Post Office Box 1110
Richmond, VA 23218-1110
804.588.3903

COMMONWEALTH *of* VIRGINIA

*Board of Juvenile Justice*

# BOARD MEETING

March 11, 2020
Main Street Centre, 600 East Main Street, 12th Floor, North Conference Room, Richmond

# AGENDA

9:30 a.m. Board Meeting

1. **CALL TO ORDER and INTRODUCTIONS**

2. **APPROVAL of November 13, 2019, MINUTES** (Pages 3-22)

3. **PUBLIC COMMENT**

4. **DIRECTOR'S CERTIFICATION ACTIONS** (Pages 23-74)

5. **OTHER BUSINESS**

**A. Sale of Natural Bridge**
- James Towey, Legislative and Regulatory Affairs Manager, Department of Juvenile Justice

**B. Spit Guards Presentation** (Pages 75-83)
- Kristen Peterson, Regulatory and Policy Coordinator, Department of Juvenile Justice
- Mark Murphy, Health Services Unit Director, Department of Juvenile Justice
- Jason Houtz, Superintendent, Fairfax Juvenile Detention Center
- Joyce Holmon, Deputy Director of Residential Services, Department of Juvenile Justice

**C. Proposed Amendments to Juvenile Correctional Center Regulation Regarding Spit Guards** (Pages 84-85)
- Kristen Peterson, Regulatory and Policy Coordinator, Department of Juvenile Justice

**D. Proposed Amendments to Juvenile Correctional Center Regulation Advancement to Final Stage** (Pages 88-161)
- Kristen Peterson, Regulatory and Policy Coordinator, Department of Juvenile Justice

**E. Legislative Update**
- James Towey, Legislative and Regulatory Affairs Manager, Department of Juvenile Justice

6. **DIRECTOR REMARKS AND BOARD COMMENTS**

7. **NEXT MEETING DATE:** June 24, 2020

8. **ADJOURNMENT**

## GUIDELINES FOR PUBLIC COMMENT

1. The Board of Juvenile Justice is pleased to receive public comment at each of its regular meetings. In order to allow the Board sufficient time for its other business, the total time allotted to public comment will be limited to thirty (30) minutes at the beginning of the meeting with additional time allotted at the end of the meeting for individuals who have not had a chance to be heard. Speakers will be limited to 5 minutes each with shorter time frames provided at the Chair's discretion to accommodate large numbers of speakers.

2. Those wishing to speak to the Board are strongly encouraged to contact Wendy Hoffman at 804-588-3903 or wendy.hoffman@djj.virginia.gov three or more business days prior to the meeting. Persons not registered prior to the day of the Board meeting will speak after those who have pre-registered. Normally, speakers will be scheduled in the order that their requests are received. Where issues involving a variety of views are presented before the Board, the Board reserves the right to allocate the time available so as to insure that the Board hears from different points of view on any particular issue. Groups wishing to address a single subject are urged to designate a spokesperson. Speakers are urged to confine their comments to topics relevant to the Board's purview.

3. In order to make the limited time available most effective, speakers are urged to provide multiple written copies of their comments or other material amplifying their views. Please provide at least 15 written copies if you are able.

P.O. Box 1110
Richmond, VA 23218
(804) 371.0700
Fax: (804) 371.6497
www.djj.virginia.gov

# COMMONWEALTH of VIRGINIA

*Department of Juvenile Justice*

# DRAFT MEETING MINUTES

November 13, 2019
Main Street Centre, 600 East Main Street, 12th Floor, South Conference Room Richmond, Virginia 23219

**Board Members Present:** Tyren Frazier, Scott Kizner, Greg Underwood, Robert "Tito" Vilchez, and Jennifer Woolard

**Board Members Absent:** David Hines, Robyn McDougle, Quwanisha Roman, Dana Schrad

**Department of Juvenile Justice (Department) Staff Present:** Ken Bailey, Melinda Boone, Valerie Boykin, Ken Davis, Mike Favale, Stephanie Garrison, Stephanie Green, Joyce Holmon, Linda McWilliams, Mark Murphy, Margaret O'Shea (Attorney General's Office), Shaun Parker, Jamie Patten, Kristen Peterson, Jessica Schneider, Beth Stinnett, James Towey, and Angela Valentine

