILE CORRECTIONAL ADMINISTRATORS, PERFORMANCE-BASED STANDARDS FOR YOUTH CORRECTION AND DETENTION FACILITIES (2006)(hereafter *PbS Standards 2006*).

that rate of improvement and remedy the longstanding and serious problems identified while nurturing the relationship-based philosophy which is also important to D-Wing's success.

II. SPECIFIC CONCERNS REGARDING YOUTH WITH DISABILITIES IN D-WING

> ***"Perhaps the most unifying theme underlying many of the studies reviewed for this report and the comment from respondents is the long-standing and continuing absence of a comprehensive continuum of disability-related services within the juvenile justice system." Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current State of Knowledge, Daniel P. Mears & Laudan Y. Aron, Urban Institute Justice Policy Center, (November 2003).***

Woodside's D-Wing is licensed to house sixteen male and female juveniles, ages ten to eighteen. As would be anticipated by national studies,[6] we discovered that a high percentage of youth detained on D-Wing have mental health, developmental and/or learning disabilities. For example, VP&A found that, depending on the census at the time:

- from 40% to 90% of youth detained at D-Wing are on Individual Education Plans (IEPs) covered under federal special education laws;
- from 40% to 80% percent of the youth detained at D-Wing have prescriptions for psychotropic medications;
- there is no comprehensive/adequate assessment at intake that would identify a youth with a disability that would require accommodations;

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[6] *See, e.g.*, Linda A. Teplin et al, *Psychiatric Disorders of Youth in Detention*, JUVENILE JUSTICE BULLETIN, April 2006. The article collects previous studies and describes the Northwestern Juvenile Project measuring prevalence at Cook County Juvenile Temporary Detention Center in Illinois. That study found that two-thirds of males and three-quarters of females met diagnostic criteria for one or more psychiatric disorders. Similar studies have found high rates of learning disabilities among detained youth.

- there is no documented training for staff on compliance with state and federal laws protecting youth with disabilities nor on how to assess if accommodations are needed to insure a youth's full participation in programming.

The D-Wing staff, mostly very experienced and committed to the relationship philosophy model, all expressed an "I know it when I see it" attitude toward recognizing potential accommodation-requiring disabilities. D-Wing staff also appeared unified in their perception that more often than in the past youth were detained in D-Wing for long time periods with difficult mental health symptoms, including self-harming behavior. VP&A found that in many cases the ad hoc practice embraced by D-Wing was insufficient to assure accurate and consistent recognition and response to youth with disabilities. At all stages of a youth's experience in D-Wing, youth with disabilities face unnecessary challenges and obstacles to equally accessing or benefiting from the D-Wing program.

1. Intake and Screening:

Most definitions of screening describe a relatively brief process designed to identify youth who may have disorders that warrant immediate attention (suicidal ideation, for example) or more comprehensive review. The screening may identify possible suicide risk, psychiatric, medical, substance abuse difficulties, and developmental and learning disorders. Screening, therefore, is a "triage" process, and

should be employed with every youth entering a detention facility.[7] As indicated above, VP&A found that D-Wing does not employ an adequate screening process to identify which residents may have disabilities and need either immediate services or a full assessment.

It is true that all youth admitted to D-Wing are required to complete an intake screening form that includes questions regarding medical history, current medical conditions, substance use, and mental health status. However, VP&A found that the screening is very limited in its usability and even more limited in its value in predicting risk. With the exception of youth observed to possibly be under the influence of alcohol or other drugs, there is no policy outlining specific steps to be taken by staff when "red flag" responses are provided by youth during the intake screening process. Similarly, VP&A found no consistency in staff response to areas of concern presented by youth during intake that may warrant closer observation or further evaluation.

VP&A is concerned about the lack of a specific screening tool that would assist in the identification of youth who have serious mental illness and/or who may be at increased risk of self-harm or suicide during their placement in D-Wing. There have been few serious suicide attempts in D-Wing and, fortunately, there are no reported successful attempts. There has been, however, a reported increase in episodes of self-harming behavior. Attention to this crucial aspect of the intake process and consistent planning to ameliorate the potential risks associated with self-harming behaviors are necessary in order to avoid putting many youth, especially some youth with disabilities, in jeopardy of serious harm. D-Wing's staff has the ability to obtain information about a youth with a

[7] THOMAS GRISSO AND LEE A. UNDERWOOD, U.S DEP'T OF JUSTICE, SCREENING AND ASSESSING MENTAL HEALTH AND SUBSTANCE USE DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM, p. 2 (2004)(hereafter *Grisso and Underwood 2004*).

relationship with the DCF system from that system. However, that kind of information transfer is not a substitute for the adoption of a normed and validated screening tool such as the MAYSI – 2 instrument discussed below.

Assessment is a more comprehensive and individualized examination of issues identified during the screening.[8] Although most screening instruments are designed to be administered by trained but not necessarily clinical staff, mental health professionals should do assessments. If the screening indicates a need for an assessment, it should be undertaken within a reasonable time, ideally within a week.[9] Youth detained in D-Wing are required to complete a Personal Medical History soon after they enter the Unit. There was some confusion among D-Wing staff and administrators regarding when an additional screening tool, the Achenbach Child Behavior Checklist (CBCL), Youth Self-Report (YSR) for Ages 11-18, is administered, with some personnel reporting the YSR is done before the youth is allowed out of Orientation, and others reporting the YSR is done sometime before the youth has been in the Unit for three days. Youth remaining in D-Wing for more than three days participate in additional surveys, the Connor's Rating Scales (CRS-R Teacher and Parent forms completed by D-Wing staff).[10] VP&A found that these surveys are not necessarily used for the purpose of accommodating the youth's emotional and behavioral needs during their detention placement. Rather, the information from the screening tools is reportedly used to provide data regarding the population served in D-Wing and, on some occasions, to provide potentially useful information to

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[8] Id. at 2-3.

[9] Recognized standards require that all youth be screened on admission, no matter the anticipated length of their stay in detention. We recognize that some youth identified for assessment will be released before that examination can be completed.

[10] See id. at 17, 18, 33 and 36 for a brief description of the Achenbach YSR and Connors Rating Scales and comparison with other assessment measures. The authors also indicate that a Master's degree and clinical experience are prerequisites for those administering the YSR instrument.

DCF for future consideration. The lack of an assessment process to elicit information regarding disabilities from new residents who may need treatment or legally required accommodations, strongly suggests that D-Wing may not be in compliance with legal mandates.

It is worth noting that the PbS system identifies the need to identify and effectively respond to youth's health, mental health and related behavioral problems throughout the course of confinement through the use of professionally appropriate diagnostic, treatment and prevention protocols.[11] The Expected Practices identified by PbS in this area include using suicide-screening instruments that are age appropriate, normed and validated such as the Massachusetts Youth Screening Instrument – Second Version (MASYI-2).[12] D-Wing is not currently using such an instrument. In addition, PbS Standard, Health and Mental Health Goal Expected Practice HEP3 states: *Suicide, mental health and health intake screenings are completed for all youths within one hour of their presentation for admission at the facility.* An additional Standard requires that if screening is not done within 1 hour after admission youth are "under constant supervision until the screenings take place."

DCF has recently indicated it plans to institute the use of the Youth Assessment and Screening Instrument (YASI) and a derived detention-screening instrument.[13] Although these instruments may be of value in determining appropriate supervision needs

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[11] *PbS Standards 2006,* Health and Mental Health Goal, p. 14, "To identify and effectively respond to youth's health, mental health and related behavioral problems throughout the course of confinement through the use of professionally-appropriate diagnostic, treatment and prevention protocols."

[12] Although MAYSI is widely used it is not the only screening instrument. Grisso and Underwood list the available instruments. *Grisso and Underwood 2004*, fn. 6 at 4.

[13] See YASI Presentation available in electronic format at www.orbispartners.com for detailed information about the use of YASI as a case planning tool for juvenile justice service providers.

throughout a juvenile's involvement in the justice system i.e., secure detention versus community placement, case planning and risk of recidivism predictions, there is no indication that they would also meet the need to identify those youth who may require emotional and/or behavioral evaluation and treatment interventions while detained in D-Wing.

Without intensive training and consistent use of adequate screening and assessment tools youth with disabilities entering D-Wing will continue to be subject to unnecessary and illegal obstacles to their full participation in programs with a variety of detrimental consequences to the child, their families and D-Wing staff.

