



**WRITTEN TESTIMONY**

**before the DC Council Committee on Recreation, Libraries, & Youth Affairs**  
Public Oversight Hearing for the Department of Youth and Rehabilitation Services



**Fiscal Year 2022 Proposed Budget Hearing**

**by Caitlin Holbrook**

**DC Justice Lab**

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## Oral Testimony

before the DC Council Committee on Recreation, Libraries, & Youth Affairs

by

Caitlin Holbrook

DC Justice Lab

Hello Councilmembers, my name is Caitlin Holbrook, and I am a policy advocate and research associate at the DC Justice Lab and a resident of Ward 6. I am testifying today on behalf of the DC Justice Lab to demand the Department of Youth and Rehabilitation Services (DYRS) **direct funds away from the practice of keeping children in room confinement and towards programming to make the facility more healthy and homelike and to center positive relationships between correctional staff and children.**

In the Youth Justice Amendment Act of 2016, the DC Council recognized the psychological and neurological harm that placing children in solitary confinement can cause, therefore, limiting room confinement to six hours.<sup>1</sup> Before the pandemic, DYRS in 2019 reported using room confinement for more than an hour 50 times and used isolation for mental health services 31 times.<sup>2</sup> The Youth Justice Amendment Act of 2016 placed a limit on room confinement to six hours, however, **this is still much too long as nationally 50% of suicides in youth facilities occur within six hours of isolation.**<sup>3</sup> Despite this, DYRS increased the practice<sup>4</sup> of room confinement, as a response to COVID-19.<sup>5</sup> I will include in my written testimony studies from facilities across the nation showing how isolation did not stop the spread of COVID-19 and instead resulted in isolating people from needed medical, mental health, and social attention.<sup>6</sup> With the recent end to the 35-year court oversight of the DYRS and with vaccinations increasing and COVID cases decreasing, there is no better time for the Council to step up and make DC a model in juvenile justice by eliminating the practice of keeping children

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<sup>1</sup> [https://lms.dccouncil.us/downloads/LIMS/35539/Committee\\_Report/B21-0683-CommitteeReport1.pdf](https://lms.dccouncil.us/downloads/LIMS/35539/Committee_Report/B21-0683-CommitteeReport1.pdf)

<sup>2</sup> DC Council, Performance Oversight Hearing Requested Information, Washington DC (2019) Available at: <https://dccouncil.us/wp-content/uploads/2020/02/dyrs.pdf>

<sup>3</sup> Holder, Eric et al, “Juvenile Suicide in Confinement: A National Survey”, Office of Justice Programs, U.S. Department of Justice, p.viii. Available at: <https://www.ojp.gov/pdffiles1/ojdp/213691.pdf>

<sup>4</sup> Sam P.K. Collins, “Parents of DYRS Youth Detainees Demand Covid-19 Response”, The Washington Informer(2020):Available at: <https://www.washingtoninformer.com/parents-of-dyrs-youth-detainees-demand-covid-19-response/>

<sup>5</sup> We do not have the exact time that children were being kept in room confinement, particularly if it was for over six-hours as the DYRS’ response to COVID-19. This is why transparency is needed.

<sup>6</sup> See section “ Isolation in U.S. Jails and Prisons and the Containment of COVID-19” beginning on page 6.

in solitary confinement.<sup>7</sup> The DC Council should primarily allocate funding for Youth Development Services, Residential Services, and Health and Wellness Services to make the center more healthy and homelike. Due to the expanded use of room confinement last year, DYRS should create exit plans for children who transition out of room confinement. **The budget should expand to include alternative programming to room confinement, these should be modeled off of Colorado and Massachusetts Youth Services.** These alternative practices should include fostering positive relationships between correctional staff and children. The budget for DYRS should expand staff training in mental health and brain development in adolescents, conflict mediation, and alternatives to punitive punishments. Finally, oversight and transparency are crucial for the DYRS. The Mayor’s new Office of Independent Juvenile Justice Facility Oversight (OIJJFO) can be responsible for this oversight, but utmost transparency needs to be practiced. **Anytime a child is placed in any form of room confinement, for any amount of time, the facility needs to report the reason why, for how long, who authorized the room confinement, and the services they received following their release from room confinement.**

The DC Justice Lab is willing and able to work with the Council to create legislation to officially end the practice of keeping youth in solitary confinement in the District.

Thank you for your time.

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### **Response to Interim Director Lindsey Appiah’s Oral Testimony**

In her testimony, Interim Director Lindsey Appiah, by her definition of solitary confinement and isolation, stated that DYRS does not engage in these practices because to do so would mean that DYRS places children in a separate unit.<sup>8</sup> Although Director Appiah stated one definition of solitary confinement in her testimony, it does not mean that it is the only definition. As is recognized by many national organizations, including the National Commission on Correctional Health Care, the terminology to describe solitary confinement varies by jurisdiction.<sup>9</sup> Solitary confinement, as defined by the national campaign to end solitary confinement, Unlock the Box, for adults, is confinement for more than 20 hours per day, alone or with a cellmate, without meaningful human contact, and the definition of solitary confinement

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<sup>7</sup> Office of the Mayor, DC.gov, “ Mayor Bowser Announces the End of Court Oversight of the DC Department of Youth Rehabilitation Service” (2021) Available at:

<https://dc.gov/release/mayor-bowser-announces-end-court-oversight-dc-department-youth-rehabilitation-services>

<sup>8</sup> Appiah, Lindsey. “The Committee on Recreation, Libraries and Youth Affairs: Public Oversight Hearing Department of Youth Rehabilitation Services”, June 07 2021, Zoom Virtual Hearing Platform, Time of quote: 1:29:51 , Available at: [http://dc.granicus.com/viewpublisher.php?view\\_id=2](http://dc.granicus.com/viewpublisher.php?view_id=2)

<sup>9</sup> Office of the Child Advocate, State of Connecticut, “OCA Report on Conditions of Confinement for Incarcerated Youth Ages 15-21at Manson Youth Institution and York Correctional Institution” (2020) p.28 Available at: <https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/OCA-Report-MYIYCI-Nov-2020.pdf>

for children, **is involuntary confinement alone in a cell, room, or other area for more than 4 hours.**<sup>10</sup> Although Director Appiah says they do not engage in solitary confinement, by this definition, they do for all intents and purposes because they keep children confined in a room or cell for more than 4 hours. In regards to DYRS, because the cells are called rooms, and based on the aforementioned definition of solitary confinement, I interchangeably refer to room confinement as solitary confinement in my testimony.

**The crux of my testimony is that DYRS confines children in the room that DYRS assigns to them, reportedly only for a mental health crisis, medical health crisis, or violent episodes. I argue that this practice should be shortened or eliminated.** The data of the mental health effects on children, particularly on brain development, of isolation, even within the maximum of six hours set by the Youth Justice Act of 2016, is the evidence I provide to support this argument. I also stated that because the practice of room confinement continues, **the Council should allocate funds from the budget to the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) to increase the transparency surrounding it as to why, who, and how long children are confined.** Lastly, I argue that the Council should direct funding into developing and implementing **preventive alternative policies to end the practice of room confinement as an unnecessary solution to all emergency situations and crises.** Emergencies such as COVID-19 or mental health crises are examples of situations that need to have procedures set in place proactively and training conducted preventatively.

Director Appiah corroborated in her testimony, as I stated in mine, that DYRS increased the use of confinement in response to COVID-19.<sup>11</sup> However, my argument and what is substantially supported by research from Mass Design Group and the Prison Policy Initiative, is that isolation, which many U.S prisons and jails turned to, did and continues to fail at stopping the spread of COVID-19. Instead, releasing people to their homes is the best way to prevent the spread of COVID-19.

Director Appiah stated that the DYRS had not increased using room confinement as a form of punishment.<sup>12</sup> I never claimed that this was the case in my testimony, both written or oral. I believe that the need for her to clarify this supports my recommendation of increased transparency. The lack of clarity as to why children are in room confinement, who places them there, and how long they are confined, does not provide strong evidence to support her claim. Therefore, oversight should be conducted by an independent office, either the Office of Independent Juvenile Justice Facilities Oversight or another established office, to clear up any misconceptions of the practices within DYRS and to provide needed transparency for families and community advocates.

