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COMMONWEALTH of VIRGINIA

Board of Juvenile Justice

MEETING MINUTES

January 8, 2019

Main Street Centre, 600 East Main Street, 12th Floor, South Conference Room
Richmond, Virginia 23219

Board Members Present: Tyren Frazier, Scott Kizner, Quwanisha Roman, Dana Schrad, Robert "Tito" Vilchez, and Jennifer Woolard

Board Members Absent: Michael Herring, David Hines, and Robyn McDougle

Department of Juvenile Justice (Department) Staff Present: Ken Bailey, Andrew "Andy" K. Block, Jr., Valerie Boykin, Patrick Bridge, Carol Brown, John Colligan, Ken Davis, Wendy Hoffman, Joyce Holmon, Joanna Laws, Charisse Mullen (Attorney General's Office), Edward Petersen, Kristen Peterson, Deron Phipps, Lara Todd, James Towey, and Angela Valentine

Guests Present: Marilyn Brown (Chesterfield County Juvenile Detention Center), Kerry Chilton (disAbility Law Center of Virginia), Gina Mingee (Merrimac Center), Cathy Roessler (Blue Ridge Juvenile Detention Center), and Amy Woolard (Legal Aid Justice Center)

CALL TO ORDER

Chairperson Jennifer Woolard called the meeting to order at 9:34 a.m.

INTRODUCTIONS

Chairperson Woolard welcomed all who were present and asked for introductions.

APPROVAL of November 7, 2018, MINUTES

The minutes of the November 7, 2018, Board meeting were provided for approval. On motion duly made by Dana Schrad and seconded by Tyren Frazier, the Board approved the minutes as presented.

PUBLIC COMMENT PERIOD

Amy Woolard, Legal Aid Justice Center, provided public comment on the Board's contemplation of the use of the restraint chair. Ms. Woolard stated that the Legal Aid Justice Center recognizes and acknowledges the complex nature of crisis situations and takes the position that the Board should amend its regulations and policy to prohibit the use of the restraint chair in all facilities under its purview. The Legal Aid Justice Center appreciates and commends the Board for bringing experts to their last meeting and found the presentations by Michael Umpierre of Georgetown and Kelly Dedel from One in 37 to be the most compelling in helping them reach a position.

Ms. Woolard noted that because the chair is so rarely used in Virginia's juvenile detention centers and juvenile correctional center, and because several juvenile detention centers do not have the chair, eliminating its use is feasible. The potential harm to youth physically and in terms of trauma, both acute and ongoing, from the Legal Aid Justice Center's perspective suggest a prohibition on its use. Ms. Woolard reminded the Board of Kelly Dedel's observations, as noted at the previous meeting, that even when staff have good intentions or when regulations require stringent oversight, concerns still arose and procedures sometimes were not followed. Youth were often placed in the chair for too long, less restrictive measures were not used, staff were not engaged with youth, and sometimes it appeared the chair was used punitively.

Ms. Woolard remarked that eliminating the chair would further signal the Department's commitment to a trauma-informed practice focused on the need to address and reduce situations that might lead to consideration of the chair. Ms. Woolard commended the Board for hearing from outside experts, looking at the research, and taking the time to make a thoughtful decision.

Ms. Woolard added that, with respect to Option 4, which deals with the use of the spit guard and other implements, the Board should gather more information.

DIRECTOR'S CERTIFICATION ACTIONS

Ken Bailey, Certification Manager, Department

Included in the Board packet were the individual audit reports and a summary of the Director's certification actions completed on November 28 and December 6, 2018.

The audit for Chesapeake Juvenile Services and Postdispositional Program found four areas of non-compliance. The Chesapeake Juvenile Services and Postdispositional Program demonstrated compliance in all four areas following the monitoring visits, and the program was certified for three years.

The audit for the Lynchburg Youth Group Home found eleven deficiencies. The Lynchburg Youth Group Home combined two old facilities into one modern facility located next to their detention center. Issues arose with the new facility. The Lynchburg Youth Group Home demonstrated compliance in all areas following two subsequent monitoring visits, and the program was certified for three years.

The Andrew B. Ferrari Argus House is a group home that requested to modify its certification in order to better utilize the facility by dividing it into two wings: one for the general population (youth up to age 17) and the other for an independent transitional living program (youth through the age of 20). Director Block agreed to these program modifications, and the certificate was changed to reflect this request. The girl's group home in Falls Church recently requested and received approval for a similar change.

The initial audit for the new Summit Transitional Living Program in Chesterfield County reviewed the physical environment, policies and procedures, and forms. The facility is a transitional living program for male youth discharged from the Department and ranging from ages 17½ to 21. The Department found the program fully compliant with the regulations. The Certification Team will return in April for another phase of the audit, which will review program implementation, service planning, treatment effort, and medical care. The facility was given a conditional certification valid until June 7, 2019.

REQUEST AUTHORIZATION TO PROCEED WITH RECOMMENDATIONS TO AMEND SEVERAL REGULATORY CHAPTERS PURSUANT TO THE PERIODIC REVIEW PROCESS

Kristen Peterson, Regulatory and Policy Coordinator, Department

State agencies are required to conduct a periodic review of their regulations every four years to determine whether the regulations need to be amended, retained, or repealed. Of the agency's 12 regulatory chapters, five chapters are past due for conducting the periodic review, which has prompted the Department to embark on an aggressive effort to bring the Department into compliance with the statutory requirement set out in § 2.2-4007.1 of the *Code of Virginia*.

The periodic review process involves filing notice regarding a particular regulation through the Virginia Regulatory Town Hall and the Virginia Register of Regulations, which prompts a 21-day public comment period on the regulation. State agencies have 120 days from the close of public comment to complete a report that makes recommendations as to whether to amend, retain, or repeal the regulation. The Department filed notices for four of the regulatory chapters for which the reports will come due before the next Board meeting and is requesting the Board to approve the recommendations to amend these four regulatory chapters.

State agencies need to consider the following when conducting periodic reviews:

- The continued need for the rule and whether there are statutes in place requiring the regulation;
- The types of complaints received from the public regarding the regulation as it currently exists;
- The complexity of the regulation. The Governor's Executive Order regarding regulations requires regulations to be simple and easy to understand;
- The extent to which the regulation overlaps with federal or state laws; and
- The time that has passed since the agency last reviewed the regulation.

Ms. Peterson then highlighted the four chapters currently under periodic review.

Regulations Governing State Reimbursement (6VAC35-30)
The Department last reviewed this chapter in 2011. This chapter sets the regulatory framework for localities conducting construction or enlargement projects for which, under state code, they are entitled to obtain state reimbursement for 50% of the construction costs. For example, at a previous meeting, Prince William County presented the Board with a needs assessment for a proposed new facility.

Current law requires the Board to have regulations that establish criteria for evaluating state reimbursement requests; however, the reimbursement mechanism currently is frozen. A legislative moratorium prevents the Board from approving this reimbursement.