**Guests Present:** Marilyn Brown (Chesterfield County Juvenile Detention Center), Kerry Chilton (disAbility Law Center of Virginia), Erin Madden (Office of the Lieutenant Governor), Erika Rains (New River Juvenile Detention Center), Cathy Roessler (Blue Ridge Juvenile Detention Center), Amy Woolard (Legal Aid Justice Center), and Joseph Young (New River Juvenile Detention Center)

## CALL TO ORDER

Chairperson Jennifer Woolard called the meeting to order at 9:43 a.m.

## INTRODUCTIONS

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

## APPROVAL of June 19, 2019, MINUTES

The minutes of the June 19, 2019, Board meeting were provided for approval. On motion duly made by Tyren Frazier and seconded by Jennifer Woolard, the Board approved the minutes as presented.

## PUBLIC COMMENT PERIOD

There was no public comment.

## 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 for July and October 2019.

The Fairfax Boys Probation House requested to repurpose by renovating and moving into an old shelter care facility and to change their age capacity. The Certification Team performed their audit on the new location, and it met all the physical plant requirements. The Department Director approved the relocation and the age range. The Fairfax Boys Probation House will have their current certification continue and remain in effect until July 2020.

The Shenandoah Valley Juvenile Center was certified for three years and received a congratulatory letter for 100% compliance.

Summit Transitional Living Program is a new facility that has challenges but is showing improvement. The Department Director reviewed the audit report, and requested a status report in December. The Summit Transitional Living Program will continue its current certification.

Some court service units are having difficulty complying with the new implementation requirements for the reentry program causing the audit team to find documentation issues. The audit for the 16th Court Service Unit found six deficiencies. A follow-up review on August 19 found all but one deficiency, a failure to properly document, had been corrected. The DJJ Director certified the 16th Court Service Unit until September 13, 2022, with a status report from the Regional Program Manager due in June 2020.

The audit for the 26th Court Service Unit found seven deficiencies. The Certification Team conducted a status follow-up on August 5 and found the unit 100% compliant. The DJJ Director certified the 26th Court Service Unit until July 19, 2022.

The audit for the Chesterfield Juvenile Detention Center and Post-Dispositional Program found two minor deficiencies, which were corrected prior to the Certification Team's status follow-up. The DJJ Director certified the facility until October 28, 2022.

Board Member Greg Underwood asked what jurisdictions encompass the 16th and 26th Court Service Units. Regional Program Manager Stephanie Garrison responded that the 16th unit includes Albemarle, Charlottesville, Culpeper, Fluvanna, Goochland, Greene, Louisa, Madison, and Orange. Director Valerie Boykin said the 26th unit includes Winchester, Harrisonburg, and surrounding counties.

## BOARD OF JUVENILE JUSTICE ELECTIONS

The bylaws for the Board of Juvenile Justice authorize the election of a Chairperson, Vice-Chairperson, and Secretary from its membership. Each officer must be elected by the Board at its first regular meeting of the fiscal year. Officers serve for a term of one year and are eligible for re-election.

Chairperson Woolard asked for nominations from the Board members for the three positions.

On motion duly made by Scott Kizner and seconded by Tyren Frazier, the Board of Juvenile Justice approved the nomination of Jennifer Woolard as Chairperson.

On motion duly made by Jennifer Woolard and seconded by Tito Vilchez, the Board of Juvenile Justice approved the nomination of Tyren Frazier as Vice-Chairperson.

On motion duly made by Tyren Frazier and seconded by Jennifer Woolard, the Board of Juvenile Justice approved the nomination of Tito Vilchez as Secretary.

**NEW RIVER VALLEY JUVENILE DETENTION CENTER VARIANCE EXTENSION**
Kristen Peterson, Regulatory and Policy Coordinator, Department

New River Valley Juvenile Detention Center (New River Valley) is seeking an extension to the variance originally approved by the Board in January 2014. This variance is to the regulatory requirement set out in 6VAC35-101-520, which requires juvenile detention centers to have a control room that integrates the internal and external communication networks and the security functions of the facility. The control center must be staffed 24 hours a day and secure from juvenile access. New River Valley has never had a control center since they began operating in 1974, and they are seeking an extension of the 2014 variance.