I agree with Director Appiah that, based upon the reporting by the DYRS, DYRS is following the Youth Justice Amendment Act of 2016.<sup>13</sup> Despite this reduction to six hours, we

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<sup>10</sup> Goal Page, What We Do, Unlock the Box National Campaign Webpage, Available at: <https://www.unlocktheboxcampaign.org/>

<sup>11</sup> Appiah, Lindsey. Time of Quote: 1:31:24

<sup>12</sup> Appiah, Lindsey, Time of Quote: 1:32:02

<sup>13</sup> Appiah Lindsay, Time of Quote: 1:29:31

see nationally that the effects of incarceration and isolation are fatal for children who are in these conditions. The District needs to adopt new measures in rethinking our approach to handling these issues. I provided Colorado and Massachusetts Youth Divisions as models for these new measures in my oral testimony and have expanded on them in the written testimony. I have also included Connecticut Youth Services as another model. These states are models and provide evidence to my argument that alternative practices to room confinement not only work but substantially benefit the facilities for which they practice and can direct the Council on how to reallocate the budget and to what type of programming.

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### **Isolation in U.S. Jails and Prisons and the Containment of COVID-19**

#### **Relevant Portions of: Mass Design Group’s Report on Carceral Spaces and COVID-19,**

May 15 2020

**Summary:** The Mass Design group released this informative document for correctional facilities to reduce the spread of COVID-19 by changing the physical carceral space and procedures other than increasing isolation. It emphasizes the ramifications of the increasing isolation in response to COVID-19 on the health of incarcerated people.

**Read full report here:**

[https://massdesigngroup.org/sites/default/files/file/2020/Carceral%20Environments%20and%20COVID-19\\_0.pdf](https://massdesigngroup.org/sites/default/files/file/2020/Carceral%20Environments%20and%20COVID-19_0.pdf)

- People who are incarcerated are disproportionately more likely to experience chronic or acute physical and mental health issues, putting them at higher risk of death due to COVID-19.<sup>14</sup>
- In responding to the pandemic, care must be taken to design for social distancing, not social isolation.<sup>15</sup>
- One of the first inclinations in prison spaces is to restrict visitation and institute lockdowns and increased solitary confinement, but these actions can not only aggravate major physical and mental health conditions, but also have not been proven to be effective in the fight against contagion. There is no evidence that increased time in individual cells slows the transmission of the virus. In fact, shared HVAC systems between units can still spread the disease.<sup>16</sup>

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<sup>14</sup> Mass Design Group, “ Carceral Spaces and Covid-19: The Role of Architecture in Fightin Covid-19” Designing Decarceration and Investing in Restorative Justice.(2020) p.1 Available at:

[https://massdesigngroup.org/sites/default/files/file/2020/Carceral%20Environments%20and%20COVID-19\\_0.pdf](https://massdesigngroup.org/sites/default/files/file/2020/Carceral%20Environments%20and%20COVID-19_0.pdf)

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

- Even the best-intentioned plans will fail if they do not consider the needs of the individuals and communities (both staff and residents) who will be affected. Be aware that solitary confinement and isolation have been shown to be “profoundly damaging and sometimes deadly.”<sup>17</sup>
- Options like lockdown, tent dorms, or converting gyms into warehouse dorms may seem like the easiest interventions to implement, but can result in increased fear, panic, and distress, and subsequently increased distrust, violence, vandalism, and recidivism. Keep in mind that the social and emotional needs of incarcerated people are different and often more severe than those who practice social distancing outside confined facilities. Sensitivity to an increased need for emotional and counseling support, transparency, and family connection should guide how correctional institutions balance social distancing with social connectivity.<sup>18</sup>

**Relevant Portions of : The Prison Policy Initiative’s article “ Mass Incarceration, COVID-19, & Community Spread, December 2020**

**Summary:** The Prison Policy Initiative released this report outlining their findings regarding the effect of mass incarceration on increasing cases of COVID-19 in high incarcerated cities and counties.

**Read full article here:** <https://www.prisonpolicy.org/reports/covidsread.html>

\*\*It should be noted that the data provided is within the context that the DC jail began a medical lockdown where all incarcerated persons there were either in isolation or confined with one other person for 400 days. The results of this study occurred in parallel with the medical lockdown and increased use of solitary confinement.

- COVID-19 caseloads grew much more quickly over the summer of 2020 among counties in multi-county economic areas with more people incarcerated.<sup>19</sup>
- Mass incarceration added to COVID-19 caseloads in multi-county economic areas and states. Nationally, this impact reached a tragic scale: Mass incarceration added more than a half million cases in just three months.<sup>20</sup>
- Washington DC lagged in decarceration in response to COVID-19, in comparison to San Francisco, whose incarceration rates in the pandemic were half of Washington DC, or in New York, where the rates of incarceration were four times lower than the District.<sup>21</sup>

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<sup>17</sup> Mass Designs Group, p.9

<sup>18</sup> Ibid.

<sup>19</sup> Hooks, Gregory and Sawyer Wendy, “Mass incarceration, COVID-19, and COMMUNITY SPREAD”. Prison Policy Initiative, December 2020. Available at: <https://www.prisonpolicy.org/reports/covidsread.html>

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

- Once we estimated the impact of local levels of incarceration on the number of COVID-19 cases (both inside and outside correctional facilities) per 100,000 residents in the county and BEA area analyses described above, we calculated the number of additional cases for each county based on its actual population. In turn, we were able to aggregate (add together) these county estimates to calculate the total impact of mass incarceration on caseloads across larger geographical areas — namely states, BEA areas,<sup>22</sup> and finally the nation as a whole. (Again, our estimates include cases both inside and outside correctional facilities.) The results were staggering.<sup>23</sup>
  - An estimated 526.9 additional cases of COVID-19 for every 100,000 people in DC were caused by mass incarceration.<sup>24</sup>
  - If ranked according to the number of additional cases per 100,000 residents, Washington, D.C. would be first — and by a wide margin: its estimated 526.9 additional cases per 100,000 was eleven times that of Michigan (with 48), which had more additional cases.<sup>25</sup>
  - The BEA(multi county) areas based around Houston, Orlando, Philadelphia, and Washington, D.C. were left to deal with an additional 20,000 cases.
- For the entire United States, we estimate that mass incarceration was linked to an additional 566,804 cases — or roughly 13% of all new cases — from May 1st to August 1st alone.<sup>26</sup>

## NOT IN ISOLATION

### HOW TO REDUCE ROOM CONFINEMENT WHILE INCREASING SAFETY IN YOUTH FACILITIES

- Fact Sheet for Facilities and Agencies
- Report by: [www.stopsolitaryforkids.org/not-in-isolation](http://www.stopsolitaryforkids.org/not-in-isolation)
- Contact: Jenny Lutz, [jlutz@cclp.org](mailto:jlutz@cclp.org), (202) 637-0377

**Read the report here: <https://bit.ly/2IR4dni>**

**Check out the Not in Isolation webpage for more resources: <http://bit.ly/2GDxv7Y>**

### KEY TAKEAWAYS:

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

- 1.) Room confinement is not an effective tool to manage youth behavior to ensure safety, contrary to traditional views. In fact, misplaced reliance on room confinement can create a facility culture of mistrust and violence.
- 2.) There are effective ways to hold youth accountable without room confinement.
- 3.) It is possible to reduce room confinement in a diverse range of youth facilities without sacrificing staff safety. This includes facilities and agencies with large youth populations, detained and committed youth, older youth, youth charged as adults and youth with violent charges.
- 4.) Reducing room confinement is inseparably related to changes in staffing, training, mental health services, programming, behavior management, and other factors.