In its Periodic Review Report, the Department plans to recommend amending the regulation to address several concerns, including, for example, a concern that at least one existing provision may exceed the scope of the Board's authority by requiring localities that are not seeking reimbursement now or in the future to comply with every requirement in this chapter.

Minimum Standards for Virginia Delinquency Prevention (6VAC35-60)
The Department reviewed this chapter in 2011. These regulations set out the requirements for grant recipients pursuant to the Delinquency Prevention Act. The Director, under existing law, is required to develop programs and services for delinquency prevention and is authorized to provide grants to localities to develop these types of programs. Much like the state reimbursement regulation, grant funding has not been available for several years (since 2002). The Department cannot recommend repealing these regulations because an existing statute requires the Board to have these regulations in place.

The Department hopes to recommend in its report that this chapter be amended. A number of provisions in the regulation are outdated, and some of its provisions will be impacted by amendments to other regulations.

Regulations for Nonresidential Services (6VAC35-150)
These regulations govern the court service units as well as programs authorized by the Virginia Juvenile Community Crime Control Act (VJCCCA). There are a number of outdated provisions in this regulatory chapter, such as reference to the Department's Reception and Diagnostic Center, which closed in 2015. In addition, as part of the Periodic Review process, the disAbility Law Center of Virginia submitted comments asking the Department to review the provision related to restraints. Given these concerns, the Department hopes to recommend amending the regulation in the required report.

Regulations Governing Mental Health Service Transition Plans (6VAC35-180)

This regulation was last reviewed in 2008 and addresses the mental health programs developed for residents transitioning out of commitment to the Department. The disAbility Law Center of Virginia submitted public comment asking the Department to amend provisions related to who can be involved in case planning. Given these comments and the time that has passed since the last review, the Department would like to recommend amending the regulation in the required report.

Ms. Peterson clarified that the Department is not asking the Board to change the content of the regulations at this time. Rather, the Department seeks the Board's permission to proceed with making the recommendations to amend the four regulations in the report that must be submitted within 120 days.

Board Member Kizner asked whether the General Assembly's actions this session would affect any of these regulations.

Ms. Peterson responded that changes during the 2018 legislative session regarding truancy will necessitate changes to the court service unit regulation and that several bills introduced this session may impact juvenile justice.

The Department's Legislative Liaison James Towey noted one bill could potentially affect the Virginia Delinquency Prevention Act, which has not been funded since 2002. If that bill moves forward, presumably and hopefully, there will be funding attached. Bills are still being introduced, and some may impact the regulatory process.

Board Member Schrad noted her understanding of the Department's need to revise and update these regulations in case they are funded. The regulation is an empty vessel but cannot be omitted because of the potential for funding. Ms. Peterson answered that she was correct.

Director Block clarified that the Department is not asking the Board to make specific changes to the regulations. The Department is simply asking for authority to proceed with the regulatory process.

Ms. Peterson noted that if the Board approved the request, the Department would proceed with amending the four regulatory chapters by following the normal regulatory process. The Department would gather a group of internal and external stakeholders, conduct a review of the regulation, determine if the chapter should proceed with the standard regulatory process or a more expedited process, and then present the amendments to the Board.

On motion duly made by Dana Schrad and seconded by Tyren Frazier, the Board of Juvenile Justice granted the Department of Juvenile Justice permission to recommend in the report required as part of the periodic review process mandated by § 2.2-4007.1 of the *Code of Virginia* that the following regulatory chapters be amended: (i) Regulations Governing State Reimbursement of Local Juvenile Residential Facility Costs (6VAC35-30); (ii) Minimum Standards for Virginia Delinquency Prevention and Youth Development Act Grant Programs (6VAC35-60); (iii) Regulation for

Nonresidential Services (6VAC35-150); and (iv) Regulations Governing Mental Health Service Transition Plans for Incarcerated Juveniles (6VAC35-180).

REQUEST BOARD ACTION ON FOUR ALTERNATIVES FOR AMENDMENTS TO THE REGULATIONS GOVERNING JUVENILE SECURE DETENTION CENTERS (6VAC35-101) REGARDING MECHANICAL RESTRAINTS AND RESTRAINT CHAIRS

Kristen Peterson, Policy and Regulatory Coordinator, Department

Director Block introduced the mechanical restraint and restraint chair discussion.

At the September Board meeting, the Department discussed the litigation with Shenandoah Valley Juvenile Center and the subsequent investigative report. He reminded the Board that they adopted regulatory changes, currently in the fast track process, to help the Department address an oversight for youth at local detention centers involved in third party contracts, specifically with the Office of Refugee Resettlement. In addition, the Director noted concerns on the use of the restraint chair in Department-regulated facilities. He then summarized a presentation that was offered by a panel of experts at the November board meeting, providing a variety of perspectives on the use of the chair.

- Jason Houtz and Cathy Roessler, Virginia Juvenile Detention Association representatives, noted that some local juvenile detention centers have the chair, others do not, and some have the chair but do not use it. In their view, chair use is rare and necessary as a last resort to address youth whose behavior, often related to mental health issues, cannot be controlled. Many local juvenile detention centers believe that the chair is safer than a hands-on restraint for youth and staff.
- Dr. Jaime Bamford, Medical Director of the Commonwealth Center for Children and Adolescents, which is the only state-operated mental health facility for youth in crisis, explained that the Commonwealth Center began using the chair because staff believed the chair was less traumatic than the alternatives and safer given that youth do not have bodies on top of them during a chair restraint. During a chair restraint, staff can talk with the young person. Dr. Bamford explained the Center's frequent use of the chair, primarily for clinical and safety reasons.
- Michael Umpierre, the Center for Juvenile Justice Reform at Georgetown, gave a summary of the use of the mechanical restraint chair nationally and described the chair as being used infrequently around the country. Mr. Umpierre detailed the various professional standards regarding the chair. The Annie E. Casey Foundation discourages the use of fixed restraints like the chair, and the American Correctional Association permits it only under certain conditions. Mr. Umpierre stressed that there are better ways to work with youth and recommended that the Board prohibit the use of the chair in state and local facilities.
- Dr. Kelly Dedel, One in 37 Research, who often consults with the Justice Department or federal courts to help state and local facilities cited for overuse of the chair, observed that there could be trauma for youth restrained in chairs or in a physical restraint. While fewer staff are needed once the resident is restrained in the chair, there is a potential for misuse because the chair does not necessitate the same level of staff involvement as a multiple person

physical restraint once the resident is restrained. Dr. Dedel discussed conditions she thought should be in place if the Board permitted the use of the chair and offered that if the chair is used properly, it is not necessarily any more or less traumatic than a prolonged physical restraint.

Director Block acknowledged the difficult decision before the Board and the challenges for staff who must respond to troubled youth acting in extremely troubled ways. He noted that between choosing a prolonged physical restraint or the chair, there is no clear win. He then asked Ms. Peterson to present several regulatory options for the Board's consideration to address mechanical restraints.

Ms. Peterson detailed the options regarding mechanical restraints and the use of the restraint chair.