2. Strip Searches:

We recognize that, because of legitimate security concerns, strip searches are occasionally necessary. It is not unusual for facilities to determine that strip searches of youth may be necessary upon admission, after some contact visits, and upon return from trips outside the facility. However, the D-Wing strip search procedure is troublesome and the lack of consistent accommodations is even more troublesome. For example, VP&A found that some shifts handcuff a youth and force her or him to stand in the corner if she or he refuses to be strip-searched. Other shifts will allow the youth to enter a room and be supervised until she or he is willing to be searched, perhaps not fully stripped. While the discretion allowed and expected from staff in this regard is commendable, the potential exists that youth with disabilities may be unnecessarily exposed to the more rigorous and traumatizing response to refusal to be searched.

Strip searches, even when warranted, are humiliating experiences. For youth with unrecognized, unreported, or under appreciated disabilities, the strip search and potential consequences of refusing to be searched may by themselves trigger severe reactions resulting in more forceful reactions by staff. It is particularly important that strip search policies be implemented consistent with principles of Trauma Informed Care i.e., searches of youth who have a history of trauma should be undertaken in a manner that does not recreate the abuse experience and in a manner consistent with trauma informed principles of care. For the purposes of this report trauma is defined as the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss and/or the witnessing of violence.[14] "*Trauma Informed Care* is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive...services."[15] D-wing policies, procedures and training regarding the strip search protocol should reflect evidence based best practices in this area, including rigorous independent review and periodic reevaluation of relevant policies and procedures.

3. Orientation:

Youth are required to read the facility's orientation book and satisfy a written examination on it prior to being allowed out of their locked room for any significant amount of time after the initial twenty-four hours of room restriction. Many youth on D-

[14] NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, NASMHPD POSITION STATEMENT ON SERVICES AND SUPPORTS TO TRAUMA SURVIVORS, p. 1, n.1 (re. 2005).
[15] Id. at 1.

Wing have cognitive, intellectual or learning disabilities. VP&A found that the reading and examination requirements are not consistently and uniformly tailored to accommodate a youth's disabilities. The discretion allowed and expected from staff in this regard is commendable and it is clear that, in some cases, ad hoc accommodations are attempted by staff in the form of reducing expectations, allowing a peer to assist, or assistance by staff themselves. However, the lack of consistency and uniformity, including clear policy direction, peer review and oversight of these decisions, creates an environment where youth with disabilities are likely to be obstructed from equal participation in the program and be subjected to increased confinement.

VP&A found that an adequate comprehensive disability assessment at intake, prior to strip search and orientation requirements, would greatly reduce the likelihood of inadvertent violation of youth with disabilities' rights for appropriate accommodations in these crucial aspects of their detention experience.

4. Education:

> ***"Rosenbaum emphasized that children entering the juvenile justice system who are entitled to special education and related services often experience an 'unwarranted reduction of services' due to resource constraints, even when the services have previously been determined to be necessary by independent professionals in the community school systems. Despite significant attention to the issue in recent years, reviews suggest that the prospects are dim that significant changes in disability-related programs and services will change in coming years." Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current State of Knowledge, Daniel P. Mears & Laudan Y. Aron, Urban Institute Justice Policy Center (November 2003).***

The Department has been aware that it is failing to provide adequate educational services on D-Wing since at least 1988. In the 1988 Program Evaluation of D-Wing, Dr.

Roush stated unequivocally "the education program needs to be expanded through additional resources."[16] The Department's own original licensing study in 1988 identified a failure to provide adequate educational resources when it stated "[o]ne drawback is that there is not enough space to separate any kind of educational activity from the rest of daily routine. Another regulation requires the provision of appropriate space and supervision for quiet study and they [D-Wing] are not in compliance with this regulation."[17]

The Department has not addressed this major failing in their program. Dr Roush, in his 2006 report, states clearly: "The D-Wing education program occurs in the dayroom area on the living unit. Due to program space limitations, D-Wing schoolteachers do not have enough space for instruction, for material and storage supply, or for separating or grouping youth according to academic levels. The absence of privacy in this small space makes it difficult for teachers to teach and even more difficult for residents to learn."[18] The impact on youth with disabilities and, specifically, youth with certain IEPs required under federal special education law, is likely greater than on the rest of the detention population.

D-Wing administrators state that short-term "educational and special educational programming" is available to adjudicated and pre-adjudicated juveniles.[19] They assert, however, that "[b]ecause the Detention Program is not considered a placement and is short in duration, the Individualized Educational Programs (IEPs) of students who are

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[16] *Roush 1988* at 1; see also *Roush 2006* at 14.
[17] RESIDENTIAL LICENSING UNIT, STATE OF VERMONT, RESIDENTIAL CHILD CARE FACILITY ORIGINAL LICENSING STUDY, p. 15 (1988)(hereafter *RLU Licensing Study 1988*)
[18] *Roush 2006* at 14.
[19] DR. JUDITH CHRISTENSEN, WOODSIDE JUVENILE REHABILITATION CENTER DESCRIPTION OF PROGRAMS, p. 5 (2004).

handicapped and eligible for special education services are implemented as developed by the adolescent's sending school. If it is not possible to implement the resident's IEP as it was written by the responsible school district, Woodside School staff will assist the responsible school district in the development of an interim IEP."[20] VP&A found evidence to contradict these assertions.

VP&A found evidence that strongly suggests federal special education requirements may not be complied with consistently and uniformly. Based on staff interviews, between 40 and 90% of youth in D-Wing have an IEP. Despite having a high percentage of youth on IEPs, D-Wing does not have consistent, comprehensive policies or practices on the acquisition, implementation and assessment of IEPs for youth with disabilities detained in D-Wing. As have others, VP&A found that the classroom area in D-Wing is not adequate to allow youth with disabilities a focused, productive learning environment in most circumstances. In addition, according to D-Wing's Standard Operating Procedure, Chapter 10, Number 1001, "...Students on 'correctives' and placed in their rooms generally will not participate in education until the 'correctives' have been completed..." We found no evidence to demonstrate consistent implementation of the behavioral or other aspects of the youth's IEPs that may have been relevant to both the use of confinement and the ability to learn while detained in D-Wing.

The overall impression formed from interviews and record reviews was that insufficient effort was being made to provide a substantive educational program consistent with youth with disabilities' IEPs. One staff member stated that, if youth get anything out of the educational program in D-Wing, "that's a bonus. Behavioral

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[20] Id. at 31.

management comes first and school really isn't a high priority for the kids." We were told that if a youth is identified by staff as having an IEP and the youth is detained in D-Wing for approximately three days or more, educational staff will attempt to contact the youth's most recent school to obtain the IEP and confer about the youth's education. Yet we found no evidence that demonstrates that D-Wing provides actual implementation of established, or even appropriately revised, IEPs even if the youth is detained beyond a few days.

VP&A did not find a consistent or clear policy or practice guideline that demonstrated effective implementation of IEPs by the various staff responsible for providing education. Rather, interviews made it clear that the teaching and substitute teaching staff are making efforts on an ad hoc basis to implement accommodations in the educational program. Without appropriate facilities, environment, and other resources, including the IEPs themselves, even the most valiant efforts on the part of D-Wing educational staff will not meet the actual needs of youth with special educational needs. The response from D-Wing staff and administration to these concerns, as with many other problems identified by VP&A and others, is that D-Wing is meant to be a short-term stay facility. However, as we have noted above, the reality of length of stay data contradicts the programmatic assumption that D-Wing houses youth for only several days at a time. That assumption can no longer be tolerated. Instead, action must be taken to address the educational rights and needs of youth who will be detained in D-Wing for weeks and months, often on repetitive stays.

As of this writing DCF has requested and received funding from the Legislature to commence a study on converting the existing and underutilized racquetball court into

educational spaces. VP&A is aware of no plans to provide immediate improvement to the educational aspects of the D-Wing program that are demonstrably inadequate to provide special education services to the hundreds of youth with disabilities for whom such services are necessary. VP&A has also found no evidence that D-Wing policies or practices are being improved to require consideration of the broad array of areas that impact IEPs and special education, including positively reinforced behavioral management and counseling services.