#### **TOPICS COVERED:**

- Important elements of isolation policies;
- How to communicate changes and goals while addressing staff concerns;
- Examples of changing institutional culture around the use of isolation;
- What data to collect on isolation and how to use it;
- How staff can respond to youth behavior without using isolation; and
- How to leverage external relationships to seek additional resources to reduce isolation

## **NOT IN ISOLATION**

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### **JURISDICTION** **HIGHLIGHTS**

#### **COLORADO DIVISION OF YOUTH SERVICES:**

- Developed an organizational model to change agency culture and improve practices;
- Used the legislative process to request additional staffing resources;

- Implemented an incentive-based behavior management system;
- Remodeled physical environments to align with rehabilitation; and
- Relied on regular data analysis to steer reforms
- Reduced average length of isolation from 7 hours to .75 hours between 2014 and 2018

### **STATE LEGISLATION:**

In May 2016, with strong support from the Child Safety Coalition, the Colorado legislature approved HB16-1328<sup>27</sup>, a bill to strengthen the protection of youth in state-run facilities with respect to restraint and seclusion. The new law codified into statute the Division’s policy that seclusion could never be used as punishment, sanction, retaliation, or as part of a treatment plan. The bill limited seclusion to emergency situations when “ a serious, probably, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.”<sup>28</sup> The bill prohibited the use of isolation for more than four hours unless a prescribed protocol was followed, including the examination of a mental health professional, and prohibited isolation for more than eight hours in two consecutive days without a court order. HB16-1328 also established the Youth Seclusion Working Group to advise DYS on policies, procedures, and the best practices related to seclusion and alternatives to seclusions.<sup>29</sup>

### **REQUIREMENTS ESTABLISHED BY HB16-1328**

- Seclusions could never be used as punishment, sanction, retaliation or as part of a treatment plan;
- Limited seclusion to emergencies when “ a serious, probably, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm;
- Required increasing approval at four and eight hours;
- Created a statewide Youth Seclusion Working Group to review data and make recommendations on reducing seclusion and restraints.

### **LIMITED STAFF:**

In late 2016 and early 2017, Jacobson hoped that increasing the number of staff—and thereby decreasing staff-to-youth ratios and improving supervision—would improve the situation. The ratio at that time was 1:11, while the national standard and accepted practice in the field was 1:8.<sup>30</sup> Governor John Hickenlooper requested \$5 million to add 80 full-time employees to DYC,

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<sup>27</sup> Colorado HB16-1328, Use of Restraint and Seclusion on Individuals, 2016 Regular Session, Available at: <https://leg.colorado.gov/bills/>

<sup>28</sup> Ibid.

<sup>29</sup> “Youth Seclusion Working Group,” Colorado Department of Human Services, accessed May 9, 2019, Available at: <https://www.colorado.gov/pacific/cdhs-boards-committeescollaboration/youth-seclusion-working-group>

<sup>30</sup> “Juvenile Detention Facility Assessment: Guidelines for Conducting a Facility Assessment (2014 Update),” Juvenile Detention Alternatives Initiative: A Project of the Annie E. Casey Foundation (2014), at 68. Available at: <http://www.cclp.org/wp-content/uploads/2016/06/JDAI-Detention-Facility-Assessment-Standards.pdf>; U.S.

and another \$3 million for enhanced mental health and physical health care.<sup>31</sup> At the time, the agency only received funding for a portion of the requested staff positions. However, with continued legislative advocacy, the agency eventually received funding necessary to maintain a 1:8 ratio.<sup>32</sup>

In May 2017, again with strong support from advocates, the legislature passed a new bill, HB17-1329, designed to bring about major culture change in DYC facilities.

### **Changes Made by HB 17-1329:**

- Changed the name of the Division of Youth Corrections to the Division of Youth Services (DYS)(at the request of the Division)
- Clarified as its primary mission to focus on rehabilitation;
- Established a 20-bed pilot program with a low staff-to-youth ration to test the effectiveness of a therapeutic group treatment approach and the ability of the Division to keep youth and staff safe without the use of seclusion and restraints other than handcuffs;
- Provided additional training to staff of the pilot program as needed;
- Called for the integration of trauma-responsive principles and practices into all elements of programming;
- Codified the phase-out of physical strikes on youth, pain-compliance and pressure-point techniques, the WRAP, and the use of isolation that the Division had already prohibited via policy;
- Expanded the role of statewide Youth Seclusion and Restraint Working Group;
- Required an independent assessment of the Division;
- Created community boards in each region of the Division; and
- Required extensive documentation of each instance of the use of restraint or seclusion in DYS facilities.

### **Encouraging Results**

Within a year there were important developments. In November 2017, DYS issued a formal policy<sup>33</sup> (which it amended in 2018), defining the criteria and limits for use of involuntary seclusion in a locked room or area; voluntary youth-initiated time outs (not to exceed 60 minutes, usually in an open area); and staff-initiated time outs (not to exceed 60 minutes, usually in an

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Department of Justice, National Standards to Prevent, Detect, and Respond to Prison Rape, 28 CFR § 115.313(c), (May 16, 2012), [http://www.ojp.usdoj.gov/programs/pdfs/prea\\_final\\_rule.pdf](http://www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf)

<sup>31</sup> Debbie Kelley, “‘Culture of violence’ in Colorado Youth Corrections includes physical restraints, solitary,” Colorado Springs Gazette (Denver, CO), March 2, 2017, Available at: <https://kdvr.com/2017/03/02/new-report-puts-colorado-division-of-youth-corrections-under-fire/>.

<sup>32</sup> Verbal Judo is a widely-used method of verbal de-escalation, with more than one million graduates of Verbal Judo courses worldwide; See, “Verbal Judo” Verbal Judo Institute, Inc., accessed May 2, 2019, <http://verbaljudo.com/>.

<sup>33</sup> Colorado Department of Human Services, Division of Youth Services, Policy S 14.3 B, Time-out; Seclusion and Program Refusal (Denver, CO: Effective November 1, 2017, amended April 1, 2018), <https://drive.google.com/file/d/0B32vshZrERKsUTBqZjFMcnNUS28/view>

open area). The WRAP devices were removed from DYS facilities. The staff-to-youth ratios were 1:8 in seven of the 10 DYS facilities.

Staff members were consistently assigned to the same group of youth, allowing the development of stronger relationships between youth and staff. The job title of correctional officers was changed to “youth services specialists.”<sup>34</sup> The job description for the position sought candidates who want to “engage with youth and build positive relationships.”<sup>35</sup> Routine strip searches after family visits were discontinued because they can be traumatic for youth. Strip searches were only conducted if there was probable cause and with approval from facility administration. Youth dressed in school uniform-type polo shirts and khaki pants rather than prison-like hospital scrubs. A number of the units were remodeled, with more homelike furniture, softer colors on the walls, and plants. Metal beds and 3” mattresses were replaced with more homelike beds and 7” mattresses. Simple blankets were replaced with comforters. Jacobson described the reforms as part of the culture change: “It really feeds into our vision of where we are going.”<sup>36</sup>

### **Encouraging Progress in Colorado:**

- Developed new policy on seclusion
- Banned the WRAP
- Stopped routine strip searches after family visits
- Youth clothing switched to polo shirts and pants
- Remodeled units to be more homelike
- Increased staffing
- Changed job title to “youth service specialist” to prioritize positive relationships with youth
- Remodeled units to create less institutional environments and more comfortable beds

### **Key Elements of New Seclusion Policy**

- Seclusion only permitted during an emergency as defined by Colorado Revised Statute 26-20-102(3), or when there is a serious imminent threat of bodily harm and the present ability to cause such bodily harm;
- Staff must attempt less restrictive alternatives or determine that such alternatives would be ineffective or inappropriate;
- Seclusion may be used only for the period of time necessary to prevent the continuation or renewal of an emergency;
- Staff must conduct visual checks at least every 5 minutes;

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<sup>34</sup> Jennifer Brown, “Assaults Down by Nearly Half as Reforms Take Hold in Colorado Youth Lock-up Centers,” Denver Post, February 26, 2018, <https://www.denverpost.com/2018/02/26/colorado-youth-lock-up-centers/>.