- **Option One** maintains all of the amendments to the regulation governing juvenile detention centers that were approved by the Board at the June 13, 2018, meeting.
- **Option Two** sets out additional parameters on the use of mechanical restraints, specifically the use of the restraint chair. Option Two incorporates some of the recommendations made by Dr. Dedel.
- **Option Three** imposes an absolute prohibition on the use of the restraint chair but retains many of the other provisions in Option Two.
- **Option Four** prohibits the use of the spit guard and similar protective devices used to prevent residents from spitting or biting staff and retains all other provisions in Option Two.

The Department convened a workgroup of internal and external stakeholders to craft the proposed language contained in these options that will address all the needs of the staff as well as the residents.

For purposes of efficiency, the Department thought it best to present the Board with proposed amendments to the mechanical restraint provisions in the Regulations Governing Juvenile Detention Centers. Depending upon the decision of the Board, those provisions will be incorporated into the juvenile correctional center regulation after that regulation completes the public comment period. The juvenile correctional center regulation is currently moving through the regulatory process and has been in the Governor's Office for 100 days.

OPTION 1 – AMENDMENTS APPROVED BY BOARD JUNE 2018

6VAC35-101-10 Definitions. The definition for mechanical restraint includes a reference to the mechanical restraint chair; thus, whenever mechanical restraints are referenced in the regulation, any restrictions that are applicable to mechanical restraints also will apply to the restraint chair under the approved provision. Option 1 does not address the use of spit guards or protective devices in the mechanical restraints definition or elsewhere in the regulation.

6VAC35-101-190 Required initial training; 6VAC35-101-200 Retraining requirements for employees. Sections 190 and 200 address training requirements for direct care staff authorized to use restraints (including mechanical restraints). Subsection C of Section 190 requires employees

authorized to restrain a resident to be trained in those techniques within 90 days of this authorization.

Subsection E of Section 200 requires staff who are approved to apply mechanical restraints to be retrained annually.

6VAC35-101-1130 Mechanical restraints. This section requires the facility administrator to approve written procedures related to mechanical restraints.

In Subdivision (A)(4), one of the requirements the detention centers added was to allow residents to be restrained to a hospital bed or wheelchair in an outside medical setting. This will protect staff in non-secure settings and ensure residents are not a flight risk.

Subsection B requires staff authorized to restrain residents to receive the mandated initial and annual training, which must address how to check the resident's circulation and check for injuries.

6VAC35-101-1140 Monitoring restrained residents. Under Subdivision (A)(2), staff must make a face-to-face check on the resident at least once every 15 minutes, and more often depending on the resident's behavior.

Subsection C provides that if the resident, while mechanically restrained, self-injures, staff must first do whatever is necessary to stabilize the situation, then must immediately consult with a qualified mental health professional and document that consultation. Staff must monitor the resident in accordance with the protocols in place.

6VAC35-101-1150 Restraints for medical and mental health purposes. This provision requires detention centers to have written procedures governing the use of restraints for mental health and medical purposes, and the written procedures must meet certain requirements.

OPTION 2 – NEW PARAMETERS ON MECHANICAL RESTRAINTS AND THE MECHANICAL RESTRAINT CHAIR

6VAC35-101-10. Definitions. A separate article established under Option Two addresses mechanical restraint chair use solely and details specific provisions related to its use.

The committee identified a weakness in the existing definition for mechanical restraints. The definition presents an all-inclusive list of items considered mechanical restraints. If facilities utilize a different restraint mechanism not named in the all-inclusive list, the facility would not need to comply with the mechanical restraint requirements for that particular restraint. Language was added to indicate that the list of items identified as mechanical restraints is not all-inclusive.

A new definition for mechanical restraint chair was added along with two definitions regarding mental health professionals. With respect to the use of the restraints and restraint chair, there is

often a requirement that mental health staff be consulted or provide approval prior to use. Mental health professionals are referenced in the existing regulation, but the language does not specify who is included in that reference. The committee added a definition for "qualified mental health professional" consistent with the definition in Title 54.1 of the *Code of Virginia*. Under the definition, a qualified mental health professional must be registered by the Board of Counseling and provide collaborative mental health services to adults and children. Most local juvenile detention centers do not have in-house mental health or behavioral services units like the Department's. Local juvenile detention centers rely on their local community service boards to conduct medical assessments on their residents. Many individuals who conduct the medical assessments satisfy the requirements of the qualified mental health professional definition but are not mental health clinicians under the proposed definition. The individuals may not have a master's degree in topics set out in the definition of mental health clinician. For that purpose, a definition was added for both qualified mental health professional and mental health clinician. Most staff in the Behavioral Services Unit at the Department must have a master's degree in those subjects in order to work in the unit.

Additionally, the existing definition for mechanical restraint does not address spit guards, protective helmets, or other similar devices. The committee believed it did not make sense to include spit guards and protective devices in the definition of mechanical restraint because they do not restrict an individual's movements. Rather, they protect or prevent the individual's movement from impacting another person. For example, the youth can manipulate their mouths and tongue to express saliva, so their movement is not being restricted. Instead, the spit guard is intended to protect staff from being spit on. This equipment serves a protective function rather than an actual restraint function. The committee recommended adding a separate category of devices called protective devices under which these spit guards and protective helmets will fall. Devices are referred to as spit hoods and spit masks, but all of them serve the same purpose of covering the resident's mouth and preventing him from spitting on or biting staff members.

6VAC35-101-80 Serious incident reports. Facilities are required to complete serious incident reports when certain incidents occur in their facility. For example, if there is a death, fire, or other emergency in local juvenile detention centers that warrants a serious incident report, the facility staff must complete a report and notify the Director of the Department within 24 hours of the incident's occurrence. Under the existing regulation, use of the restraint chair does not constitute a serious incident. It was recommended to expand the list of serious incidents to include any instance in which a resident is placed in a restraint chair, no matter the purpose or duration, such that all such placements will trigger a requirement to complete a serious incident report and comply with all other provisions in Section 80.

6VAC35-101-190 Required initial training for employees and 6VAC35-101-200 Retraining requirements for employees. The committee expanded these sections to create an additional category for protective equipment and to require individuals authorized to use such equipment to be trained in that use. The language in Sections 190 and 200 was changed to reflect these expansions.

Article III – Mechanical Restraints and Protective Devices

6VAC35-101-1130 Mechanical restraints and protective devices. For simplification purposes, the regulation is divided into separate articles: 1) mechanical restraints and protective devices and 2) mechanical restraint chairs.

The current wording of the regulation allows for use of a mechanical restraint for any purpose other than punishment or sanction. The committee recommended additional restrictions on the use of mechanical restraints. Under the amendments, the facilities may use mechanical restraints for three purposes: 1) to control residents whose behavior poses an imminent risk to the safety of the resident, staff, or others; 2) for purposes of controlled movement, either from one area of the facility to another or to destinations outside the facility; or 3) to address emergency situations. The regulation provides a definition for an emergency and lists emergencies such as fires, natural disasters, hostage situations, etc. In those rare incidents, staff may use the mechanical restraint.