5. Mental Health Treatment:

> ***"Children with emotional disorders are especially vulnerable to the difficult and sometimes deplorable conditions that prevail in correctional facilities. A correctional facility is a very bad place to put a child with an emotional disorder, and NMHA is on record in favor of maximum reasonable diversion." Children With Emotional Disorders In The Juvenile Justice System, National Mental Health Association (re. March 12, 2005), http://www.nmha.org/position/ps37.cfm.***

While it is clear that not every youth with disabilities entangled in the juvenile justice system can be diverted to a non-detention situation, VP&A agrees with the National Mental Health Association statement recited above. In the cases that require detention, adequate mental health treatment for youth with disabilities cannot be overlooked or avoided without severe and harmful consequences. Nationally the prognosis is bleak for children in the juvenile justice system who need mental health treatment but do not receive it. Incarceration presents potential risks for these children, including victimization, self-injury and suicide.[21] A number of studies estimate that

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[21] NATIONAL MENTAL HEALTH ASSOCIATION, MENTAL HEALTH TREATMENT FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM – A COMPENDIUM OF PROMISING PRACTICES, p. 3 (2004)(hereafter *NMHA Compendium 2004*).

children with mental health treatment needs make up between 60 and 75% of youth in detention.[22] It is not uncommon for almost every child in D-Wing to have a significant mental health problem, many are on psychotropic medications upon admission and the incidence of self-harming behavior, especially "cutting" among female residents, is increasing according to staff.

Even with this information, staff interviewed and documents reviewed demonstrate that one of the biggest impediments to implementing an adequate and necessary mental health treatment program in D-Wing, unfortunately, is the attitude of staff and administrators themselves. When we questioned line staff, supervisory staff and some administrators about staff training, experience and level of skill the response has consistently been, "This is a detention program, not a treatment program." However, as noted in a 2005 RLU Report, "The [D-Wing] Program Description (also) states, 'Short and long-term counseling models and methods are designed to be developmentally appropriate.' Because the Program Description and practice do not appear consistent, Woodside is found in non-compliance with regulation 104. RLU recommends that training increase or the program description be revised to more accurately reflect the services provided."[23] Our interviews indicate that staff believe that RLU's expectations are inappropriate.

For those juvenile offenders who are detained in facilities, there is general agreement among the standards, the literature, and court opinions that an effective mental

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[22] NATIONAL MENTAL HEALTH ASSOCIATION, CHECKING UP ON JUVENILE JUSTICE FACILITIES: A BEST PRACTICES GUIDE, p. 2 (1999)(hereafter *NMHA Best Practices Guide 1999).*

[23] RESIDENTIAL LICENSING UNIT, STATE OF VERMONT, RESIDENTIAL CHILD CARE FACILITY, LICENSING REPORT, p. 2 (2003)(hereafter *RLU 2003*).

health system in detention settings should have the following components, in addition to the screening and assessment practices described earlier:

- available services that are more than segregation or close supervision;
- trained mental health staff in sufficient numbers;
- complete, accurate, and confidential records;
- the prescription and administration of psychiatric medications by qualified staff in a professionally acceptable manner;
- crisis intervention services for short-term treatment;
- the availability of acute care mental health services in a hospital or hospital-like setting;
- outpatient services;
- consultation; and
- adequate discharge and transfer planning.[24]

VP&A found that in most cases youth with disabilities, many of whom were being provided prescription psychotropic medications, were not provided with any other form of treatment consistent with community standards during their stay. While mental health screenings are taken and scored within three days of an admission to D-Wing per policy, it did not appear that consistent further evaluation and treatment while in D-Wing were provided to youth with disabilities despite the fact that treatment may be

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[24] CENTER FOR PUBLIC REPRESENTATION, MENTAL HEALTH SCREENING IN JUVENILE FACILITIES, Q&A PREPARED FOR TRAINING AND ADVOCACY SUPPORT CENTER OF NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS (recently renamed NATIONAL DISABILITY RIGHTS NETWORK), p. 5 (2004); See also, MICHAEL DALE ET AL, REPRESENTING THE CHILD CLIENT, pp. 2-1 – 2.111 (2006). This chapter describes the "C.H.A.P.T.E.R.S." juvenile facility assessment method that has been adopted for use by the Annie E. Casey Foundation in developing the JDAI assessment instrument.

particularly beneficial for youth who may be in the unit for weeks or months at a time. In fact, as noted earlier, it appears that the data collected from these various screening instruments may be utilized primarily for research purposes. The lack of behavioral and therapeutic programming was identified by some participants in the juvenile justice/child welfare community, including outside residential program staff, as being a serious problem with D-Wing.

VP&A is also concerned that non-medical staff is largely responsible for distributing psychoactive medications, including PRN medication (meaning medication provided to a patient at the request of the patient under a general order from the physician). Interviews suggested that there is variation among non-medical staff that may be called upon to administer such PRN medications in terms of their willingness to do so. The lack of on-site, around-the-clock nursing staff is an issue in this area as well as in the response to use of restraint discussed below. At least one federal court that has reviewed the issue of providing medical evaluation of youth entering detention facilities has ordered that if a youth comes to the facility with a prescription for psychotropic medication, he must be seen by a psychiatrist within twenty-four hours and have a full psychiatric evaluation within a week.[25]

6. Discharge Planning:

> ***"Children should have a discharge plan prepared when they enter the correctional facility in order to integrate them back into the family and the community. This plan should be updated in consultation with the family (as appropriate) and community treatment facilities before the child leaves the facility. It should include the continuation of treatment, therapy and services begun in the facility. Correctional facilities should***

[25] Williams v. McKeithen, 121 F. Supp. 2d 943, 997-998 (M.D. La. 2000).

take an active role in promoting continuity of treatment for those released." Children With Emotional Disorders In The Juvenile Justice System, National Mental Health Association (re. March 12, 2005) http://www.nmha.org/position/ps37.cfm.

VP&A found that youth with disabilities were being held in D-Wing for weeks and months at a time and were discharged without any comprehensive or uniform discharge plan regarding their medications and other treatment issues. The failure to provide appropriate discharge planning has been previously identified by DCF's RLU in 2003. "...RLU expects that discharge summaries will be comprehensive and completed when a youth is discharged from the program. This continues to be an area that needs improvement."[26] Again in 2005 RLU reported "Regulation 504.2 states, 'When a child in care is discharged a residential care facility shall compile a complete written discharge summary.' This year it was noted that pertinent discharge information has been added to this form as [previously] requested by Licensing. However, this form continues to be filled out inconsistently or not at all. Woodside continues to be in noncompliance with this regulation."[27]

Of additional concern in the area of discharge planning is the reported disconnect between D-Wing staff and DCF workers assigned to youth within the social services system of care. We were told by several D-Wing staff that when they have attempted to provide discharge recommendations to DCF staff, they have received very little feedback or follow up information regarding their suggestions.

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[26] *RLU 2003* at 12.

[27] RESIDENTIAL LICENSING UNIT, STATE OF VERMONT, RESIDENTIAL CHILD CARE FACILITY, LICENSING REPORT, p.12 (2005)(hereafter *RLU 2005*).

III. USE OF RESTRAINT AND CONFINEMENT

> ***"Far too often, we find that predictable behavior relating to mental illness is interpreted by inadequately trained staff as disobedience, defiance or even threats. Staff respond with anger, discipline or even force – even though other interventions could have defused the situation." Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current State of Knowledge, Daniel P. Mears & Laudan Y. Aron, Urban Institute Justice Policy Center (November 2003).***

The use of force, restraint and segregated confinement in juvenile detention facilities have been widely identified as serious concerns affecting the welfare of both residents and staff.[28] "Use of force restraints are inherently dangerous. They pose the risk of injury to the staff executing the restraint as well as the youth being restrained. They tend to escalate the emotional state of adolescence and can re-traumatize youth with histories of abuse."[29] "There are many reasons for the increasing focus in human services on the prevention of seclusion and restraint…there is considerable risk associated with their use, particularly use of restraint. Serious injuries and even deaths have occurred during restraint administration and this remains an ongoing concern each time a restraint is applied…individuals being restrained almost invariably experience this as psychologically stressful and even terrifying, and staff applying a restraint may have similar reactions. Restraint is thus traumatizing and - for those previously traumatized – potentially re-traumatizing."[30]

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[28] "Each use of restraint or seclusion poses an inherent danger, both physical and psychological. Restraint and seclusion are widely acknowledged to be violent, stressful, and humiliating incidents, both for patients and for the staff members imposing them. Never benign, the use of restraint and seclusion can be lethal." STEPHAN HAIMOWITZ ET AL. RESTRAINT AND SECLUSION – A RISK MANAGEMENT GUIDE, p. 6 (2006)(hereafter *Haimowitz et al 2006*).

[29] JUDITH G. STORANDT, ESQ., NATIONAL DISABILITY RIGHTS NETWORK, USE OF FORCE IN JUVENILE CORRECTIONAL FACILITIES (abridged), p. 16 (2006)(hereafter *Storandt 2006*).