<sup>35</sup> “Youth Services Specialist I – Mount View Youth Services Center,” State of Colorado, accessed May 6, 2019. <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Job-Description.pdf>

<sup>36</sup> Ibid

- Staff must conduct a verbal check and try to engage the youth back into programming every 5-15 minutes;
- The shift supervisor, direct care staff, and behavioral health staff must meet to discuss a plan to process the youth out of seclusion as soon as possible;
- Seclusion may not exceed 4 hours except in rare circumstances involving input from a mental health professional an approval from the Director of DYS;
- Seclusion exceeding 72 hours requires a court order; and
- Facility directors review a monthly report on seclusions, including the incident leading up to seclusion and the staff members involved.

\*\*Equally important, seclusion incidents were down from a high of 302 in October 2016 to 97 in July 2018, a reduction of 68%. The median length of time in seclusion also decreased to 37 minutes for the period of March to August 2018. Average isolation time has been under one hour since September 2016.<sup>37</sup>

Figure 1

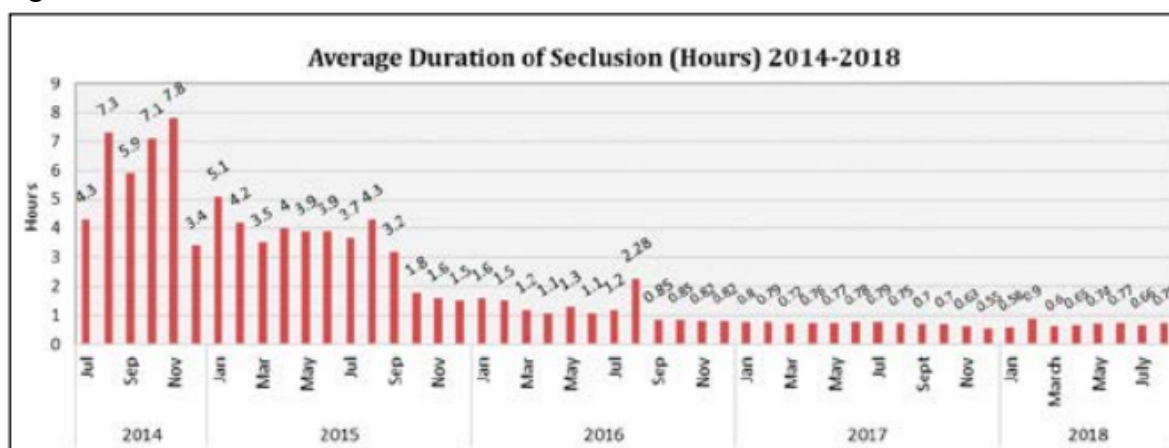
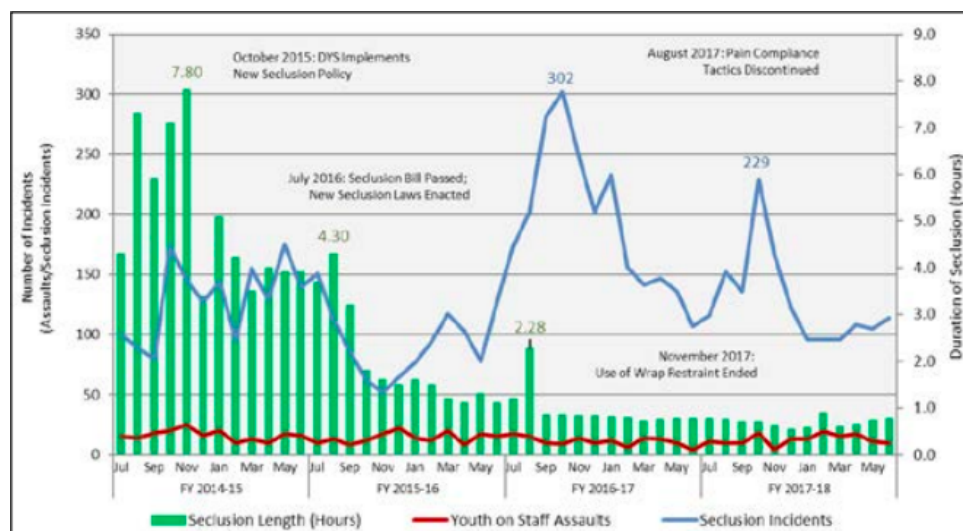


Figure 2

<sup>37</sup> Mark Soler and Anders Jacobson, "More States Need to Limit Solitary Confinement, Which Doesn't Work," Juvenile Justice Information Exchange, September 12, 2018, Available at: <https://jjie.org/2018/09/12/more-states-need-to-limit-solitary-confinement-which-doesnt-work/>.



## WHAT WORKED

### Exposure of the Problems

The members of the Colorado Child Safety Coalition performed an important public service by investigating reports of abusive conditions in DYS facilities, putting their findings into a widely-publicized report, and continuing to prod DYS to do better. The Bound and Broken report did not initiate reforms in the Division, but it strongly accelerated the pace of reforms that were in process. The report is a well-researched and careful analysis of the Division's own data and reports as well as a powerful collection of the voices of young people who were subjected to seclusion and restraint. For example, one youth described isolation as "like being treated like an animal. You're doing bad, go to your cage."<sup>38</sup> Sometimes a single statement is as powerful as a raft of data. Figure 4 shows a typical DYS isolation cell prior to the reform process.

### Multiple Legislative Responses

HB16-1328 and HB17-1329 were important for codifying reforms that DYS had already undertaken and for prompting more change. The Missouri-like pilot project authorized by HB17-1329 was a thoughtful effort to try a different approach on a limited scale before expanding it to the entire agency. The legislature provided an opportunity to demonstrate the effectiveness of small groupings with low staff-to-youth ratios, without using seclusion or restraints, in actual practice.

### Direct Confrontation of the Problems by Agency Leadership

Jacobson began working on the problems with seclusion and restraints when he took over as temporary director of DYS and continued those efforts when he became permanent director.

<sup>38</sup> Colorado Child Safety Coalition, Bound and Broken, note 1.

As noted above, his first approach, particularly at Spring Creek, was primarily to increase the number of staff at facilities, in order to bring down the staff-to-youth ratios and make supervision more effective. When that proved inadequate to the scope of the problems, he developed a more comprehensive approach. When the Bound and Broken report came out, he expressed concern about some of the allegations, but largely agreed with many of the policy recommendations.<sup>39</sup> Even before the Bound and Broken report was released, he traveled to Missouri with Representative Pete Lee, who represented Colorado Springs and was a legislative leader in reform efforts; Rebecca Wallace, staff attorney at the ACLU of Colorado; and other agency leaders, to see that system firsthand.<sup>40</sup> He continued to push the legislature for more staff for DYS facilities. He was committed to changing the culture of the agency. He developed a model with a sound, evidence based foundation. DYS had been training staff on the Sanctuary Model since 2014, but Jacobson increased the agency's efforts once he became the director.

### **Talking with Staff about Their Concerns**

A critical element of reform at DYS was the commitment of leaders to talk with unit staff to hear their concerns about the reforms. Reforms such as those needed at DYS cannot be imposed solely from the top down. Staff have genuine, sincere concerns about their own safety when the traditional disciplinary methods are removed. Staff must develop new skills to provide alternatives to seclusion and restraints, and must feel confident that their new skills will protect them as well as the youth. A central part of the process for administrators is listening to staff concerns, and addressing those concerns in new training, policies, and practices.

### **Setting Specific Limits on the Use of Seclusion**

HB16-1328 set specific limits for the use of seclusion and conditions for extending those limits. After the Bound and Broken report demonstrated that the practices continued, the legislature passed the much more comprehensive HB17-1329. The two pieces of legislation were important for codifying limits that DYS had previously put into policy.