The Board has the authority to issue variances and establish a duration for that variance. New River Valley requested that the Board grant the variance on a permanent basis. New River Valley has never had a control center and must continuously seek variance extensions from the Board every few years. The Board may issue a variance on a permanent basis.

The Regulation Governing Juvenile Secure Detention Centers is moving through the regulatory process. The workgroup looked at this provision specifically and questioned whether the regulation should be amended to accommodate New River Valley's nonexistent control room. The workgroup recommended retaining this provision because New River Valley currently is the only facility not able to comply with the regulation.

Ms. Peterson introduced the New River Valley Juvenile Detention Center Superintendent, Joe Young.

Chairperson Jennifer Woolard asked Mr. Young to describe how things work at New River Valley without a control room.

New River Valley is located in Christiansburg and was built in 1974. New River Valley has always operated without a control center and, according to Mr. Young, has done well. In January, the facility was deemed 100% compliant on their certification audit. The facility averages ten youth and is licensed for 24. There are cameras throughout the facility with no blind spots. The facility's receptionist, the superintendent, the deputy director, the school principal, and the shift supervisor on duty monitor the cameras. Staff have two-way radio and intercom communications in every room a youth can access. Mr. Young noted that through

the years, New River Valley has learned to adapt and meet the spirit of the regulation. New River Valley asked for a permanent variance or an extension of the existing variance until the facility is renovated. Renovation plans have been put on hold, but if approved to move forward, a control room will be added to fully comply with the regulation.

Board Member Tyren Frazier asked Mr. Young to talk about the renovation or update plans.

New River Valley started the study in 1999. They went through the process of renovation up until the drawing of plans when the detention population dropped, which caused a decrease in funding. Mr. Young's Board is evaluating how to fund the renovation, which is currently estimated at $7 million to bring everything up to code. New River would still like to pursue the renovation and are in contact with architects.

Board Member Tyren Frazier wanted to verify that bringing the renovation "up to code", means including a space for the control room. Mr. Young responded affirmatively.

Director Valerie Boykin raised the concern that a permanent variance might hurt New River Valley's opportunity to secure funding for the renovations. Mr. Young confirmed this was a concern.

Board Member Tyren Frazier asked if the Board could make the extension longer than normal but not permanent.

Chairperson Jennifer Woolard said the variance period could be as long as the Board deemed necessary. Chairperson Woolard noted her understanding that a permanent variance, if granted, might give the impression that renovations are not needed. Currently, New River Valley is creative with their control room circumstance, and ideally, will move forward with renovation at some point. Chairperson Woolard expressed her comfort with continuing the five-year variance as done in the past.

Board Member Tyren Frazier said he might be inclined to grant a ten-year variance, noting that this might be a stretch considering other variances issued by the Board. Board Member Scott Kizner agreed with the five-year period.

On motion duly made by Scott Kizner and seconded by Tito Vilchez, pursuant to 6VAC35-20-92, the Board of Juvenile Justice approved an extension of the variance that exempts New River Valley Juvenile Detention Center from the regulatory requirement provided in 6VAC35-101-520. The regulation requires secure juvenile detention centers to have a control center, secured from residents' access and staffed 24 hours per day that integrates all external and internal security functions and communication networks. This variance shall remain in effect for five years or until New River Valley Juvenile Detention center undergoes renovations, whichever occurs first.

**FISCAL YEAR 2019 HUMAN RESEARCH REPORT**

Jessica Schneider, Research Manager, Department

The Research Unit is responsible for external human research studies that vary in complexity and agency involvement. During FY2019, the Department's Research Unit approved five new studies and have 24 active studies.

Historically, the Research Unit has experienced problems with researchers involved in ongoing studies dropping communication. In the past year, the unit focused on contacting delinquent researchers in order to receive their progress or final reports. The unit tracked down several final reports and closed them out. It is important the agency learn the study outcomes in order to benefit from the results. For instance, after the conclusion of a successful photography program in a court service unit, the youth provided positive feedback. This evaluation showed that the program did what it intended, had a good outcome, and the agency learned the program did well.