[30] GORDON R. HODAS MD., RESPONDING TO CHILDHOOD TRAUMA: THE PROMISE AND PRACTICE OF TRAUMA INFORMED CARE, p. 49 (2006).

The National Mental Health Association has issued a position statement on *Children With Emotional Disorders In The Juvenile Justice System.* It also describes best practices regarding use of force: "When restraint must be used to prevent injury to self or others, there should be stringent procedural safeguards, limitations on time, periodic reviews and documentation. Generally, these techniques should be used only in response to *extreme* threats to life or safety and only after other less restrictive control techniques have been tried and failed."[31]

Commentators have identified that "many of the shortcomings found in juvenile facilities are due to a failure to take into account what is now known about adolescence based on research in the fields of developmental psychology and neurology. Even during late adolescence, youth are still psychologically and socially immature, and their brains have not reached structural maturity. Youth do not have an adult's ability to reason, understand, engage in long range planning, self-regulate, evaluate risks and rewards, and make decisions. However, these deficiencies are not permanent character traits and youth are more likely than adults to age out of engaging in criminal behaviors."[32] The United States Supreme Court recently relied heavily on theories of adolescent development in an opinion holding that the death penalty for individuals who committed crimes before they were eighteen years old is unconstitutional.[33] This information informs best practices in responding to behavior in juvenile detention facilities.

Throughout D-Wing's existence there have been concerns about the use of restraint and confinement and the ability to review and assess the appropriateness of the

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[31] *Storandt 2006* at 13 (emphasis added).
[32] Id.at 14.
[33] Roper v. Simmons, 543 U.S. 551 (2005).

frequency and intensity of their use.[34] As indicated in Woodside's original licensing study, "the use of isolation and mechanical restraint demands careful monitoring due to the restrictiveness of these interventions...It is incumbent upon the administration to ensure that all incidents have supervisory oversight, that all incidents are well documented, and that the use of these techniques are monitored and/or reviewed periodically for appropriateness and necessity."[35] In 2005 RLU also found that the content of the Incident Reports in D-Wing continue to be of concern even though a new form was developed and implemented.[36] The use of force, such as "hands on escorts," were not consistently reported or documented.

VP&A found that currently D-Wing does not provide adequate documentation in its Incident Reports to allow for comprehensive and effective oversight and quality assurance. Based on VP&A's review of Incident Reports we found that it is often difficult to determine exactly what precipitated the use of force and what alternatives or de-escalation techniques were used to avoid use of force. The Reports continue to be non-descriptive; e.g. "John was having a very bad day" – another resident: "agitated" – another: "escalated behavior" – each provided as an explanation of why a resident was restrained. None of those justifications is a sufficient ground for restraint under any commonly accepted restraint criteria. That is, none evidences an immediate threat of

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[34] *RLU 2003* at 6, "The original licensing report and subsequent reports on file state that *passive* physical restraint is the primary restraint intervention after all attempts to de-escalate have failed. Then the 1992 report indicates, 'VARIANCE' and has been carried forward since. No documentation explaining this shift from *passive* physical restraint to the non-passive modality offered by the Vermont Police Academy can be found. Licensing requests that Steve Antell submit to RLU a written request for approval to use mechanical and non-passive physical restraint. This request needs to explain the reason passive physical restraint from a nationally recognized organization is not sufficient. Examples include Therapeutic Crisis Intervention, Crisis Prevention Institute, Handle with Care or MANDT."

[35] *RLU Licensing Study 1988* at 14.

[36] *RLU 2005* at 13.

serious or extreme harm to the youth or others. Numerous restraints were for property damage although, because of the lack of detail, it is hard to know what actually occurred and what actual alternatives to the use of force were attempted. While some incidents of property damage may rise to the level of a threat of serious harm, without more documentation it is possible to infer that the purpose of a restraint after property damage was for deterrence rather than for protection from harm.

The most recent report from Dr. Roush also found restraint to be a concern by identifying that "Staff have not produced a specific curriculum, certification for trainers, independent reviews of restraint practices, or an evaluation of restraint effectiveness."[37] Dr. Roush goes on to state, "Woodside uses a law enforcement approved physical restraint strategy. The implementation of this approach...suggests and approximates pressure-point control (PPCT) or bone-lock techniques. Use of PPCT restraint in juvenile justice facilities is controversial. Litigation and investigative journalism reveal frequent misapplications of techniques when applied to children and adolescents. Misuse often causes injury, including broken bones. Several leading experts are on record in opposition to the use of PPCT restraint."[38] RLU noted that D-Wing Incident Reports document the use of compliance restraints that are not allowed in any other licensed residential facility.[39] We would go further than Dr. Roush and RLU. From our consultation with national experts, comprehensive review of the literature and experience in other settings, we believe that PPCT or other systems relying on pain compliance are inappropriate, unnecessary and potentially dangerous restraint techniques when used in a juvenile justice setting.

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[37] *Roush 2006* at 20.
[38] Id. at 17.
[39] *RLU 2005* at 13.

VP&A's review found that restraints often involve pain compliance; as one staff member said to us, "Pain gets the job done." Wrist compression, wrist lock and joint immobilization are all used. VP&A is aware of a recent incident wherein a fourteen year-old D-Wing resident sustained a broken wrist as the result of a use of force that included pain compliance techniques. We understand that the Agency of Human Services investigation unit is investigating the incident and we plan to review the Agency's findings.

We found that, in most cases, D-Wing staff lacked adequate training, oversight and understanding of the best practices in use of seclusion and restraint. Youth with disabilities may be harmed or obstructed from full participation in the D-Wing program due to unnecessary use of restraints and confinement by the D-Wing staff. Inconsistencies among shifts can confuse youth about what they are allowed to do and how staff will respond. Youth interviewed by VP&A all expressed that even overhearing the use of force on D-Wing residents was troubling for them. Yet there appears to be no systemic effort to reduce the use of force and confinement in effect in D-Wing.

VP&A agrees with the National Mental Health Association's statement: "Correctional facilities should train staff to use behavior management techniques that minimize the use of intrusive, restrictive, and punitive control measures. When restraint must be used to prevent injury to self or others, there should be stringent procedural safeguards, limitations on time, periodic reviews and documentation. Generally, these techniques should be used only in response to extreme threats to life or safety and after other less restrictive control techniques have been tried and failed."[40] D-Wing staff and

[40] National Mental Health Association, *Children with Emotional Disorders in the Juvenile Justice System*, (Oct. 2, 2006 visit) available at ww.nmha.org/position/ps37.cfm.

administrators have not made significant progress in adopting these best practices in terms of either the system used to control dangerous or disruptive behavior, or of documenting the use of force to allow comprehensive and effective oversight and quality assurance. The RLU noted "Residential Treatment Facilities do not respond to noncompliant behavior with restraint and they do not use restraint techniques that cause pain. Mechanical restraints are not allowed in other programs. While D-Wing staff are not using as many of the 'pain-compliant' techniques as they have used in the past, RLU continues to object to this facility's lack of interest to adopt a nationally recognized curriculum which focuses on primarily de-escalation techniques."[41] The willingness and demonstrated ability to adapt to the best practices in this area is crucial because the evolving standard takes as a given that "the decision to use restraint or seclusion nearly always is arbitrary, idiosyncratic, and generally avoidable."[42]

When we expressed concern that there was no current effective oversight or check and balance regarding use of force at D-Wing, DCF responded that the Juvenile Defenders' Office has a presence in the Unit and receives each Incident Report. In contrast to that assertion, staff at the Juvenile Defender's Office indicated that they do not have the time, resources or expertise necessary to adequately review each documented use of force in D-Wing in order to determine if the force used was excessive or otherwise not in compliance with policy or best practices. VP&A has been advised that DCF is considering the option of outside, independent review of the use of force and confinement in D-Wing, but as of this writing, no independent review occurs.

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[41] *RLU 2005* at 13.
[42] *Haimowitz et al 2006* at 7.