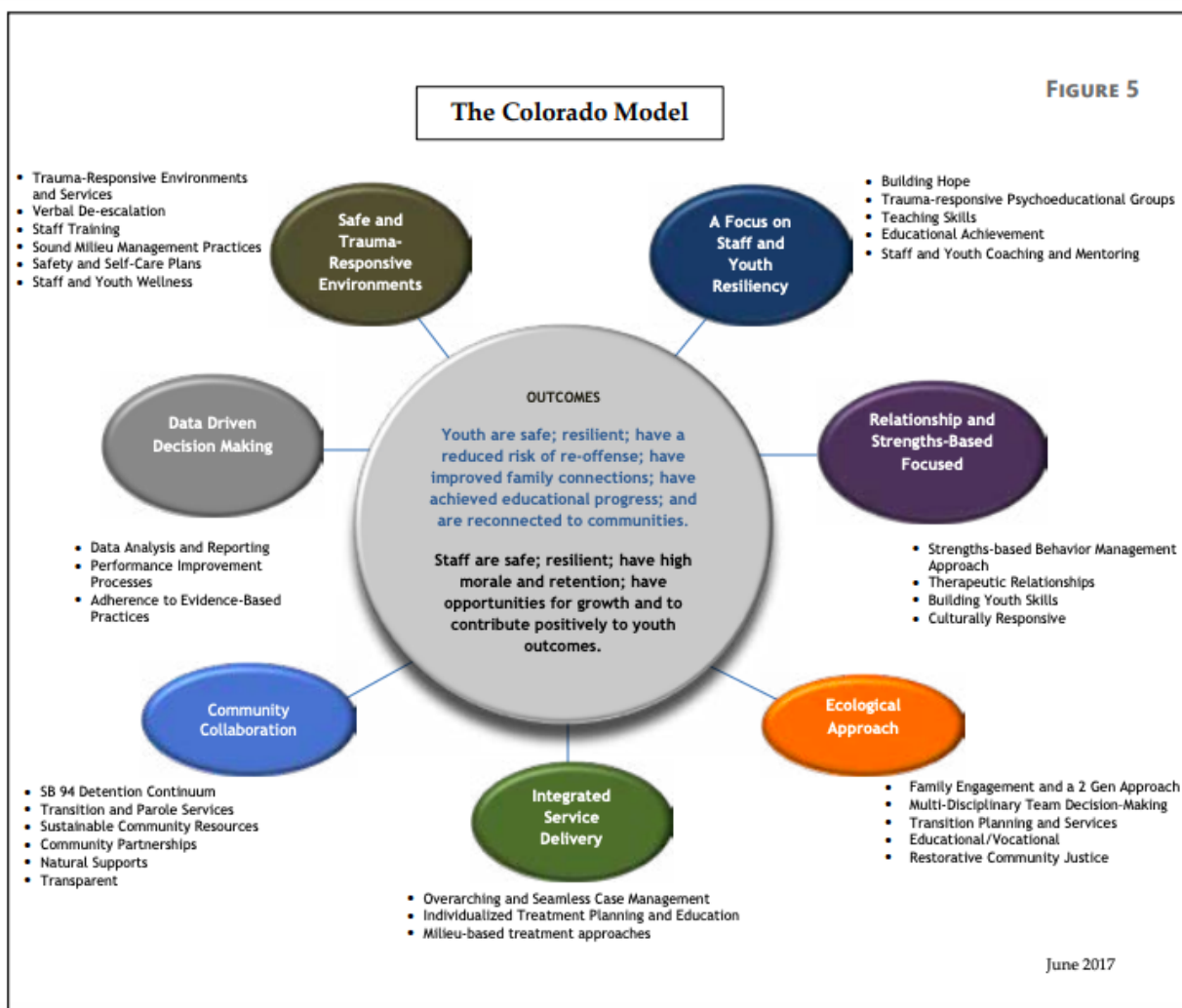
### **Limitations of Legislation**

Legislation and policies do not guarantee compliance. Legislation is not self-executing and agency policies are not always implemented properly. However, there is a considerable benefit in having the desired policy—very limited use of seclusion—on the record in state law for agency leaders and staff, and for the public. At a minimum, a formal statutory statement of desired policy provides a goal for agency personnel and a standard by which to hold them accountable.

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<sup>39</sup> Drew Engelbart, "Report puts Colorado Division of Youth Corrections under fire," Fox 31 News (Denver, CO), March 2, 2017, <https://kdvr.com/2017/03/02/new-reportputs-colorado-Division-of-youth-corrections-under-fire/>.

<sup>40</sup> Debbie Kelley, "'Culture of violence.'"



### MASSACHUSETTS DEPARTMENT OF YOUTH SERVICES:

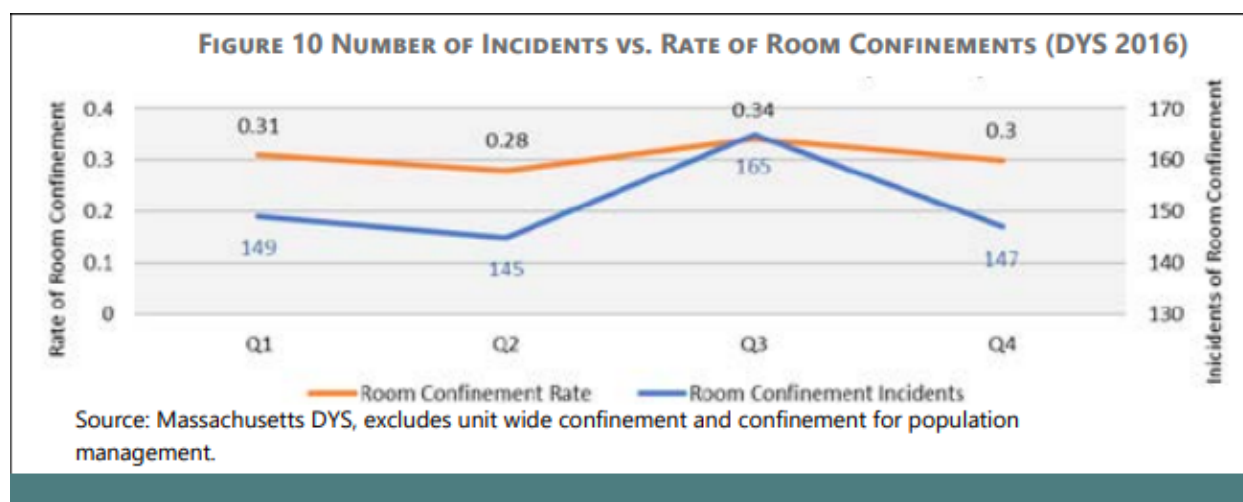
- Integrated Dialectical Behavior Therapy (DBT) into the behavior management system and living unit management;
- Redefined accountability based on skill-building-rather than punishment- to change behavior;
- Developed “exit strategy” guidelines to help youth transition out of room confinement quickly;
- Created individual support plans for youth who continuously acted out or could not respond to programming

- Average length of isolation under 1 hour, 6 minutes since 2016 and assaults on staff did not increase.

### Using Data to Advance Reform:

DYS measures the duration and frequency of room confinement. Frequency can be displayed as the actual number of room confinements or by the number of room confinements per 100 client days. The per client-days ratio allows DHS to compare the rate of room confinement relative to the number of youth. A client-day equals one youth for one day. Ten youth over 30 days is 300 client-days. A per 100 client-day rate of 0.5 in a program with 10 youth means one-half a room confinement over 10 days (10 youth x 10 days = 100 client-days or 1 ½ room confinement over 30 days (10 youth x 30 days = 300 client days).<sup>41</sup> Figure 10 on the next page illustrates the difference in the two measurements using DHS data from 2016.

- DHS views room confinement within the broader context of agency safety. Administrators and program leaders use data to determine how room confinement trends compare to other important safety indicators: assaults on youth, assaults on staff, restraints, property damage, industrial accidents, and staff time out of work.
- DHS administrators use data to help anchor conversations with union officials and other stakeholders around a shared set of facts.