Subdivision B(1) speaks to the duration of mechanical restraint use. The mechanical restraint may be used only for as long as necessary to address any of the three situations identified in the above paragraph. For example, if a resident is placed in a restraint chair because his behavior poses an imminent risk to the safety of himself or others, he must be removed from the mechanical restraint as soon as the imminent risk is abated. If the resident is placed in a mechanical restraint for purposes of controlled movement, once the resident reaches his intended destination on or off campus, then the restraints must be removed. If the restraint is used for emergency situations, once the emergency is resolved or addressed, the restraints must be removed.

Subdivision (B)(2) requires that the facility administrator or designee be notified in emergency situations when mechanical restraints are used, but there is no requirement that either individual approve the use of the mechanical restraint.

Subdivision (B)(3) is language already in the regulation but has been expanded to include protective devices. The protective devices and mechanical restraints may not be used for punishment or as a sanction. This is consistent with federal constitutional provisions.

Subdivision (B)(5) speaks to who can order termination of the restraints. The existing regulation does not allow staff to voice a concern regarding the use of a particular restraint. Language was added that gives a mental health clinician, a qualified mental health professional, or another qualified licensed medical professional the authority to order termination of the restraint at any point upon determining the restraint poses a health risk to the resident.

Subdivision (B)(6) addresses documentation and requires each use of the mechanical restraint device or protective device, except during transport or a video court hearing proceeding, to be reported in the resident's case file or central logbook.

Subdivision (B)(7) is also in Option One. The detention center must have a system of accountability to determine where mechanical restraint equipment is at any given time.

Subdivision (B)(8) cross-references the earlier Sections 190 and 200. The training for staff authorized to apply restraints must cover how to check residents for signs of circulation and injuries. Health services staff raised a concern that it might be inappropriate for staff to check the resident for signs of circulation or injury if they are not health-trained. The amendments strike this requirement and instead require that any time a resident is mechanically restrained and staff conduct their fifteen-minute checks, a health-trained staff member should check the resident for signs of circulation.

Subsection B [*sic*] deals with continued use of a mechanical restraint on a resident after the imminent risk is abated. In situations when a resident is mechanically restrained, such as when a resident is extremely aggressive and de-escalates but still poses some level of threat either to others or to himself, the facility may believe continued restraint is necessary. Language was added to provide that in such situations, if the facility wishes to continue with the restraint, staff first must consult with a qualified mental health professional or mental health clinician.

Subsections C and D [*sic*] address protective devices. Subsection C permits the use of a protective device only in connection with a restraint. The idea behind this restriction is to ensure protected devices will be used sparingly and only in connection with a restraint.

Subsection D [*sic*] involves the use of spit guards and was added to address concerns of staff being spat on and communicable diseases that may be transmitted as a result. The committee recommended that if provisions are established permitting the use of spit guards, those spit guards should be used sparingly, and in a manner to ensure the protection of staff and residents. Language was added in Subsection D to restrict the use of spit guards to residents who have spit on staff previously or are threatening to spit on staff during the course of a current restraint. Detention centers would not be permitted to use spit guards as a preventive cure-all for all restrained residents.

Subdivision (D)(2)[*sic*] requires the spit guard or similar device be designed and applied in a manner that will not inhibit the resident's ability to see or breathe. The workgroup wanted to ensure that if there was any respiratory distress or other impediment to breathing, the spit guard may not be used. If the device is manufactured in a way that prevents the resident from breathing, this provision will prohibit the facility from using that type of device.

While the spit guard remains in place, staff must ensure the resident's reasonable comfort and access to water and meals as applicable. When the spit guard is in place, staff must employ constant one-on-one supervision with the resident to ensure the resident is not experiencing any respiratory distress. Additionally, if the resident is vomiting, unconscious, or in obvious need of medical attention, the facility would be prohibited from using the spit guard.

<u>6VAC35-101-1140 Monitoring residents placed in mechanical restraints.</u> The current regulation requires staff to conduct face-to-face checks every fifteen minutes on mechanically restrained

residents. During Dr. Dedel's presentation on the restraint chair, she indicated that engaging mechanically restrained residents can often contribute to de-escalation. Thus, the committee recommended adding language directing staff, when conducting fifteen-minute checks of mechanically-restrained residents, to attempt to verbally engage with the resident. These efforts may include, for example, explaining why the resident is being mechanically restrained and what steps are necessary for the mechanical restraint device to be removed.

The workgroup recommended adding language mandating that health-trained staff conduct their checks to monitor the resident's circulation and to ensure he is not sustaining injuries. This will be part of the required fifteen-minute checks.

Ms. Peterson also pointed out the definition in the regulation for health-trained staff, which is a staff member who has been trained by a licensed healthcare provider to provide certain services, and screenings and to respond to medical requests by residents.

The committee also added language to reflect a recommendation of the National Commission on Correctional Healthcare that if a resident is restrained for more than an hour, staff must permit the resident to exercise his limbs for a minimum of 10 minutes every two hours.

In the interest of time, Director Block asked the Board whether they wanted a detailed discussion of the remaining changes or a summary of key provisions. The Board was comfortable with a summary. Ms. Peterson continued with an abbreviated presentation.

ARTICLE IV – MECHANICAL RESTRAINT CHAIRS

This section addresses the use of the mechanical restraint chair for controlled movement, for other purposes, and generally.

This article is different from that of mechanical restraints in that the facility administrator must provide approval for the restraint chair to be used. Once the resident is placed in the restraint chair, staff must notify the health authority who makes a determination as to whether there are any contraindications or other reasons why the resident should not be in the restraint chair. The health authority can also determine if other accommodations should be made, and if the resident's mental health or medical condition is such that they require transfer out of the detention center and into a medical or mental health unit.

Several sections cover self-injurious residents and use the same language as the mechanical restraint provisions.

The documentation provision still requires documentation when a resident is placed in a mechanical restraint chair, documented in either the resident's case record or logbook, and providing all the information set out in number 8. Based on Dr. Dedel's advice regarding the usefulness of a "Monday Morning Quarterback session," the detention centers will be required to conduct a debriefing if they used the restraint chair in order to determine if things could have been done differently.

6VAC35-101-1155 Mechanical restraint chair use for controlled movement; conditions. In order to use the mechanical restraint chair for controlled movement, the resident's refusal to move from one area of the facility to another must pose a direct and immediate threat to the resident and others and interfere with required facility operations. For example, a resident has grown belligerent, placed himself in one of the classrooms, and refused to move while the class is trying to start. The use of the restraint chair must be the least restrictive intervention available to ensure the resident's safe movement.

6VAC35-101-1156 Mechanical restraint chair use for purposes other than controlled movement; conditions for use. In order to utilize the restraint chair for purposes other than controlled movement, the resident's behavior or actions must present a direct and immediate threat to the resident or others; less restrictive alternatives must be attempted first and must be unsuccessful in bringing the resident under control; and the resident may remain in the chair only for as long as necessary to abate the threat or help the resident regain self-control.