The relevance to youth with disabilities of inappropriate or unregulated use of force cannot be overlooked or avoided. No effective D-wing policy exists for dealing with youth that self-harm, are exhibiting suicidal ideation/behaviors, or may have a clinically relevant trauma history. Staff uses restraint and "correctives" even when such responses would appear contrary to therapeutic standards and to the youth's mental health. In the context of self-harming behavior, the Vermont Department of Corrections recently abandoned the practice of punishing inmates when they engage in self-harming behaviors.[43] The current practice of using force and "correctives" in response to D-Wing youth who engage in self-harming behaviors is often not therapeutically appropriate and is no longer considered the best, or even standard practice in juvenile detention facilities. "When psychological trauma is not recognized or addressed, people may be unintentionally traumatized or re-traumatized...Re-traumatization can be overt as in the use of coercive interventions, such as seclusion and restraint. It can be less obvious and insidious as occurs when clinicians are not sensitive to the potential inflammatory impact of their words or behavior or when the design and physical environment of treatment facilities emphasize control..."[44]

VP&A found that restraints often occur due to power struggles between staff and residents. For example, staff have asked a resident to give them the scotch tape back, or to go into his or her room, or to spit out his or her gum, or to give staff his or her walkman – then refusal to comply has resulted in use of restraint. VP&A reviewed an incident report involving a young woman who, on entry to Woodside, refused to be strip-

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[43] VP&A v. Hoffman, 2:04-CV-245, (D.VT 2006) settlement agreement at http://www.vtpa.org/Investigations.htm.

[44] OFFICE OF MENTAL HEALTH & ADDICTION SERVICES, OREGON DEPARTMENT OF HUMAN SERVICES, TRAUMA POLICY, p. 3 (2006)(hereafter *ODHS Trauma Policy 2006*).

searched. There is no indication in the report that staff were aware or concerned that she may have had a history of trauma. Instead, staff responded to her refusal by placing her in leg irons and handcuffs for approximately one hour until she agreed to comply with the strip search.

We were disappointed to find that there is very limited internal review of the Incident Reports. The limited review that is done appears primarily to justify staff behavior rather than take a systematic approach to reducing the use of coercion. RLU identified the possibility that "staff, on occasion have escalated rather than de-escalated some situations."[45] There is no adequate debriefing for staff or resident. For example one form contains the following: "*How was the Incident processed with the resident afterwards?* Finally the next morning [the youth] was able to process the situation. [The youth] was given her consequences and is currently working on completing them. *How did the team on duty process the incident?* Staff discussed what things they could have done differently." The reports are replete with these types of examples which do not provide any basis to believe that comprehensive, constructive debriefing is being required or administered by the Department or D-Wing administrators in terms of analyzing and reducing use of force situations. We found that recognized factors that should be taken into account with all youth who may be subjected to restraint, including the amount of seclusion in the youth's experience, whether the youth is taking psychiatric medications, the youth's health, and his or her history of trauma, were not reviewed or assessed in a documented and consistent manner either prior to or when reviewing use of restraints and confinement.

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[45] RESIDENTIAL LICENSING UNIT, STATE OF VERMONT, RESIDENTIAL CHILD CARE FACILITY LICENSING REPORT, p. 9 (2001)(hereafter *RLU 2001*).

We also found that confinement was too often used and used without comprehensive assessment of its impact on the individual youth. D-Wing staff does consult with one another and attempt to impose the most appropriate discipline under the circumstances. However, the amount of confinement in the youth's experience combined with the large amount of youth taking psychotropic medications indicates that youth with disabilities may be unfairly impacted by confinement, either because their disability results in or is exacerbated by the confinement. Experience and research have demonstrated that "...segregation raises a number of concerns for youths who have a mental illness or a serious emotional disturbance. Because in general youth are developmentally different from adults the effects of seclusion, segregation, and isolation can be more traumatizing and damaging. If a youth has a cognitive or emotional disability, the youth's capacity to cope with sensory deprivation might be very limited."[46]

Many facilities have traditionally relied on locked-room time to deal with youth who were repeatedly disruptive or having problems conforming in regular living unit programs. In one such facility "many of these youth had underlying mental health problems... With assistance from a mental health consultant, administrators and mid-level supervisors discovered options other than locking youth in their rooms to enable them to participate more fully in institutional programs. These options could include drafting behavior contracts, assigning a staff member to work one-on-one with the child, and other modifications to help the child succeed. Eventually, living unit staff were brought in to the process of identifying youth having difficulties and meeting with mental health staff and supervisors to develop special programs that relied much less on locked-

[46] JUDITH G. STORANDT, ESQ., NATIONAL DISABILITY RIGHTS NETWORK, SECLUSION, SEGREGATION AND ISOLATION IN JUVENILE CORRECTIONAL FACILITIES, p. 12 (2005)(hereafter *Storandt 2005*).

room time."[47] Dr. Roush clearly states in his recent report that Woodside should reduce the amount of mandatory and non-disciplinary room confinement.[48] Apparently use of confinement has increased over the years in D-Wing as Dr. Roush reports that, in 1988, room confinement with the resident's room door unlocked and/or open was used whereas today that is not the case.[49] While the D-Wing administration has indicated plans to implement a policy change regarding the use of room confinement within the next month, there has been no effort to obtain input from VP&A or other local experts in the drafting of this new policy nor has the draft policy been circulated for comment or implemented as of the time of this writing.

The lack of training in de-escalation and trauma sensitive best practices was identified as a serious problem for D-Wing staff during this review. VP&A has been informed that, in September 2006, D-Wing staff attended training on trauma issues provided by Dr. Sherry Burnette, the Trauma Coordinator for the Vermont Agency of Human Services. The post training staff evaluations were extremely positive and reflected a desire for more advanced training in this area. VP&A supports D-Wing staff and administrators in their efforts to build upon the information they received in this training and their desire to seek out additional, ongoing training on this subject given its endemic nature.

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[47] SUE BURRELL, *Improving Conditions of Confinement in Secure Juvenile Detention Centers, in* PATHWAYS TO JUVENILE DETENTION REFORM, p. 35 (The Annie E. Casey Foundation no. 6, 1999)(hereafter *Burrell 1999*).
[48] *Roush 2006* at 18.
[49] Id.

IV. GENERAL CONCERNS

VP&A found that there were problems with the D-Wing program generally that impact on all youth detained there including youth with disabilities.

1. Relationship with DCF Caseworkers:

D-Wing exists as part of a juvenile justice system that is embodied in the person of the caseworker. Our interviews demonstrated that significant interaction between the caseworker, the detained youth and D-Wing staff can positively impact the youth's experience in D-Wing. However there was significant concern that this dynamic is becoming less common. Specifically, Dr. Roush states: "The following information should prompt DCF to re-examine the role of caseworkers. …the concern is the level of caseworker involvement and interaction with detainees. For example: 1) 80% of D-Wing residents said that caseworkers have very little time to encourage residents. This is an increase from 70% in 1988. 2) 90% of D-Wing residents indicated that caseworkers sometimes do not show up for their appointments with residents. This is an increase from 70% in 1988. 3) 90% of residents indicated that residents never know when a caseworker will ask to see them. This is an increase from 60% in 1988. 4) 100% of residents indicated that they never know when they will be transferred from this unit. This remained the same from 1988. These responses suggest that residents do not perceive themselves as getting significant information from caseworkers. The situation warrants additional investigation and should involve the caseworker supervisor."[50]

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[50] Id. at 25-26.

VP&A found that D-Wing staff have similar concerns, most notably as they relate to discharge planning. Ideally, collaboration at all stages of a youth's detention should occur among D-Wing staff, the DCF Caseworker, educators, community program staff, and when indicated, mental health professionals. One staff member interviewed brought this ideal a step further by stating the involved youth should also be engaged in "the problem-solving process." The reason identified for the perceived lack of collaboration and the lack of youth involvement in the process was that the DCF Caseworkers "are so limited in their time."

2. Mixed Gender:

D-Wing is a rarity among juvenile detention facilities due to the practice of housing both genders in such small quarters. VP&A did not encounter any significant support for continuing this practice and, instead, was told repeatedly that the dual gender aspect of D-Wing was a serious problem.

Staff indicated that more girls are being detained in D-Wing for longer periods of time than was the case in the past. Separate girls and boys bathrooms were only recently created. There are situations in which older males with predatory behaviors are detained along with younger females who have survived trauma and are otherwise vulnerable. Research has demonstrated that youth, particularly girls, involved in the juvenile justice systems have high rates of physical and sexual victimization as well as exposure to other kinds of trauma. "As awareness of the prevalence of trauma exposure among at-risk and delinquent youth has developed new research in Psychology, Child Development and

Neuroscience is providing valuable insights into how trauma exposure affects behavior, mental health, and treatment-responsivity."[51]

Staff has identified a variety of ways they attempt to eliminate inappropriate interactions between the girls and the boys, including lining up separately to move from place to place and not going through doorways at the same time, yet some inappropriate behaviors are apparently unavoidable. The opinion of several individuals interviewed was that youth in residential programs may attempt to be placed in D-Wing in order to begin or maintain relationships with other detainees there. While staff reported a need for increased sensitivity to the special issues female youth present to the Unit, including the reportedly higher incidence of trauma histories among the female detainees,[52] VP&A also learned of concerns regarding inconsistency in the ability of some male staff to effectively interact with the female detainees.