Researchers are, at times, unaware of the regulations. They reach out directly to Department staff to ask them to participate in a study that has not been approved by the Research Unit. Department staff have learned the correct process and provide the information to the Research Unit. It is a challenge to prevent external researchers from reaching out directly.

There has been one potential violation of the regulation committed by Westat, which conducted a study addressing the Prison Rape Elimination Act by asking a series of questions to the residents at Bon Air. Data collection was completed, and Westat included protocols and forms for Spanish speaking youth that were not approved in advance by the Department, even after prompting. The Research Unit has struggled with getting a proper response from Westat to ensure the residents' rights as study participants were not violated. It is challenging to get external researchers to comply with the Department's process.

Chairperson Woolard has collaborated with Westat and offered her help with contacting them. Ms. Schneider accepted.

Ms. Schneider indicated that researchers are sometimes surprised by the Department's in-depth and detailed process for research studies, and struggle with why the Department's process is important. They are accustomed to getting quick and easy approvals from their universities or organizations. The Research Unit continues to communicate with researchers to explain the regulation.

Chairperson Woolard inquired about the general timeframe for processing an application.

Ms. Schneider responded that many factors influence the timeframe. The Research Unit receives a proposal and can usually ascertain whether the university or organization has a strict and rigorous Institutional Review Board (IRB) based on the quality of the proposal. It may require a few conversations about what the Research Unit needs and how operations will impact their study. The Research Unit receives the proposal, the Committee convenes to review, and a decision is made, which takes a minimum of two months. Frequently, it takes longer because the submitted proposal lacks detail or contains assumptions that are not feasible. The process involves coaching, communicating, and revising. The Research Unit tries for a quick turnaround, but it can take a year to complete.

Chairperson Woolard asked if the Research Unit provides resources to help researchers with the process.

The Department has a page on its website specifically dedicated to research studies. It includes a flow chart to help the researcher determine whether they should seek aggregate data, case specific data, or conduct a human research study. The procedure is also available on the website, as well as a consent form that the unit borrowed from VCU's website; however, most universities and organizations use their own consent form.

Board Member Scott Kizner asked if most requests were from graduate students.

Ms. Schneider responded that there tends to be a mix. The Research Unit receives many requests from students and the unit ensures their advisors or professors are involved in all communications because sometimes students are confused by the process. There are also requests from professors at universities, researchers with research organizations such as Urban Institute, Child Trends, or Westat. Organizations receive grants to help with their research and collaborate with the Department.

**REGULATORY UPDATE**
Kristen Peterson, Regulatory and Policy Coordinator, Department

The regulatory update is on page 129 of the Board packet. The Governor's Office has approved amendments to the Regulation Governing Juvenile Correctional Centers at the proposed stage of the process and it is currently undergoing public comment. The public comment period is 60 days and expires on November 29, 2019, after which time the Department will have 180 days to make additional changes to the regulation to address the public comments received. The regulation will then be presented to the Board for consideration.

The Department neglected to incorporate language from 2012 legislation into its Public Participation Guidelines. The amended language ensures interested parties are afforded the opportunity to be represented by counsel, if needed, when the Board considers regulatory actions. The 2012 language has been added to the regulation, and the regulation took effect on October 31, 2019.

The Department introduced a change to the Regulation Governing Juvenile Secure Detention Centers regarding contracts entered into with separate entities. When juvenile detention centers contract to house residents under the custody of a separate entity, a provision should be included in the contract that gives the Department the same access to the juveniles in those programs as they currently have with all other juveniles at that detention center. The provision took effect on August 22, 2019.