When the restraint chair is used for controlled movement or other purposes, once that purpose is accomplished, staff must make efforts to release the resident from the restraint. If the imminent risk was addressed but there are still threats, and staff want to continue use of the restraint chair, they must consult a qualified mental health professional or mental health clinician for approval for the continued restraint.

6VAC35-101-1157 Monitoring residents placed in a mechanical restraint chair. Subsection B adds a requirement that every use of the mechanical restraint chair be videotaped. If placement in the chair is for purposes of controlled movement, only the actual placement must be videotaped because logistically, it may be difficult to fully capture the actual transportation of the resident from one area of the facility to another. If a resident is restrained in the chair for purposes other than controlled movement, the entire restraint must be captured on video from the time the resident is placed in the restraint chair until they are removed.

6VAC35-101-1158 Department monitoring visits. This section adds a requirement that any use of the restraint chair, regardless of the duration or purpose of the use, will automatically trigger a monitoring visit by the Department's Certification Unit. Typically, under the existing regulation, the Certification Unit will conduct one monitoring visit annually, although they may conduct more if requested. This new provision will trigger a monitoring visit for every use of the restraint chair.

Most of the facilities would agree that the monitoring visit serves a dual capacity: (1) to determine whether the facility complies with the regulations; and (2) to provide an opportunity for education.

At the close of the presentation regarding Options 1 and 2 for amendments to the *Regulation Governing Juvenile Secure Detention Centers*, the Board discussed the proposed amendments.

Chairperson Woolard noted Subsection B on page 87 of the Board packet, which allows a youth to remain in a restraint or restraint chair even if the imminent risk to safety has abated if there are indications or threats that something else may occur. Chairperson Woolard raised concerns regarding the capacity to keep a youth in the restraint chair even though the reason they are put in the chair is resolved and asked for the rationale and justification for this provision.

Cathy Roessler (Superintendent, Blue Ridge Juvenile Detention Center) provided an example of a resident with an established history of following through on threats from jumping off his bunk, to banging his head, to assaulting staff or others. In these cases, the resident would be placed in the restraint chair with staff trying to obtain compliance from him during the process. Each sign of compliance with staff would eventually lead to the resident's release from the restraint. If the resident is continuing with the threats to others or himself and has an established history of following through, staff might wait until there is more compliance from the resident before they release him from the restraint. Youth who engage with staff face-to-face and begin to de-escalate and comply with staff could be released from the restraint limb by limb until the resident is fully released.

Chairperson Woolard asked about partial release from the chair.

Ms. Roessler described instances in which staff would release one arm to allow the resident to drink or eat and the resident then spits their food at staff or throws water in their face. Gaining more compliance from the resident is a sign the resident is gaining control.

Board Member Schrad said that there might be legal limitations to the word "imminent," which communicates a sense of immediate urgency. De-escalation still has to occur. After the imminent risk is removed, immediately and completely removing the resident from the chair might risk them escalating again.

Board Member Kizner asked if the resident would be placed back in the chair if he escalated greatly.

Ms. Roessler responded that typically, if staff are at the point of using the mechanical restraint chair, the resident already has escalated. Anytime you restrain an individual, this contributes to further escalation, which is why staff are in that situation in the first place.

Board Member Kizner asked whether staff is accelerating escalation by using the chair and then hoping the resident will de-escalate eventually.

Ms. Roessler answered this tends to depend upon the case and the resident. Some residents feel more secure if they are physically restrained and may calm down immediately once staff physically intervene. Other residents amp up even more because of the trauma they have experienced. Staff remain responsible for ensuring the resident and everyone around him remains uninjured.

Gina Mingee (Superintendent, Merrimac Center) noted her observations that some youth want to fight and hurt staff, but once they are in the restraint chair, they can no longer continue that behavior. It de-escalates them and they are incapable of fighting. Residents want to be released, and staff go through the gradual release process to gain their trust.

Chairperson Woolard read from Subsection B on page 87 of the Board packet, which provides in part, "the facility determines that continued use of the mechanical restraint is necessary to maintain security due to the resident's ongoing credible threat to injure himself or others". She asked why, if the issue involves personnel and staff safety, it is described as "maintaining security."

Ms. Roessler answered that all her staff respond to the situation when they decide to use mechanical restraints or the chair. Blue Ridge Juvenile Detention Center has four living units and residents primarily are out of their rooms and in the main living unit. When an emergency arises, staff ensure all residents are locked in their rooms and then respond to the emergency. Depending on levels of staffing, other issues such as intake and normal operations may be suspended while staff focuses on the restrained resident.

Chairperson Woolard read Subsection C on page 87 of the Board packet, which provides, "a detention center may not use a protective device unless such use is in connection with a restraint and shall remove the device ***when the resident is released from the restraint***." She asked whether this provision would prevent staff from removing the device before the resident is released from the restraint.

Ms. Peterson offered up the following proposed amendment, "and shall remove the device ***on or before the resident is released from the restraint***." Chairperson Woolard agreed with the language.

Chairperson Woolard asked for an explanation for the face-to-face conversation and constant supervision requirement with residents while in the chair and asked Ms. Peterson to elaborate on why checks are required only every fifteen-minutes for other kinds of restraints.

Ms. Peterson responded that there is a heightened need for additional scrutiny when the restraint chair is used, which explains the need for the constant one-on-one supervision.

Chairwoman Woolard asked to hear more about the exception in Subsection C on page 88 that requires consultation with the healthcare provider or qualified mental health professional or clinician when a resident is in restraints for more than two hours cumulatively in a 24-hour period with the exception of use in routine transportation of residents.

Ms. Peterson explained that this provision has been in existence for some time. When transporting residents, specifically off campus for long distances, these requirements may not always be feasible logistically.

Board Member Kizner asked about the decision process to move a resident from a mechanical restraint to the mechanical restraint chair.

Ms. Roessler provided an example where two residents are fighting and staff physically intervene. Staff first verbally direct the residents to stop and then intervene physically. At that point, both residents may be physically restrained. One resident might stop resisting, follow staff instructions, and leave the area. The other resident might continue to fight with staff, and handcuffs and leg irons might be used to restrict movement. The fight continues to escalate and the resident starts banging his head against the wall and is at risk of significant injury. Staff considers using the mechanical restraint chair. Staff would physically restrain the resident while in mechanical restraints to prevent him from hitting his head on the wall.

Board Member Schrad noted that even in this scenario, the attempt to protect the resident from a head injury could lead to a staff member breaking their hand.

Ms. Roessler added staff have been head-butted, bitten, spat on, and needed stitches due to their close proximity to the resident when performing a physical restraint.

Deputy Director for Residential Services Joyce Holmon added that many of the alternatives described in the discussion already have been tried before the resident is placed in the restraint chair in the juvenile correctional center. Ms. Holmon indicated that in her time with the Department, a resident has never gone from a standing position directly into the chair. The least restrictive measures are applied first, and if the resident's behavior escalates, something else needs to be done. Generally, by the time the chair is an option, staff have already been hurt.