### Exit Strategies

In addition to limiting the permissible use of room confinement, DHS also focused on shortening the amount of time that youth spent in room confinement. The new room confinement policy

<sup>41</sup> DHS Safety Task Force Recommendations, note 46, at 8.

outlined a release process for staff to follow when a young person is in room confinement.<sup>42</sup> According to policy, this process typically takes anywhere from 5 to 30 minutes. “How they get out [of room confinement] is just as important as how they get in,” says Forbes.<sup>43</sup> Group workers and clinical staff immediately begin talking to youth in room confinement to help them process emotions. “We don’t just close the door and leave them in there to calm down on their own. That’s not helpful if we want them to regain control,” notes a DYS clinician.<sup>44</sup>

As soon as youth are calm, staff begin a process of small steps to get youth out of the room confinement space. These steps may include:

- Opening the door while youth are still inside;
- Allowing youth to move slightly outside the doorway of the cell/room;
- Taking youth outside the room to an area away from other residents;
- Discussing the incident with youth using the Dialectical Behavioral Therapy (DBT) Coaching Protocol for Conflict Resolution;
- Using DBT tools to help youth process the incident (e.g., Behavior Chain Analysis, repair assignments);
- Using relationships with youth to determine whether they are calm enough to exit room confinement; and
- Assessing whether a youth needs to complete conflict resolution work with other residents before rejoining the program.

Release from room confinement does not necessarily mean that a resident immediately returns to regular group programming. A facility administrator explains that “[i]nitially staff thought that there was no room confinement and we were going to put the kids in the population no matter what—and that’s not what we do.”<sup>45</sup> In 2016, DYS and AFSCME developed the DYS Guidelines for Release from Room Confinement,<sup>46</sup> which give staff additional guidance on getting youth out of room confinement.<sup>47</sup> The Guidelines instruct staff to create an individualized set of activities or steps to help youth successfully transition back into general programming.

After introducing the room confinement policy in 2008, DYS leaders balanced concerns for staff safety with a firm resolve to stay the course. The agency invested heavily in a new behavior

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<sup>42</sup> Massachusetts Department of Youth Services, Involuntary Room Confinement 03.03.01(a), Section G (effective 03-13-13), <https://www.mass.gov/lists/dys-policiesregulations>.

<sup>43</sup> Peter Forbes, February 13, 2018.

<sup>44</sup> Lynn Allen, interview with Jennifer Lutz, July 9, 2018

<sup>45</sup> Lenny Beatty, interview with Pretrial Justice Institute, October 31, 2017

<sup>46</sup> Massachusetts Department of Youth Services, DYS Guidelines for Release from Room Confinement, November 21, 2016, Available at: <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/Guidelines-for-Release.pdf>

<sup>47</sup> Peter Forbes, February 13, 2018.

system framework over the next few years to equip staff with skills and alternatives to avoid room confinement. By April 2011, almost all cases of room confinement lasted less than four hours.<sup>48</sup>

## **TRANSFORMING RESPONSES TO YOUTH BEHAVIOR: DIALECTICAL BEHAVIOR THERAPY**

While DYS was developing the room confinement policy, it was also testing a new clinical approach that would eventually become a touchstone for all agency programs—DBT, originally developed by Marsha Linehan at the University of Washington to treat chronically suicidal clients. Dialectical Behavior Therapy (DBT) has since been adapted for people who are impulsive and have difficulty controlling their emotions.<sup>49</sup> Research shows that DBT is associated with reductions in recidivism for justice-involved youth and has positive effects on reducing aggression.<sup>50</sup>

DYS adapted Linehan’s original model as a behavioral management framework to decrease the use of room confinement. The DYS Director of Clinical Services, Dr. Yvonne Sparling, first piloted DBT at the Grafton short-term residential program for girls in 1999.<sup>51</sup> The results were impressive. Girls who received DBT had fewer restraints and moved through the behavioral level system more quickly. The following year, a second pilot program for boys yielded similar results. In 2006, the DYS Clinical Advisory Council endorsed the use of DBT as the therapeutic framework in all secure care facilities and developed a DBT Manual for all DYS secure facilities.

As part of the DYS DBT Manual, Sparling wrote “Dialectical Behavior Therapy as a Behavior Management Approach,” which established the fundamentals of DBT practice within the agency. In addition to the DBT program practices (described below), all clinical staff within the first six months of hire complete an online training course developed by Dr. Linehan through Behavior Tech, a Linehan Institute Training Company. DYS also hired DBT coaches for each region of the state to provide training and consultation to facility leaders and staff.<sup>52</sup>

The core premise of DBT is that problem behavior is caused by a deficit in skills, not a moral failing or disregard for consequences.<sup>53</sup> In other words, youth engage in dysfunctional behaviors because they do not know how or when to use more effective strategies. They may not

<sup>48</sup> Council of Juvenile Correctional Administrators, Toolkit: Reducing the Use of Isolation, March 2015, 20, Available at: <http://cjca.net/wp-content/uploads/2018/02/CJCA-ToolkitReducing-the-Use-of-Isolation-1.pdf>.

<sup>49</sup> Marsha Linehan, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (New York, NY: The Guilford Press, 1993); Marsha Linehan, *Skills Training Manual for Treating Borderline Personality Disorder* (New York, NY: The Guilford Press, 1993)

<sup>50</sup> California Department of Corrections and Rehabilitation, *Dialectical Behavior Therapy: Evidence for Implementation in Correctional Settings*, March 2011, 1–2, Available at: [https://www.cdcr.ca.gov/Juvenile\\_Justice/docs/DBT\\_Evidence\\_Draft\\_04\\_06\\_2011.pdf](https://www.cdcr.ca.gov/Juvenile_Justice/docs/DBT_Evidence_Draft_04_06_2011.pdf).

<sup>51</sup> Massachusetts Department of Youth Services, *DBT as a Behavior Management Approach*, Available at: <http://www.stopsolitaryforkids.org/wp-content/uploads/2019/05/DBT-as-BMA.pdf>.

<sup>52</sup> Ibid.

<sup>53</sup> How DBT Helps,” The Linehan Institute, Accessed May 1, 2019, Available at: <https://behavioraltech.org/research/how-dbt-helps/>

even understand how their current behaviors contribute to undesirable outcomes. DBT focuses on four main areas of skill development: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness.

The goal of DBT is to help youth learn skills to understand and change their behavior, especially in difficult situations.<sup>54</sup> Under this theory, room confinement will not deter negative behavior because it doesn't teach youth the skills they need to behave differently.

As practiced in DYS facilities, DBT is rooted in key values about young people:

- Youth are doing the best they can;
- Youth want to improve and must learn and practice new behaviors;
- Staff can help youth change to meet their goals;
- Relationships with youth are a core strategy in helping youth change their behavior;
- Behavioral principles apply to both youth and staff;
- Youth learn by seeing staff model positive skills and behaviors; and
- Staff need support when using DBT.

Eventually, DYS incorporated elements of DBT in many aspects of facility programming. DBT became a common language for youth, clinical staff, direct care staff, and administrators across all DYS programs. Perhaps most importantly, it created alternatives to room confinement.

DYS used four primary practices to integrate DBT into the daily lives of youth and staff.

- 1.) Weekly DBT Skills Group
- 2.) Distress Tolerance Plans
- 3.) DBT Coaching Protocol for Conflict Resolution
- 4.) Behavior Chain Analysis

#### **DYS BEHAVIOR MANAGEMENT(IN A NUTSHELL):**

- Youth earn incentive points/opportunities for positive participation in programming and using DBT skills
- Youth must make repairs for negative behavior. Youth lose the opportunity to participate in recreational programming or redeem previously earned incentives during the repair period.
- Repairs are categorized by the severity of the rule violation. Violence against other youth or staff are the most serious. Youth have a menu of incentives and repairs and can make choices based on the situation.
- Youth who continuously act out or cannot respond to programming may receive an ISP
- Serious behaviors may result in an agency-level Incident Response Team (IRT) hearing.

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<sup>54</sup> Ibid.

## **STEPS TO SUPPORT STAFF SAFETY:**

Staff and labor unions voiced concerns about how changes to the room confinement and behavior management policies affected staff safety. They pointed out other problems including mandatory overtime, burnout, and high staff turnover. DYS took several steps to affirm the importance of staff safety and provide resources and support to staff.