**REGULATION GOVERNING MINIMUM STANDARDS FOR RESEARCH INVOLVING HUMAN SUBJECTS OR RECORDS OF THE DEPARTMENT OF JUVENILE JUSTICE; REQUESTS SUBMITTED THROUGH THE VIRGINIA LONGITUDINAL DATA SYSTEM**
Kristen Peterson, Regulatory and Policy Coordinator, Department

Ms. Peterson reminded the Board that proposed amendments to the regulation governing human research were discussed at the June Board meeting. Several recommendations made in June sought to address

confusion generated by changes to the regulation in 2016. The Board voted to approve those amendments but, unfortunately, failed to address external case specific data requests submitted through the Virginia Longitudinal Data System (VLDS). Since October 2017, the Department has been a part of VLDS, which allows data researchers and external parties access to research from multiple agencies. A number of agencies are current participants in the VLDS, including the Department of Social Services and Department of Education. A researcher can submit a data research request through the VLDS and gain access to certain data across multiple agencies. This helps inform their policy based on the information obtained from the VLDS.

External case specific data requests are made from outside the Department for data on individuals who have touched the juvenile justice system. External case-specific data requests must undergo certain requirements in order to be approved. The Department's Coordinator of External Research reviews data requests and ensures all regulatory requirements are met, and an internal committee reviews the requests and determines if the scope should be narrowed. The Department Director has final approval authority.

One proposed amendment would allow the Chair of the Human Research Review Committee (HRRC) to approve data requests submitted through the VLDS, which would expedite the process. The expectation is for VLDS requests to be completed quicker than the Department's current drawn-out process. In order to align with the VLDS process, the proposal removes the Department Director from the review process, and gives the Chair of the HRRC some authority to approve these data requests. The Chair will not have full authority to make this determination; requirements are set out in Subsection C on page 102 of the Board packet.

The other change the Department is recommending is to add a new Section 69 to address amending data requests that have gone through the process set out in Section 65. There is a process in place for minor amendments to human research proposals but no comparable process for data requests. The Department seeks to have the Chair of the HRRC approve the minor amendments to data requests that have already gone through the lengthy process.

The Department also proposes a minor change to Section 140. There is a process in place for expediting minor amendments to human research proposals. Under Subsection B, the HRRC is given authority to conduct expedited reviews if the proposal was reviewed and approved by another agency's HRRC, or the review involves only minor changes to a research project. The proposal adds language to clarify that if the proposal undergoes expedited review under subdivision B.2, the Chair of the HRRC would need to provide approval in writing.

These amendments are necessary to help research proposals and data research requests move more efficiently through the process and to allow the Department Director to concentrate on more significant human research proposals and data requests.

Chairperson Jennifer Woolard asked whether VLDS is essentially another portal for individuals to submit their requests. Ms. Peterson responded affirmatively. Chairperson Woolard followed up by asking if the Department was acknowledging the VLDS process in addition to the Department's process.

Ms. Schneider responded it would not be in addition to the Department's process, it would be in place of the Department's process. If a case specific request comes through the normal process, then the Department's internal committee would review and the Department Director would approve. Logistically, that does not work well through the VLDS portal because not all reviewers and approvers can have log-in access to the portal. The submissions would come through the VLDS portal, at which time the chair of the HRRC would review and approve it within the portal, bypassing the other steps in the process.

On motion by Jennifer Woolard, seconded by Tyren Frazier, the Board of Juvenile Justice approved the additional proposed amendments to 6VAC35-170, Regulation Governing Minimum Standards for Research Involving Human Subjects or Records of the Department of Juvenile Justice, as established on November 13, 2019. The Board grants the Department of Juvenile Justice permission to incorporate these additional amendments into the fast-track regulatory package for 6VAC35-170, approved by the Board on June 6, 2019.

**JUVENILE CORRECTIONAL CENTER VARIANCE EXTENSION AND CORRESPONDING WAIVER**
Kristen Peterson, Regulatory and Policy Coordinator, Department

In November 2014, the Department sought a variance to the regulatory requirement contained in 6VAC35-71-160, which is the regulation that governs minimum initial training requirements for juvenile correctional center staff. Section 160 currently provides that direct care staff and staff who are responsible for the direct supervision of residents receive at least 120 hours of training before they assume their direct supervision responsibilities. This provision is specific to direct care staff and direct supervision staff. Direct care staff are responsible for maintaining the security of the facility, the well-being of residents in the facility, and the implementation of the Department's behavior management program. Other staff are responsible for the direct supervision of residents, for maintaining the well-being and safety of residents, and for providing specific services to residents. For example, teachers, recreation staff, and mental health counselors are personnel considered direct supervision staff under the Department's current procedures.