While there did not appear to be any documented effort on the part of staff or other professionals to alter the mixed gender nature of D-Wing, Dr. Roush was clear in his admonition: "Detained girls do not have access to gender-responsive programs and services. With the exception of Nurse Beane and medical services there was no evidence of gender-responsive programs, no evidence of staff training on gender-responsive issues, and no acknowledgement of the different needs of male and female detainees."[53] The RLU also identified their concerns about the mixed gender nature of D-Wing in 2005

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[51] Florida Department of Juvenile Justice Headquarters, *What Works Projects* (last updated Dec. 2, 2005), http://www.djj.state.fl.us/whatworks/Projects.html (hereafter *Florida DOJ 2005*).
[52] *NMHA Compendium 2004* at 10 "Adolescent girls who come into contact with the juvenile justice system report extraordinarily high levels of abuse and trauma. As a result of repeated exposure to multiple forms of violence and trauma, PTSD (Post Traumatic Stress Disorder) is prevalent among girls in the juvenile justice system, with nearly 50 percent meeting diagnostic criteria for the disorder."
[53] *Roush 2006* at 22.

when they reported, "the RLU continues to be concerned about housing together, in a small space, severely disturbed children who can range from 10 to 17 years of age and coed."[54] Applicable standards from PbS require a support system that ensures services to youth in detention are gender specific.[55]

Dr. Roush also reported, "D-Wing employs a dangerous practice of not providing female staff supervision on every shift when a girl is detained. This practice violates basic professional standards and common sense. For the safety of residents and staff, WRJC should end this practice immediately."[56] In response to this particular criticism DCF has expressed a desire to staff each shift with a female youth counselor. As of this writing those positions have not been filled.

3. Team Differences on D-Wing:

Woodside has long used a unique staffing pattern consisting of three teams that work two and a half day schedules. The administration believes that this team approach significantly improves interaction with the youth. Indeed, with some qualifications, Dr. Roush has praised the team approach. Nevertheless, despite what may be its strengths, the approach has serious problems, the most serious being inconsistency among the teams, particularly in program continuity and their approaches to discipline.

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[54] *RLU 2005* at 13.
[55] *PbS Standards 2006,* Programming Standard 1; #3 To provide a support system to ensure that services are gender-specific, culturally sensitive, language appropriate and tailored to fit the individual needs of the youths.
[56] *Roush 2006* at 22.

The Department has been aware since at least 1988 that inconsistency among its staff teams on D-Wing was a potential problem.[57] "While the evidence is impressive that the staff schedule improves morale and reduces staff turnover, detained youth complain that program continuity is disrupted at shift change. Since these situations possess the potential for program problems, the administration might consider a supervisory team which consists of each shift supervisor plus the D-Wing Manager."[58] Both VP&A and Dr. Roush found that inconsistencies in the implementation of policies and procedures in D-Wing have still not been effectively addressed. As discussed above, inconsistencies in the way in which staff interact with youth with disabilities can have a more severe impact on them than on other youth in D-Wing.

Dr. Roush believes that these inconsistencies demonstrate a serious weakness in the administration of D-Wing that must be addressed. He states: "Beyond substantial questions about the relevance of policies and procedures, and beyond the need of each team to ensure safety on its shifts, several interviewees suggested that the inconsistencies between teams are more a product of unresolved personal conflicts between staff members. The absence of systematic programs to address the on-going development of veteran personnel sustains the plausibility of interpersonal conflicts as a source of the inconsistency.... This assessment identifies many of the same issues from previous reports. The reasons that these issues persist could be a reflection of a certain style that some have attributed to Vermont or it could be a function of leadership that has not confronted and resolved issues."[59] In his assessment of "Program Clarity," the response

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[57] Id. at 8 "Inconsistency between teams, a problem identified in the 1988 assessment, is a concern."
[58] *Roush 1988* at 10.
[59] *Roush 2006* at 9.

to: *Staff sometimes argue with each other and Staff are always changing their minds here increased from 10% in 1988 to 90% in 2006* which demonstrate that *differences between staff have had a detrimental impact on the program.* Dr. Roush notes "this size of a difference should warrant a reconsideration of the WRJC notions that inconsistency is somehow tolerable or that it really is not a problem for youth."[60] VP&A's interviews uncovered a prevalent feeling among even staff that the unique work schedule, combined with relationships among staff, created problems.

Adequate staff training would help remedy the inconsistencies identified by VP&A and other investigators. However, VP&A agrees with Dr. Roush's conclusions that "staff training is inadequate by any standard....and that there needs to be the development of a training curriculum in part because Woodside is isolated. Greater attention needs to be paid to keeping Woodside staff up-to-date with current detention programs and practices."[61]

4. Length of Stay:

> ***"From a developmental point of view, prolonged detention is (also) problematic because the child is undergoing developmentally important phases of life in institutional settings with idiosyncratic demands particular to that setting. Consequently, the child is adapting to incarceration and an institution, not the community from which she came and to which she will return. It is imperative that the juvenile justice decision-maker understands that virtually every effective evidence-based intervention for delinquency occurs in the home and the community." Mental Health Screening in Juvenile Facilities, Q&A prepared by the Center for Public Representation for the National Association of Protection and Advocacy Systems, Center for Public Representation, March 2004.***

[60] Id. at 47.
[61] Id. at 20.

Since Woodside opened the length of time a detainee spends in D-Wing has been a concern. The original licensing study identified that the "program seems to have more impact with residents whose stay is short. Impact and effectiveness as 'the bottom line' seem compromised with longer stays and mixing detention residents with extended-stay detention residents."[62] In the original licensing study, under *Summary Program Description, Basic Treatment Approach,* the Department noted the facility was to provide "close supervision in a secure environment for a maximum of sixty days."[63] The licensing study reiterated their concerns about length of stay issues when discussing educational services stating, "the expected maximum length of stay in this program is sixty days. As was noted by a recent evaluator in February 1988, the goal of the Detention Program should be to provide services in as short-term program as possible. Any extension beyond a few weeks, calls for an expanded, more goal-oriented education program."[64]

D-Wing staff and administrators feel that D-Wing must be seen as providing only short-term stay options for youth, or else the system will keep youth there even longer. Yet the fact is that the average child is living in D-Wing for more than two weeks at a time. Many other children, especially those with disabilities that may make them even harder to place, live in the unit for much longer periods of time. For example, statistics provided to VP&A during a site visit to D-Wing in November 2005 indicated that while one of the thirteen juveniles detained at the time had been there for only one day, another had been living in D-Wing for the past two hundred thirty-seven days. The median length of stay for the thirteen juveniles detained at the time was thirty-five days, while the average length of stay was fifty-five days.

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[62] *RLU Licensing Study 1988* at 18.
[63] Id. at 1.
[64] Id. at 14.

Long stays by youth in D-Wing may be attributed to a variety of causes. According to staff, the most common sources of the increased length of stay include long delays in the completion of court-ordered evaluations, inflexible orders by judges, and the lack of available placements for youth whose behaviors are more difficult to manage, particularly girls with mental health and/or substance abuse treatment needs. This information further highlights the likelihood that the increasing length of stay and concomitant deficiencies in the facility, educational and mental health services is adversely impacting youth with disabilities.[65]

As of this writing there is some reason to believe the trend of increasing length of stay at D-Wing may be slowed or reversed. Legislation passed during the 2006 legislative session which provides DCF with more control of the placement of youth in D-Wing coupled with the proposed institution of a new screening tool focused on population management may reduce the number of youth held in D-Wing. This reduction may support decreased length of stay in the future.