Director Block reminded the Board that it rarely reaches this level, and when it does, often it is with extreme, troubled young people in an extreme situation. The Department has not used the restraint chair in three years. In large part, all other means are deployed first and usually are sufficient to address the problem.

Board Member Frazier asked if all the detention centers attending the meeting have the restraint chair. All three detention centers in attendance (Merrimac Center, Chesterfield County, and Blue Ridge) responded that they have a restraint chair; however, Chesterfield County does not use it.

Chairperson Woolard asked what facilities that do not have the chair do.

Ms. Marilyn Brown (Superintendent, Chesterfield County Detention Center) said when she came to the facility, (Chesterfield County) they did not use a restraint chair. Ms. Brown shared a story about a recent team restraint for a young female resident. The staff engaged in a physical team restraint for six or seven hours on this resident before finally transitioning to handcuffs. During this restraint, all other residents were locked down. Ms. Brown explained that her facility tries not to use any mechanical restraint, but the female resident continued to bang her head on the wall. Ms. Brown commented that she is still unsure where she stands on this issue because she is not sure the physical

restraint was the best approach for the female resident or staff. After the incident, several staff quit. Ms. Brown thought the chair may have been the better option, and understands her colleagues' use as an alternative to that situation. The female resident had nothing to be hopeful for and was bound and determined to hurt herself.

Chairperson Woolard remarked that the mental health professional can make a determination to terminate the use of the restraint chair if it is a health risk and asked whether health risk includes mental health risks. Ms. Peterson responded that was correct.

Chairperson Woolard pointed out page 91, Section 1156(A)(1), which provides, in part, "the resident's behavior or actions present a direct and immediate threat to the resident or others." Chairperson Woolard asked whether this means a personal safety threat. Ms. Peterson responded that the provision refers to a direct threat to the resident or other personnel and asked whether the Board wanted to add clarifying language to that effect. The Board agreed that clarifying language would be helpful.

Chairperson Woolard asked about subdivision (A)(3) of that section, which requires the resident to remain in the restraint chair only for as long as necessary to abate the threat or help the resident gain self-control as a condition for use of the restraint chair for purposes other than controlled movement. Chairperson Woolard asked the difference between "abat(ing) the threat and help(ing) the resident regain self-control."

Ms. Brown explained that the workgroup had many discussions on the reasons residents are placed in the chair. It could be because they threaten to injure themselves or others. Ms. Brown speculated that subdivision (A)(3) was trying to distinguish between the two situations. The resident is no longer actively trying to hurt himself verses the resident regaining self-control.

Ms. Peterson said the language, "help the resident gain self-control" was likely extraneous language. Ms. Roessler added that once the resident gains self-control, the threat is abated.

Chairperson Woolard and Board Member Schrad indicated their belief that the threat is the driving issue. Ms. Peterson suggested amending the language to read, "the resident remains in the restraint chair only as long as necessary to abate the threat to the resident or to others," and striking the extraneous language afterwards.

Chairperson Woolard read Section C, which provides, "the detention center shall be excused from the requirements in subsections A and B of this section when the restraint chair is requested by a resident for whom such voluntary use is part of an approved plan of care by a qualified mental health professional or mental health clinician." Chairperson Woolard asked whether qualified mental health professionals and clinicians are trained in how chair restraints work and if it is reasonable for the health professional to accede to a resident's request to be placed in the restraint chair. If so, she asked, what parameters would be in their treatment plan?

Ms. Peterson said a resident in one of the detention centers in the work group voluntarily requested placement in a restraint chair as a self-regulation tool, but that this is a rare occurrence. Facility staff are encouraged, if a resident voluntarily requests placement in the restraint chair, to allow that to take place. Ms. Peterson was not certain what that entails as far as their mental health plan and what is involved.

Ms. Roessler said she cannot speak specifically to the details of the treatment plan in terms of length of time and under what circumstances the chair can be requested since this happened in another facility. According to the Superintendent of that facility, the resident who voluntarily sat in the restraint chair was actively trying to calm herself during a situation and requested to sit in the chair. This helped her self-sooth, maintain her composure, and not escalate.

Deputy Director Holmon noted that the clinician from the Commonwealth Center referenced those occasions as well, where young people asked to be placed in the restraint chair.

Board Member Schrad asked if it was part of the resident's approved mental health treatment plan and whether it might be considered an extreme measure toward mental health treatment. She asked for ways to monitor and document this practice as part of the mental health plan?

Ms. Roessler responded that if a resident voluntarily requests to be placed in the chair, facilities would still need to follow the regulations except the reporting part since the treatment plan has been approved by a mental health clinician.

Director Block suggested adding the word "written" before "approved" in Subsection C to read, "written approved plan of care," to ensure this approach is documented and placed in the resident's file.

Board Member Schrad noted her concern that this could be a tool the mental health provider uses as an option without the resident necessarily requesting it, and her desire to ensure that this option would be used only when the resident initiates a request to be placed in the restraint chair as part of their treatment.

Ms. Mingee responded that typically, when a mental health treatment plan is written, the resident must sign the document and agree to the treatment plan, which includes interventions and objectives. Ms. Roessler also pointed out that Subsection C uses the word "voluntary".

Chairperson Woolard expressed concerns with how the resident gets out of the chair after voluntarily requesting placement. She asked, as an example, if the resident settles down and asked to be removed two minutes after having voluntarily been placed in the chair, whether the staff will release the resident?

Multiple people addressed this question affirmatively, explaining that the resident would be released because he voluntarily put himself in the chair. Ms. Roessler said it would be specific to each

resident, depending upon the circumstances. Board Member Schrad stated it would no longer be voluntary if the resident was held in the chair.

Ms. Brown shared a story of a resident in her detention center who moved back and forth to the Commonwealth Center, where voluntary use of the restraint chair is employed frequently as part of a resident's mental health plan. Because very few youth request placement in the chair at the Chesterfield Detention Center and because the resident kept asking to be placed in the chair, staff talked with the Commonwealth Center to see how it was used at that facility. Detention center staff had to tell the resident that it was not an available option, so what else could staff do to help?

Board Member Kizner noted his discomfort with a resident requesting placement in the chair, adding that if residents are telling staff they need to calm down, then it is the Board's challenge to find another alternative to help them calm down. Board Member Kizner asserted that voluntarily putting a resident in the same restraint chair used by residents who are completely out of control is not a healthy alternative.

Board Member Frazier agreed that the voluntary use of the restraint chair by residents should be prohibited.

Board Member Schrad indicated that such voluntary use seems inconsistent with the purpose of this particular section, which has more to do with necessary restraint of youth trying to be brought under control. It might be better to revisit and bring in mental health professionals to discuss.

Ms. Roessler acknowledged that voluntary restraint chair use is unusual. Detention centers receive residents with mental health issues, and the facility might not be fully equipped to deal with their issues. Staff tries to use what works for residents and accommodate the residents as much as possible with what is available.

Board Member Schrad sympathized but stated her belief that this issue might be better addressed in another regulatory area as these provisions pertain to restraint in the case of someone out of control and possibly harming himself or others.