In November 2014, the Department sought a variance to the regulatory requirement specifically applicable to direct supervision staff. The variance was intended to address the logistical challenges associated with providing training for the direct supervision staff, which are different from the direct care staff. Direct care staff typically are hired *en masse* and take their training together. Direct supervision staff have different attrition rates and rolling hire dates. The development and scheduling of the training often are logistically challenging for the Department's Training Unit. It may take several weeks or longer to schedule a three-week training course with enough individuals to participate.

The variance allows for direct supervision staff to break up the training hours. Personnel can receive the first 40 hours of required training in the topics listed in Subsection B of the regulation before assuming direct supervision responsibilities. Direct supervision staff must then receive the remaining 80 hours of training before the end of their first year of employment. This allows direct supervision staff to receive the necessary training to be able to successfully and safely interact with residents and then receive the remaining 80 hours of training after they assume their direct supervision responsibilities.

A number of compelling reasons support extending the variance. The first 40 hours of training provides direct supervision staff their essential instruction. Secondly, the Department is exceeding national standards, which require staff to receive 120 hours of training in their first year of employment. Third, the proposed amendments to the Regulations Governing Juvenile Correctional Centers require direct supervision staff to receive 80 hours of training initially and then 40 hours of training before assuming direct supervision responsibilities. Currently, direct supervision staff are receiving those 80 hours and are already complying with the proposed amendments to the regulation. Also, the variance has been in place for five years with no issues.

Board Member Scott Kizner referenced page 109 of the Board packet, which will require direct supervision staff to receive training in subdivisions B(1) through B(16) during the first forty hours, and asked what training direct supervision staff receive in the next 80 hours.

Director of Training and Operations Patrick Bridge explained how the Training Academy implemented the 2014 variance. The training staff worked with Deputy Director of Residential Services Joyce Holmon on a training plan to include 80 hours of initial training at the academy for two weeks. Those initial 80 hours addressed most of the 16 topics in Subsection B. There is one hard-to-define topic dealing with other responsibilities specific to a role that covers the remaining 40 hours of training. Each of those direct supervision roles has an on-the-job training curriculum checklist specific to that role managed at the facility.

Board Member Scott Kizner asked if direct supervision staff receive 40 hours or 80 hours of initial training before they start work with residents.

Mr. Bridge responded that although the variance requires 40 hours of initial training, direct supervision staff currently receive 80 hours of initial training, and the pending regulation will solidify what the training academy does in practice.

Ms. Peterson explained that the Department is seeking to extend the variance for an additional three years or until the proposed amendments to the juvenile correctional center regulation take effect.

Board Member Kizner asked if the Department receives feedback from staff on the training.

Mr. Bridge answered that every training provides the opportunity for feedback. The training academy reviews the input and makes amendments.

Board Member Scott Kizner asked if the Department knew the retention rate of the direct supervision staff.

Deputy Director Joyce Holmon replied that the Department's Human Resources Office does keep track of attrition rates and that the information can be provided. Director Valerie Boykin acknowledged retention can be a challenge in the residential facilities and court service units. The Department provides a lot of training, and it is unfortunate when staff move on to other opportunities.

Chairperson Jennifer Woolard asked for confirmation that the variance will continue to authorize the initial 40 hours of training and that the 80 hours of training is completed towards the end of their first year of employment, but that functionally, personnel are receiving the 80 hours before heading to the field. Ms. Peterson noted that was correct.

On motion duly made by Tyren Frazier and seconded by Scott Kizner, pursuant to 6VAC35-20-92, the Board of Juvenile Justice approved an extension of the variance to the regulatory requirement provided in subsection B of 6VAC35-71-160 that requires "direct supervision staff" in juvenile correctional centers to complete at least 120 hours of initial training, inclusive of the topics specified therein, before being responsible for the direct supervision of a resident. The variance shall continue to authorize direct supervision staff to complete an initial 40 hours of training before assuming direct supervision responsibilities and the remaining 80 hours before the end of their first year of employment. This variance shall remain in effect until 6VAC35-71 is amended or for three years, whichever occurs first.