### **Agency Safety Committee**

To create a regular and structured process for addressing concerns from staff, DYS established a state Safety Committee. Members include management and frontline staff from DYS Regional and Central Offices, human resources staff, labor relations and workers' compensation staff from the Executive Office of Health and Human Services, and representatives from all major labor unions. The committee structure allows union leaders to discuss concerns in an open problem-solving forum. The Safety Committee meets every two months to review data in safety index areas, evaluate potential reforms, and make recommendations to DYS. Safety Committee reports begin with data on room confinement, assaults on youth, assaults on staff, restraints, property damage, industrial accidents, and staff time out of work. DYS also founded a Workforce Planning and Development work group to address issues and make recommendations regarding recruitment, on-boarding, training, coaching, retention, and evaluations.

### **What Happens When Youth Assaults Staff?:**

- Youth who commit an assault do not necessarily receive room confinement. If a youth is de-escalated and has regained control, room confinement is not necessary.
- Staff use the behavior management system to respond to youth's behavior (repairs, "freezing" incentives, Behavior Chain Analysis, updating a Distress Tolerance Plan).
- If a young person is physically violent and less restrictive interventions have failed, staff may use room confinement to ensure safety.
- If a youth is in room confinement, staff follow the DYS room confinement policy and Guidelines for Release from Room Confinement to help youth exit as quickly as possible.
- Staff or youth may request an ISP
- The program follows the IRT procedure
- Staff initiate the MOU process if they choose to pursue criminal charges

### **DYS Basic Training Topics:**

- Adolescent Development
- Trauma-Informed Care
- Positive Youth Development
- Suicide Awareness and Prevention
- Safety, Security, and Searches
- De-escalation and DBT

- Practical Applications for Physical Restraints and defensive disengagement techniques educational services
- Working with girls
- Working with gang-involved youth

**Annual Recertification Training Topics:**

- Positive Youth Development
- Adolescent Brain Development
- Suicide Prevention
- De-Escalation
- Use of Force
- Situational Awareness
- Defensive and Disengagement Techniques

**DYS Staffing:**

DYS programs have an average of 21 FTE direct care staff for each 12-15 bed program. Staff in the pilot staffing program work overlapping 10-hour shifts.

**Direct Care Staff:**

- First Shift 1:5
- Second Shift 1:4
- Third Shift 1:7(minimum of three direct care staff)

**Clinical Staff:**

Clinical staff are on site during evening and weekend hours. Clinical director (psychologist or licensed independent social worker). Two master's level clinicians who are licensed or license-eligible. Each of the five regions of the state has a licensed clinical psychologist, a Regional Clinical Coordinator, and a Regional Clinician who is licensed clinical psychologist or licensed independent social worker, in addition to the Clinical Directors and clinicians who are program based.

DYS also tracks group worker attrition by calculating the turnover rate within one year of hire and the turnover rate during the initial six-month probationary period. As outlined in the DYS Safety Task Force, this information is straightforward if administrators know what information to track. Based on the example below, which does not disaggregate turnover by staff position, DYS reduced its turnover rate for new hires by more than 50%.<sup>55</sup>

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<sup>55</sup> DYS Safety Task Force Recommendations, note 46, at 26.

Calendar Year	Total Group Worker 1 Hires	Turnover Rate Within Year of Hire	Turnover Rate During Probationary Period
2014	88	31.8%	4.5%
2015	87	42.5%	4.6%
2016	114	39.5%	12.3%
2017	103	14.6%	1.0%

**Relevant portions of:** Center for Children’s Law and Policy Fact Sheet, August 2012

**Summary:** A fact sheet that fleshes out many independent monitoring systems for Youth justice centers. Highlighted sections for this written testimony include Maryland, Washington DC, and Connecticut.

**Read Full Fact Sheet Here:** <https://www.cclp.org/wp-content/uploads/2016/06/IM.pdf>

### **Independent Monitoring Systems for Juvenile Facilities**

Youth who are harmed in juvenile facilities should have a reliable and safe place to turn to report physical and sexual abuse, other staff misconduct or lack of care they need. In order for youth to step forward, though, they must also trust the investigatory process and feel safe from retaliation by facility staff and other youth. Independent monitoring systems – programs for receiving and investigating complaints from youth that are separate from an agency’s internal grievance mechanism – address that need by introducing independent eyes and ears in secure facilities.

Several states currently operate independent monitoring systems for youth in juvenile facilities. These jurisdictions recognize that independent monitoring not only protects the rights of youth, but also:

- Identifies safety and security concerns before they become systemic issues that lead to legal liability;
- Generates critical information for facility managers and agency officials that can help guide improvements to service delivery;
- Provides insights into needed policy and practice changes; and  
Increases accountability and raises public awareness of the needs of youth in the system.

This fact sheet outlines best practices common to effective independent monitoring systems for juvenile facilities and provides examples of systems currently serving youth in facilities.

## Best Practices

Independent monitoring systems for juvenile facilities vary widely in their origin and design, but successful programs share several common features. The federal Office for Juvenile Justice and Delinquency Prevention at the U.S. Department of Justice notes that effective independent monitoring systems are:

- Fully autonomous from agency control in order to ensure the independence necessary to conduct effective investigations and take appropriate next steps;
- Supported by clear statutory authority to conduct investigations, subpoena relevant information and individuals, and recommend meaningful changes;
- Given unrestricted access to facilities, records, and individuals;
- Adequately funded so that the program has sufficient staff and resources to carry out its investigatory, monitoring, and reporting responsibilities; and
  - Staffed with qualified individuals who have expertise in coordinating and conducting investigations, understanding the legal rights of youth and enforcement mechanisms, and assessing the adequacy of programs and policies within facilities.

## Examples of Independent Monitoring Systems

### **Maryland: Juvenile Justice Monitoring Unit**

In 2002, the Maryland General Assembly responded to nationwide media coverage of alleged abuses in the State's juvenile justice facilities by creating the Office of the Independent Juvenile Justice Monitor.<sup>56</sup> The Office, which was fully independent of the State's executive branch and the Department of Juvenile Services (DJS), was charged with evaluating physical conditions, staffing, grievances, and the treatment of and services for youth at each facility operated, owned, or licensed by DJS.<sup>57</sup> In 2006, the Maryland Legislature moved the Office to the State's executive branch and renamed it the Juvenile Justice Monitoring Unit. Maryland's independent monitoring system has issued a number of important reports that have led to substantial changes in DJS facilities. For example, a report in 2005 exposed numerous beatings sanctioned by authorities at the Alfred D. Noyes Children's Center, prompting a formal investigation and changes in policies, staffing, and security.<sup>58</sup> State legislators have praised the Office's work as "shin[ing] a light into the dark corners of [the State's] institutions."<sup>59</sup>

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<sup>56</sup> JUVENILE JUSTICE MONITORING UNIT, 2009 ANNUAL REPORT 68 (2010), Available at: [http://www.oag.state.md.us/JJMU/reports/2009\\_Annual\\_Report\\_Compilation.pdf](http://www.oag.state.md.us/JJMU/reports/2009_Annual_Report_Compilation.pdf).

<sup>57</sup> See Md. State Government Code Ann. § 6-401 (2010).

<sup>58</sup> OFFICE OF THE INDEPENDENT JUVENILE JUSTICE MONITOR, QUARTERLY REPORT JANUARY – MARCH 2005 (2005), Available at: [http://www.oag.state.md.us/JJMU/reports/05\\_Quarter1.PDF](http://www.oag.state.md.us/JJMU/reports/05_Quarter1.PDF).

<sup>59</sup> David Snyder, Fate of Md.'s Juvenile-Justice Monitor Uncertain, WASH. POST, Apr. 9, 2005, available at <http://www.washingtonpost.com/wp-dyn/articles/A38484-2005Apr8.html> (quoting State Senator Brian E. Frosh, then-chairman of the Judicial Proceedings Committee).