Board Member Frazier said he would rather restrict the voluntary use of the chair. If a resident self-selects, it should not be an option.

Ms. Peterson noted that by deleting the provision, facilities would be prohibited from allowing residents to voluntarily be placed in the chair because of the parameters set out in Section 1156. The Board agreed.

This ended the question and answer period on Options 1 and 2 for amendments to the *Regulation Governing Juvenile Secure Detention Centers*. Ms. Peterson next reviewed Options 3 and 4.

OPTION 3, PROHIBITION ON RESTRAINT CHAIRS

Ms. Peterson explained that this option retains all the provisions that were part of Option 2 but removes all the provisions related to the mechanical restraint chair. Article 4 is removed in its entirety, and a section is added on page 99 of the Board packet, 6VAC35-101-1155, that prohibits staff from placing a resident in a mechanical restraint chair for ***any purpose***.

OPTION 4, PROHIBITION ON SPIT GUARDS AND SIMILAR DEVICES

Ms. Peterson explained that this option retains all the language in Option Two, including the language allowing and limiting the use of the mechanical restraint chair. The only change in Option 4 is to the definition of protective device. Page 100 of the Board packet expressly excludes from the definition of protective device spit guards and similar devices. Protective devices are referenced elsewhere throughout the regulation, but the regulation adds a new Section 6VAC35-101-1159 (page 109) which prohibits the use of spit guards.

Board Member Schrad understood that this change would remove spit guards and similar devices from the definition of protective device and asked what other protective devices would be included?

Ms. Peterson said it is not an all-inclusive list. Protective helmets and other items used to protect staff or residents from injury placed on a resident or a portion of the resident's body would fall under the definition. Deputy Director Holmon added hand-mitts (anti-mutilation gloves).

Board Member Kizner asked if the use of spit guards and similar devices is dependent on the restraint chair.

Ms. Peterson answered that the workgroup added a provision allowing protective devices to be used only in connection with a restraint device, whether it be a mechanical restraint (handcuff) or the restraint chair. Protective devices must be used in connection with another restraint.

Board Member Frazier asked whether staff would be permitted to use spit guards if a physical restraint was performed.

Ms. Peterson responded that she does not believe the workgroup drew a distinction in the proposed regulation language and asked the detention centers if the facilities use protective devices with physical restraint as well. Ms. Roessler said yes, there have been situations when spit guards were used to protect staff.

Director Block advised the Board to put this issue into context, noting that the Department or the local detention centers are not looking to put hands on residents or to use restraints. The best way not to use restraints is to do good work with residents and to positively engage with them. The facilities represented at today's meeting have good programs with alternative discipline programs. None of this is reflective of things any of us want to or seek to do.

Chairperson Woolard asked if what the Board votes on today would apply to youth under the Office of Refugee Resettlement (ORR) custody. Director Block answered yes, and Ms. Peterson clarified that it would apply once the regulation takes effect.

BOARD DISCUSSION

Each of the Board members provided their perspective on the proposed options before the Board.

Chairperson Woolard noted that she felt conflicted about this issue and hopes these issues never happen, but facilities need to be prepared in case situations arise with the youth we serve. The people and experts involved in this discussion view the restraint chair as the last resort. It is difficult to regulate or pass laws on low base rate phenomena that do not happen often but have collateral consequences. Chairperson Woolard heard from facilities that use the chair under circumstances that can potentially be considered more safe or prevent injury in ways not using the chair might achieve. Chairperson Woolard also sees the other side and is influenced by the fact there are many institutions and associations that do not recommend the chair or do not use it and seem to move forward without it. Chairperson Woolard could not extract from presentations at the last meeting, if there are any characteristics of the facilities that do not have or do not use the chair that would differentiate them in some substantive way from facilities who do have and use the chair.

Board Member Schrad said she thought more tactically and through a process of elimination to arrive at her decision. Option 1 does not change anything and is not realistic. Options 3 and 4 seem to disregard detention centers that use the chair successfully in a limited fashion. The experience with grappling with the female resident for hours is more troubling than the use of the chair for a limited time. For Board Member Schrad, the only option that makes sense is Option 2.

Board Member Schrad provided what she termed a "crude corollary" of law enforcement and the use of force continuum. Law enforcement has policies that permit use of force in given situations with appropriate training. There are also policies to ensure that when force is used it is reviewed to ensure the force was within policy. There is no way to predict every possible scenario; every child, situation, and resource is unique. Board Member Schrad cannot advocate eliminating a resource, no matter how rarely it is used, if it has proven to be helpful in situations and is used in a limited fashion to protect the resident and staff. Board Member Schrad cannot see a reason to take that resource away. Board Member Schrad made the analogy that a police officer may never use his firearm in his career but cannot imagine taking the firearm away from law enforcement. Board Member Schrad apologized if the corollary was offensive. She does feel the chair is a resource and with proper training, policy, recordkeeping, and review of the heavy regulation in Option 2 would do a lot to limit the use of the chair because staff will need to justify the use.

Board Member Frazier agreed this is tougher than most decisions the Board has made during his term. Board Member Frazier indicated that he does not want to limit the resources available to the local juvenile detention centers, even if they gather dust. Board Member Frazier appreciates the workgroup making use of the chair tougher and seeking to impose more regulations and training for

its use. Additionally, he does not want to limit protective devices as they are important for the safety of the young people and staff. Therefore, Board Member Frazier is in favor of Option 2. The example of the young female resident in a physical restraint for six or seven hours helped Board Member Frazier consider staff and also the other residents behind locked doors for that amount of time, which contributes to what the residents are feeling, seeing, and hearing. Board Member Frazier acknowledged the challenges associated with the job, profession, department, and industries the Board regulates.

Board Member Kizner indicated that he is not supportive of Option 2. Board Member Kizner explained that his background is in working with children who have mental health issues. While he has no doubt the juvenile detention centers at the meeting are highly professional, he respectfully disagrees with his colleagues that we do not create trauma for children. He has known many incarcerated children who move on from their experiences personally and professionally while others do not. Board Member Kizner does not believe the Board is taking a tool away from staff. His focus is on the resident, so if other detention centers and communities are able to operate without the chair, then that should challenge the Board to figure out why all facilities are not able to do so. Board Member Kizner believes there are many potential complications with this policy, which might create an avenue for staff to have greater difficulty. Therefore, Board Member Kizner is in favor of Option 3.

Board Member Vilchez noted he is wearing two hats as a Board Member and as a court service unit employee who pays attention to prevention. He believes the mission at the Department is to rehabilitate rather than punish. Board Member Vilchez concurs with Director Block on the engagement of youth in more positive activities in the juvenile detention centers and juvenile correctional center. Board Member Vilchez thanked the public commenter earlier who noted that facilities have used the restraint chair infrequently and encouraged eliminating it. After researching the subject, Board Member Vilchez does not see the chair used nationally. These restraints are used at Guantanamo Bay; these are juveniles who have not committed heinous crimes. Board Member Vilchez concurs with Mr. Kizner and has his own experience working with youth. Board Member Vilchez does not like the idea of having these devices and restraints in Virginia's juvenile facilities and supports Option 3.