5. Physical Plant:

The Agency of Human Services has been on notice since the creation of Woodside that the physical plant was seriously inadequate and should be a significant concern. In 1988 the original licensing study reported "...the design of the facility not only works against effective programming in some instances, but also leads to discomfort for staff and residents. If this program is at capacity, there is literally no space available

[65] "Of particular concern is that, over time, there has been a significant increase in the number of children with mental health disorders. Center statistics point to a longer-than-desired average length of stay for children committed there, underlining the need for community-based alternatives." *NMHA Best Practices Guide 1999* at 8, based on findings of VT Association for Mental Health tour of Woodside on October 30, 2001.

for the staff who are back up to the awake staff to sleep."[66] Again, in 2003, RLU reported, "no janitor or any specific person is responsible for cleaning this overused, overcrowded facility. The residents and staff are responsible for cleaning the resident bathrooms, bedrooms and common areas on the units. Staff are expected to clean their own offices and staff bathrooms on the units. However, there is no one specifically responsible for cleaning the administrative area (reception area, conference room, and public bathrooms). Licensing continues to recommend that a Buildings and Grounds janitorial position be assigned fulltime to this facility... This concern was mentioned in the initial licensing report written in 1988 and has been raised in every report since that time."[67]

During site visits in 2005 and 2006, VP&A staff found D-Wing to be so unkempt and dilapidated as to be unsafe for the children. Dr. Roush also found during his site visit that resident rooms were dirty with trash, food and cluttered with resident's personal possessions. "There was no consistency on how to store items or how to clean rooms. Resident bathroom conditions were unacceptable. Algae, mold and soap scum were in most bathrooms."[68] Many individuals interviewed stated that the policy whereby staff and residents were responsible for cleaning the facility was ineffective and inappropriate. As of this writing the Department has hired a full-time janitor with a regular schedule of cleaning and maintenance assignments and had invested in a thorough cleaning and repainting process in the summer of 2006. A recent site visit by VP&A confirmed that D-Wing is much cleaner than on earlier visits and this is commendable. The question remains how and why the deplorable conditions that existed in D-Wing, and which had

[66] *RLU Licensing Study 1988* at 4.
[67] *RLU 2003* at 4.
[68] *Roush 2006* at 3.

been reported for many years, was allowed to continue until the summer of 2006. VP&A was not provided with an adequate explanation for this state of affairs.

D-Wing has lacked adequate air conditioning since its inception. In 2003 the RLU found D-Wing "continues to be incredibly uncomfortable during the summer months of overcrowding, poor air circulation, and no air conditioning. Noncompliance with Regulation 201, which reads 'A residential facility shall be constructed, equipped, used and maintained so that the privacy, safety, health and physical comfort of all children are ensured.'"[69] D-Wing administration was made aware of letters written by residents in the summer of 2005 pleading with them to provide air conditioning due to the difficulty they were having sleeping. That same summer Dr. Parker, the facility's pediatrician, sent the Department a letter identifying the lack of air conditioning as a serious threat to the health and welfare of the children housed there. Only after the commencement of VP&A's investigation did plans surface to provide adequate air-conditioning. As of the time of this writing the air conditioning system has been installed and is expected to be operational next summer.

D-Wing has not been in compliance with fire code requirements to have a complete sprinkler system. RLU reported in 2005 "a sprinkler system was installed in the gym, however there continues to be no sprinkler system where the youth reside."[70] This is a very serious concern given the fact that youth are locked into their rooms at various times during the day and at night. Only after VP&A commenced its investigation did DCF take steps to remedy this significant risk. In October 2006, VP&A was informed that the sprinkler system would be operational by early December 2006. We should all be

[69] *RLU 2003* at 4.
[70] *RLU 2005* at 4.

very concerned that the State taking custody of our children could have allowed these very serious health and safety risks in D-Wing to go unaddressed for so many years.

"The fact that many of those subjected to such conditions are young (and) nonviolent ...exacts even greater costs upon already vulnerable youth. Holding them in dilapidated, crowded, inadequately staffed facilities may result in physical and emotional damage that leaves them worse off than before the system intervened."[71] Addressing dangerous or inhumane conditions cannot be deferred until budgetary restraints are lifted or a new administrator takes over the facility. Detained youth are entitled to conditions that comply with constitutional law, state and federal laws, and state regulations. Failure to provide legally adequate conditions may result in harm to children or staff and in costly lawsuits. There is no justifiable reason for jurisdictions to fail to meet their legal obligations to detained youth."[72]

6. Overall Social Climate:

There is information in the appendix of the 2006 Roush report that gives results of the Social Climate Scales Dr. Roush administered during his recent visit. These scales measure items in four dimensions of an institution: Relationship, Treatment, Systems Maintenance and Contextual. Dr. Roush reported "from the detainees perspective the 2006 program is a poorer version of good juvenile detention"; that his visit to Woodside "raises too many concerns about questionable practices" and in terms of the Personal Problem Orientation (PPO) dimension sub-scale there is a "statistically significant decrease" between the 1988 and 2006 evaluations. "The D-Wing refusal to use a standard

[71] *Burrell 1999* at 12.
[72] *Burrell 1999* at 17.

problem-solving approach intervention is problematic."[73] These are clear warning signs to DCF and D-Wing administrators and staff that attention must be paid immediately to addressing the various issues raised by VP&A and Dr. Roush's recent report in order to prevent continuing deterioration of the D-Wing program.

V. RECOMMENDATIONS

6 Guiding Principles for Conditions Work.

1. ***Public officials are legally responsible for ensuring adequate conditions.***
2. ***Crowding had a negative impact on other conditions.***
3. ***Leadership at multiple levels is essential to improve conditions.***
4. ***Assessments should focus on best professional practice.***
5. ***Attitudes are an important part of changing conditions.***
6. ***Adolescent developmental needs must be taken into account.***

Sue Burrell, Pathways to Juvenile Detention Reform - Improving Conditions of confinement in juvenile detention centers, A project of the Annie E. Casey Foundation, 1999.[74]

The six guiding principles listed above are provided to illustrate that improving the treatment of youth with disabilities involved in the juvenile justice system generally, and D-Wing in particular, cannot succeed without real leadership, comprehensive involvement from all levels of decision-makers and participants in the system, and a constant refocusing on the issues through the lens of the science of adolescent development. The D-Wing program has been an important and heavily utilized resource over its lifetime and will be used heavily for the foreseeable future. We believe the

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[73] *Roush 2006* at 44 – 46.

[74] *Burrell 1999* at 17-20 "These principles were essential…and should play an important role in any jurisdiction wishing to engage in systematic improvement of its juvenile detention center."

information in the body of this report and the recommendations put forth below can lead to the improvement in the State of Vermont's treatment of youth with disabilities detained on D-Wing. It is our hope that the attention and resources needed to bring about effective improvements and nourish the existing strengths of D-Wing will materialize promptly and before additional youth with disabilities are subjected to unnecessary obstacles toward equality and a healthy detention environment.

VP&A recommends that an implementation plan and timeline to institute the Performance Based Standards (PbS) and effective outside oversight be established to monitor progress towards goals at regular intervals. VP&A wishes to be included among the team of reviewers assembled from outside agencies and organizations that constitute the local juvenile justice stakeholders group that review this plan and that is involved in ongoing monitoring. Dr. Roush states, "It is important that WRJC programs become participants in the PbS process. PbS is an excellent model that identifies key indicators of a programs success..."[75] DCF and D-Wing have included in their action plan their intent to "adopt new licensing standards appropriate to Woodside programs: Performance based Standards will be used to define and improve practice standards."[76] Accordingly, VP&A recommends the prompt adoption of the PbS Standards in their totality. Standards that are of particular importance to the constituency we serve are listed below as part of our recommendations.

In addition, VP&A is in agreement with Dr. Roush's Priority Recommendation that D-Wing comply, within six months and annually thereafter, with the applicable life safety mandatory standards in the American Correctional Association's 1991 edition of

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[75] *Roush 2006* at 31.

[76] Woodside Action Plan, September 13, 2006, provided to VP&A by Robert Becker, DCF Juvenile Justice Coordinator.

the Standards for Juvenile Detention Facilities (3rd edition).[77] We provide the following additional specific recommendations to the Commissioner of DCF:

1. Intake and Screening

1. Adopt and implement an age appropriate, normed and validated instrument administered on admission to screen for mental health, suicide risk, health and substance abuse;
2. All youth whose screenings indicate non-acute illnesses, injuries, or other problems should receive appropriate treatment, placement and referral for services and supervision;
3. All youth whose screenings indicate intoxication, mental illness, suicidal behavior, or acute injury should be referred to proper medical, mental health, or substance abuse facilities;
4. Develop and implement a comprehensive disability assessment to identify areas in which accommodations may be necessary at all stages of the detention placement, including the orientation and strip search processes.

2. Education

1. Ensure timely and appropriate assessment and identification of students with disabilities for special education services;
2. Develop and implement adequate individualized education programs and provide necessary related services;
3. Develop and implement a process to obtain youth with disabilities IEPs from their school district. The education records of youth confined for more than fourteen days should contain the records from their most recent school, and those records should arrive within fourteen days of a youth's admission to the facility;

[77] *Roush 2006* at 33.