### **Connecticut: Office of the Child Advocate**

In 1995, the Connecticut General Assembly established the Office of the Child Advocate (OCA),<sup>60</sup> an independent state agency charged with overseeing the care and protection of Connecticut youth.<sup>61</sup> Unlike the Texas and Maryland programs, the OCA does not work exclusively with youth in the juvenile justice system, but with other systems that serve children and families as well. State law equips the Office with a broad array of tools to carry out its mandate. These include expansive access to records, the power to institute legal proceedings on behalf of youth, and the ability to inspect publicly- and privately-run facilities.<sup>62</sup> The OCA's 3/8/12 advocacy has led to a number of landmark changes for youth in the juvenile justice system, including legislation restricting the improper and excessive use of physical restraints on children in the State's care.<sup>63</sup>

### **Washington, DC: Juvenile Services Program**

The Juvenile Services Program (JSP), currently a branch of the Public Defender Service for the District of Columbia, was formed in 1982 by the City Council in the wake of concerns regarding the treatment of detained and incarcerated youth.<sup>64</sup> JSP has offices within the walls of both of the District's secure juvenile facilities. The Department of Youth Rehabilitation Services,<sup>65</sup> the District's juvenile justice agency, grants JSP staff virtually unrestricted access to youth, allowing JSP to serve as independent eyes and ears within the secure detention and correctional facilities. The Juvenile Services Program relies on two full-time staff attorneys and several law clerks to maintain a regular presence at both locations. JSP staff monitor conditions of confinement, assist youth in filing grievances, represent youth in disciplinary hearings, educate youth about their rights, and engage in other legal and administrative advocacy on behalf of children in the District's secure facilities.

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**Relevant portions of:** The State of Connecticut's Office of the Child Advocate(OCA) Report on Conditions of Confinement for Incarcerated Youth Age 15-21 at Manson Youth Institution(MYI) and York Correctional Institution(YCI), November 2020

**Summary:** The Office of the Child Advocate in Connecticut released a report regarding the conditions of confinement in two youth detention centers, Manson Youth Institution(MYI) and York Correctional Institution(YCI). Included are sections of their analysis on youth confinement

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<sup>60</sup> State of Connecticut, Office of the Child Advocate, Homepage, <http://www.ct.gov/oca/cwp/view.asp?a=1300&q=254830>.

<sup>61</sup> Jones & Cohn, *supra* note 1, at 8

<sup>62</sup> Conn. Gen. Stat. §§ 46a-13l, 46a-13m

<sup>63</sup> Jones & Cohn, *supra* note 1, at 8.

<sup>64</sup> Patricia Puritz & Wendy Wan Long Shang, Innovative Approaches to Juvenile Indigent Defense, OJJDP BULLETIN(December 1998), Available at: <http://www.ncjrs.gov/pdffiles/171151.pdf>.

<sup>65</sup> Department of Youth Rehabilitation Services, Homepage, Available at: <http://dyrs.dc.gov/DC/DYRS/>.

practices in these detention centers, their reporting on the facilities' responses to COVID-19, and their recommendations.

**Read full report here:**

<https://portal.ct.gov/-/media/OCA/OCA-Recent-Publications/OCA-Report-MYIYCI-Nov-2020.pdf>

**Findings: Conditions Following COVID-19 Lockdown (p.56)  
Cell Confinement for Youth Age 15-21**

***DOC Report to JJPOC***

DOC's reports to JJPOC did not include data regarding cell confinement.

***OCA Site visits with Youth age 15 to 17—Findings—Most Youth Experienced Significant Cell Confinement During the Shut-Down***

The DOC halted all in-person programming at MYI between March and August. OCA found that in the absence of school and other structured programming opportunities, youth were confined to their cells much of the day, with hours of cell-confinement for most youth ranging from 19 hours per day to 22.5 hours per day,<sup>66</sup> depending on the day of week and staffing. Youth reported that Saturday was the longest day for them as they come out of their cells only once at 6:30 p.m. Some minor youth at MYI were also out-of-cell when they worked cleaning the unit or passing out food trays. Scheduled out-of-cell time typically involved youth interacting on their hardware secure wing (average population of each wing is approximately nine (9), taking showers, making phone calls, and going outside when weather permitted. Youth were provided masks to use while out-of-cell.

***OCA Site Visits. Youth age 18 to 21—Findings—Older Youth Experienced Prolonged Cell Confinement***

Per staff and youth report, the range of cell-confinement hours for most youth was 22 to 23 hours per day. Youth reported being in-cell throughout most of the day with two opportunities to come out for either a half-hour or a full hour. <sup>60</sup> Certain days of the week youth were permitted out-of-cell three times (morning, afternoon and evening) for 1 to 2 hours; other days youth came out-of-cell twice, and on Saturdays youth came out once. Quarantined youth were isolated 23 hours per day. Some youth ages 18 to 21 in the facility also come out of cell for work hours, most commonly janitorial and food-distribution.<sup>67</sup> Jobs are unit-staff directed and are not tied to youth's educational programs. For work, youth earn at least 75 cents per day.

**DOC Response**

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<sup>66</sup> Certain days of the week youth were permitted out-of-cell three times (morning, afternoon and evening) for 1 to 2 hours; other days youth came out-of-cell twice, and on Saturdays youth came out once. Quarantined youth were isolated 23 hours per day.

<sup>67</sup> Youth request and may be assigned to certain job duties per staff discretion.

In summary, the DOC acknowledged the restriction of movement within its facilities and stated that this was done in accordance with public health guidelines. The DOC wrote that “[a]s more information became available regarding COVID-19, some of the restrictions were reduced and the members of the inmate population were allowed more movement.” The DOC cites its record of success in reducing the spread of infection at MYI.

#### **OCA Recommendations(p.74):**

- **OCA 2019 Recommendation and New Requirements Contained in Connecticut Gen. Stat. §46B-133K:**
  - **Recommendation #2:** The JJPOC should ensure receipt of reports required by § 46b-133k (beginning August 2020) regarding all instances where chemical agents and prone restraints are used in juvenile and correctional facilities with incarcerated youth, instances of suicidal and self-harming behaviors; the uses of force against, and imposing physical isolation on youth; and on all identified educational and mental health concerns.
- **Increase Programming for Youth during the Remainder of COVID-19**
  - **Recommendation #6:** The state should ensure, in consultation with experts in pediatric infectious disease, that state agencies managing youth in congregate care across agencies have appropriate standards for infection control that maximize youth’s access to developmentally appropriate living conditions while ensuring public health precautions are in place. JJPOC should provide oversight for this effort as it pertains to incarcerated youth.
- **Oversight: JJPOC Should Review Standards of Service for Incarcerated Youth**
  - **Recommendation #1:** DOC reports to the JJPOC should include information regarding youth ages 15 to 21 at both MYI and YCI and Conn. Gen. Stat. § 46b-133k should be amended to ensure reporting requirements regarding conditions of confinement extend to youth through age 21.
  - **Recommendation #4:** The JJPOC members should tour the housing units at DOC facilities that confine youth age 15 to 21, including Confined to Quarters Cells, Restrictive Housing Unit cells, and Security Risk Group/Administrative Segregation cells to ensure that all members are familiar with the infrastructure of confinement and programming for youth age 15-21, and that members are able to make determinations and recommendations regarding the adequacy of housing conditions for youth.
  - **Recommendation #5:** JJPOC should review OCA findings regarding cell confinement and segregation and make recommendations for changes to state law needed to ensure that no youth ages 15 to 21 is held in prolonged isolation or in an unclean environment, and that mental health staff are not used to endorse such confinement. Standards for cell confinement should be developed consistent with

those articulated in the Federal First Step Act and/or mental health/developmental best practices.

- **Recommendation #8:** JJPOC should review, in consultation with children's health (including mental health) experts, DOC practices associated with the use of chemical agent, isolation, and in-cell restraints for youth ages 15 to 21. DOC should immediately cease the practice of responding to an individual's suicidal or self-injurious behavior with chemical agent deployment and isolation.



*DC Justice Lab is a team of law and policy experts researching, organizing, and advocating for large-scale changes to the District's criminal legal system. We develop smarter safety solutions that are evidence-driven, community-rooted, and racially just. We aim to fully transform the District's approach to public safety and make the District a national leader in justice reform. [www.dcjusticelab.org](http://www.dcjusticelab.org)*