Board Member Roman said that before the meeting she supported Option 3; however, she became concerned after hearing about the long physical restraint of the young female resident. Board Member Roman shared that she has experienced physical restraint, and it was one of the most traumatic events to happen to her. At this point, Board Member Roman is unsure of which option to support. From personal experiences and hearing from representatives, it is a tough decision.

Chairperson Woolard said any decision will be difficult for staff and residents. There is little research to help the Board figure out the less traumatic option.

Board Member Schrad added to her comments. Option 2 is a huge regulatory change that puts more regulations in place and will be monitored very closely. This is also not the end of this discussion.

Board Member Schrad recommended requiring a report be submitted to the Board on the chair use and then, after a year, having the Board revisit the issue to determine whether the chair is still needed. Board Member Schrad shared her discomfort with taking away a resource and the transition the facilities would need to undergo if the chair was not an option. Board Member Schrad feels the Board needs to give this issue another chance under stricter regulations to see if it can still be helpful. She heard too many times the testimony from the detention centers on how the chair had been used successfully, limiting the period of trauma for the resident and giving staff the ability to intervene with that individual. Board Member Schrad shared her personal belief that she would prefer to be put in the chair than physically restrained. Board Member Schrad believes Option 2 lets the Board transition to a place of better regulation, training, and policy and reminded the Board of its ability to revisit the issue.

Chairperson Woolard speculated that the traumatic impact of either option is not known, and while six hours of physical restraint would be a challenge, there is no empirical data to help make a decision based on which is less traumatic or more helpful for the resident. Chairperson Woolard is challenged to think about continuing the use of the restraint chair when so many places are successful without it. Chairperson Woolard thinks Virginia has demonstrated itself as a leader in juvenile justice policy and practice, and the Department is leading different states and moving forward on child trauma informed care. In her mind, the use of the restraint chair is inconsistent with that initiative. Therefore, Chairperson Woolard supports Option 3. She believes that with the skill and expertise of the facility staff, they can be successful without the use of the restraint chair. She acknowledged that she does not work in a facility, but she does have incredible confidence and respect for the facility staff expertise in working with the youth served.

Chairperson Woolard noted that there are six Board members present and asked what will happen if there is a tied vote. Director Block answered that the status quo will remain in effect, but the Board could revisit the issue another time.

Board Member Schrad raised a concern that a third of the Board was not at the meeting. Chairperson Woolard responded that the Board needs to proceed with those in attendance.

A motion was made by Dana Schrad and seconded by Tyren Frazier to approve the proposed amendments to 6VAC35-101, *Regulation Governing Juvenile Secure Detention Centers*, related to the use of mechanical restraints in juvenile detention centers, as established under "Option 2" in the Board packet and as further amended at the January 8, 2019, Board meeting. Board members Dana Schrad, Tyren Frazier, and Quwanisha Roman voted in favor of the motion and Board members Jennifer Woolard, Scott Kizner, and Tito Vilchez voted to reject the motion. The motion failed.

A motion was made by Scott Kizner and seconded by Tito Vilchez to approve the proposed amendments to 6VAC35-101, *Regulation Governing Juvenile Secure Detention Centers*, related to the use of mechanical restraints in juvenile detention centers, as established under "Option 3" in the Board packet and as further amended at the January 8, 2019, Board meeting. Board members Jennifer

Woolard, Scott Kizner, and Tito Vilchez voted in favor of the motion and Board members Dana Schrad, Tyren Frazier, and Quwanisha Roman voted to reject the motion. The motion failed.

The Board had a conversation about the possibility of advancing Option 2 but striking all of the provisions related to the restraint chair and addressing the issue regarding restraint chairs in the future. This long discussion did not produce any new motions or changes to the vote.

Chairperson Woolard thanked the Board, the Department, and the local juvenile detention centers for their thoughtful contribution. Chairperson Woolard recommended revisiting the vote at the next meeting given that some Board members needed to leave and some not in attendance did not have the opportunity to convey their perspective.

DIRECTOR'S COMMENTS

Andrew K. Block, Jr. Director, Department

Director Block thanked the Board for their willingness to take on this difficult issue and make the best decision for our young people.

Director Block held six listening sessions around the Commonwealth late last year with court service unit staff and stakeholders. This was a chance for staff to interact with leadership and provide direct feedback. The court service units feel positive about the agency's direction with probation numbers being down, smaller caseloads, more diversion and prevention, and more thinking about keeping youth out of the juvenile justice system.

In December, the Department opened a new part of their continuum with a transitional living center, not quite a halfway house, to serve Chesterfield County. AMIkids selected the vendor, and the first new residents came in December 2018.

The Department received funding in the Governor's budget for planning a second new facility in central Virginia. This General Assembly session the Department may receive specificity on the location for this second facility.

The Department has advanced the following legislative bills as part of its package:

(1) *Youth tried as adults*. Currently, a youth may be tried as an adult in one of three ways: 1) A youth at least 14 years old charged with murder or aggravated malicious wounding and automatically tried as an adult; 2) a youth at least 14 years old charged with any number of serious felonies, at the discretion of the prosecutor; and 3) a youth at least 14 years old transferred to circuit court by the prosecutor where the juvenile court judges can hold adversarial hearings to listen to both sides. Proposed legislation would increase the age for prosecutorial transfer or automatic transfer of youth from 14 years of age or older to 16 years of age or older. Youth charged with serious offenses who are 14 or 15 year olds could still be tried as adults, but a judge would make that decision rather than it being automatic or

prosecutorial. This would require judges to receive a transfer report from the Department in order to make a decision. Transfer reports include information on the youth's clinical status, mental health situation, and educational status. Senator Marsden is the patron for this bill.

(2) *Social History Reports* – The bill would require the court to have a social history of a youth prior to that young person who has been adjudicated delinquent of a serious or violent felony receiving a sentence or disposition. Currently, plea deals are made and lengthy sentences are imposed without the court having the benefit of the social history report. Courts should receive as much information as possible before making these decisions, particularly in cases that are more serious.

(3) *Training Standards* - A law passed in 2012 transferred authority over establishing training standards for the Department's Resident Specialists (previously called Juvenile Correctional Officers), to the Department of Criminal Justice Services (DCJS). DCJS oversees law enforcement and the Department of Corrections. Prior to that time, the Board had overseen this area, but the Department Director wanted the Department to be under their umbrella. The Board previously regulated the training successfully, and the Department believes the Board has more context to oversee this than DCJS. The Department is asking for a statutory change, which DCJS supports, to return this oversight to the Board.

BOARD COMMENTS

There were no Board comments.

NEXT MEETING

The next Board meeting is scheduled for April 17, 2019, at Main Street Centre, 600 East Main Street, Richmond.

ADJOURNMENT

Chairperson Woolard adjourned the meeting at 12:52 p.m.