4. Provide youth held in isolation with educational programming and materials.
5. Implement a policy that requires a complete behavioral assessment and creation of a behavior/educational plan that is based on positive behavioral interventions and support (PBIS) rather than on punitive confinement for all youth who are anticipated or actually are detained at D-Wing for more than fourteen days;
6. In light of the anticipated two to three year delay in developing adequate classroom space, DCF should immediately obtain a portable classroom for educational services.

3. Restraint and Confinement

1. Develop policies and procedures that minimize the use of restrictive and coercive means of responding to disorder;
2. Immediately cease the use of pain compliance holds;
3. Develop training consistent with PbS Safety Standard 2 which "stresses the use of alternative and de-escalating methods and techniques prior to the use of restraints";
4. Develop and implement a clear and consistent policy, including assessment criteria/contraindications, on the use and length of seclusion or confinement to one's room;
5. Minimize the use of locked door confinement;
6. Develop and implement a comprehensive debriefing process. The debriefing and review should include at least three levels of review: 1) a debriefing with the staff and youth involved together to determine what happened, why, and how it can be prevented from happening in the future, 2) an administrative/management review (e.g., to determine personnel actions, training needs and/or policy changes indicated by the incident); and 3) a quality assurance review;
7. It is incumbent upon the administration to ensure that all incidents of restraint and seclusion have supervisory oversight, that all incidents are well documented, and

that the use of these techniques are monitored and/or reviewed periodically for appropriateness and necessity.

4. Medical Staff

1. Provide a nurse on site at all times in order to be able to evaluate residents promptly after they have been the subject of a use of force and to provide medications such as PRN medications;
2. Provide that a medical doctor, preferably a psychiatrist, will evaluate, within twenty-four hours of admission, all youth who arrive with either a prescription or medical recommendation for psychotropic medications.

5. Strip Searches

1. Evaluate the need for and use of strip searches;
2. Develop and implement a policy on the appropriate use of strip searches and the need for accommodations for youth with disabilities, particularly those with trauma histories.

6. Trauma Informed Care

1. Develop and implement a regular cycle of training in this area and include advanced training as staff becomes more knowledgeable;
2. Train staff to understand the prevalence and impact of trauma on the mental and behavioral health of youth in their care; and provide appropriate interventions that will mitigate rather than exacerbate the effects of trauma. Training offered should also address secondary or vicarious trauma;[78]
3. Ensure that mental health and nursing staff provide trauma assessment, and when indicated, evidence-based treatment for trauma-related problems;

[78] *Florida DOJ What Works Projects 2005.*

4. Develop policies and procedures that deliver services that are sensitive and responsive to the needs of survivors of trauma. This could be accomplished through regulatory and quality assurance, specific policy guidance, workforce development and technical assistance. Policies and procedures must address ways to avoid the inadvertent traumatizing or re-traumatizing of people receiving mental health or medical services.[79]

7. Discharge Planning

1. VP&A strongly urges the Department to immediately implement an adequate process to assure comprehensive discharge planning begins upon admission of youth with disabilities to D-Wing and continues, with appropriate documentation, until the discharge is accomplished;
2. For all youth with a mental health problem at the time of release, clinical and/or medical staff should prepare a mental health summary that is transferred to the institutions or agencies that have continuing jurisdiction over the youth, and to the youth's parents/ guardians/ attorney;
3. To the extent possible, create a discharge program that provides gender-specific, culturally sensitive, and language appropriate reintegration plans for all youth.

8. Gender-Specific Services

1. Reduce or eliminate the use of D-Wing as a coed facility;
2. Develop and implement training on gender sensitive issues for all staff;
3. Immediately obtain at least one female youth counselor for each shift when a female resident is in D-Wing and provide gender responsive services.

[79] *ODHS Trauma Policy 2006* at 3.

9. Staffing Patterns

1. Immediately advertise for and hire female youth counselor for all shifts;
2. Evaluate and redefine staff roles as required to implement PbS and other best professional practices;
3. Develop a plan to identify areas of inconsistency between teams and take all necessary actions to remedy them on each team or shift.

10. Physical Plant

1. A State entity, such as the Legislature, the Agency of Human Services or the Auditor, should investigate the delay in addressing the absence of air conditioning, sprinkler system and janitorial services in D-Wing over the last twenty years;
2. The Legislature and Agency of Human Services should expedite the reconfiguration of the physical plant to provide an area for educational programming and separation of males from females;
3. D-Wing should have continued and regular outside assessments for environmental health and cleanliness with reports made public on the Departments' website and/or provided to the families of children detained there.

11. Length of Stay

1. Ultimately, the length of stay will only be effectively decreased when the state provides appropriate community based alternatives to detention. VP&A recommends that Vermont pursue the vigorous development of family-centered evidenced based, wrap-around services and similar programs as an alternative to detention and as placement opportunities for youth who remain in detention post-adjudication awaiting services. Exciting developments such as the *Community Detention Program*, an alternative to more expensive secure detention that

provides intensive supervision of youth at home, school, and work, at the McLaughlin Youth Center in Anchorage Alaska can be considered; [80]

2. Court ordered evaluations should also be streamlined. Children and adolescents should not be held unnecessarily in locked facilities merely because there are not sufficient programs available in the community. DCF could focus resources on D-Wing in order to actually make getting prompt, comprehensive behavioral assessments part of the D-Wing placement, thereby adding real value to the experience over and above simply detention and dealing with the delay caused by the wait for outside providers to do similar evaluations.

12. Leadership and Independent Oversight

1. That, as a first step, the Commissioner of DCF publicly acknowledge the need for effective, independent oversight of D-Wing;
2. That the Commissioner of DCF promptly identify a source of independent oversight and provide a mechanism for this to occur in an effective and transparent manner;
3. That the Commissioner retain the RLU regulations as appropriate to Woodside and that the RLU monitor and report every three months on conditions and compliance in D-Wing until an independent oversight mechanism is in place. Further, to the extent that RLU finds that Woodside remains on non-compliance status, that Woodside be required to provide a specific timeline for addressing areas of non-compliance.
4. That the Commissioner of DCF direct the administrators of D-Wing to develop an implementation plan that addresses the recommendations contained in this and the 2006 Roush report by December 31, 2006;

[80] http://www.hss.state.ak.us/djj/facilities/myc/default.htm.

5. That the Commissioner of DCF direct the implementation of the plan referenced in number three, above, with bi-monthly updates on the progress of that implementation to the Commissioner, the Agency and VP&A.

VI. ACKNOWLEDGMENTS

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Agency of Human Services

November 20, 2006

Ed Paquin, Executive Director
141 Main Street, Suite 7
Montpelier, Vermont 05602

Dear Ed,

Thanks for giving us the opportunity to respond to your Woodside report in writing. Although we do not agree with every word of the document nor are we agreeing to every recommendation, overall, you have identified the issues of mutual concern and we are absolutely committed to improvement in all areas.

As we begin public conversation about issues at Woodside, it is important to recognize several things.

First, Vermont's juvenile system has a secure capacity of 30 beds. We believe that our use of secure residential care is among the lowest per capita in the country. This is something to be proud of.

Second, by all accounts, Woodside is widely recognized as a "high-relationship" facility, where staff values relationships with the youth served. This is a very strong feature of the program. We are thankful for a long-term, caring staff.

Third, your report highlights some serious issues related to the Woodside facility and its operation. As you know, we have been focusing on these issues for the past 12-18 months. Back in January, 2006, we brought in David Roush, a national expert on detention facilities, to look at the program. He issued a report in May, 2006, outlining many of the issues in your report. A plan of action has been developed and progress has been made in many areas. These include a wide range of areas such as providing training to staff around trauma, installation of air conditioning, and placing female staff on all shifts. We are taking these issues very seriously. In the near future, I will be making a decision on an ongoing oversight structure, and we will adopt improvements in our overall system for managing challenging behaviors.

Finally, we have appreciated your role and have been working with you on identifying and addressing these issues. Our interests are the same--we both want only to assure that youth held in secure care in Vermont get the best care possible during their stay. We expect to continue working closely with you as we continue to implement changes. I have proposed that we formally meet no less than quarterly to review the plan and

progress on needed changes. If you have concerns about our progress in the mean time, please let Bob, Cindy, or me know so that we can address the issues.

Sincerely yours,

Steve

Stephen R. Dale, Commissioner