**CONSIDERATION OF REQUEST TO SUBMIT NOTICE OF INTENDED REGULATORY ACTION (NOIRA) FOR REGULATION GOVERNING STATE REIMBUREMENT OF LOCAL JUVENILE RESIDENTIAL FACILITY COSTS AND FOR THE REGULATION GOVERNING MENTAL HEALTH SERVICES TRANSITION PLANS FOR INCARCERATED JUVENILES**

Kristen Peterson, Regulatory and Policy Coordinator, Department

In late 2018 and the beginning of 2019, the Department began embarking on a process to bring the agency into compliance with the statutory requirement that directs state agencies and boards to review their regulations every four years. Unfortunately, the Department has fallen behind in complying with the periodic review requirement. The Department's process involves publishing an announcement in the Virginia Regulatory Town Hall, reviewing public comment, and using that information to develop a report to recommend either amending, retaining, or appealing the various regulatory chapters. Two regulatory chapters are before the Board. The Department is asking the Board to approve the filing of a NOIRA to start the process for amending these separate regulatory chapters: (i) the Regulation Governing State Reimbursement of Local Juvenile Residential Facilities; and (ii) the Regulation Governing Mental Health Services Transition Plans.

The state reimbursement regulation is currently in place to effectuate the statutory provision in 16.1-309.5, which requires states to provide 50% reimbursement of the costs associated with renovating, enlarging, or constructing local juvenile facilities. Although that statutory provision is in place, there is a moratorium on reimbursement funding that has been in effect for several years. However, the statutory provision still requires the Board to promulgate regulations to establish the criteria for evaluating reimbursement requests. Thus, these regulations need to be maintained. Although reimbursement funding is frozen, and has been for some time, the General Assembly typically adds a provision to the Appropriation Act that allows reimbursement funding for emergency maintenance projects. There is also a requirement that authorizes localities to pursue legislative enactment to receive reimbursement funding. In light of the moratorium on funding, the Department would like to simplify these regulatory provisions.

The Department does not have proposed language as the NOIRA is the first stage of the regulatory process. The purpose of the NOIRA is to put the public on notice that the Department is planning to review these regulations and make amendments.

The current regulations require localities engaged in these projects to comply with these regulatory requirements regardless of whether they are actually seeking reimbursement. The Department is contemplating simplifying the process for localities that do not intend to seek reimbursement. In addition, the current regulation contains a complicated funding formula that localities must follow when determining construction costs for reimbursement. The Department has discussed the possibility of simplifying or removing the funding formula.

If the Board approves the request to initiate the NOIRA, the Department would follow this process: the NOIRA would be submitted to the Virginia Regulatory Town Hall, the Department of Planning and Budget (DPB) would review, the Cabinet Secretary may or may not review depending on the DPB's recommendation, and then the Governor's Office would review and approve.

The Mental Health Transition Plans regulations seek to establish a process for providing post-release services to residents in post-dispositional programs and juvenile correctional centers as they transition out of commitment or detainment. The regulations specifically target residents identified as having a mental health treatment or substance abuse need. The Department would like to review current requirements; remove indefinite or vague terms; simplify language; clarify roles; change requirements related to the current memorandum of understanding with court service units, post-dispositional programs, and local community providers; and narrow the category of youth for whom mental health services transition plans are required. The Department is convening a workgroup to review both regulations.

Chairperson Jennifer Woolard recapped that the Department would like to announce they are beginning to review and potentially propose changes to these two regulations. Ms. Peterson affirmed. Chairperson Woolard asked for clarification on the process. Ms. Peterson explained that while the NOIRA is moving through the regulatory process, the workgroup will be drafting proposed amendments to the regulation. The Department hopes to have those proposed amendments ready for the Board's consideration at the March meeting. Chairperson Woolard noted that today's request is to start the process. Ms. Peterson said that was correct.

On motion by Jennifer Woolard and seconded by Tyren Frazier, the Board of Juvenile Justice granted the Department of Juvenile Justice authorization to proceed with the filing of a Notice of Intended Regulatory Action (NOIRA) pursuant to § 2.2-4007.01 of the Code of Virginia. The NOIRA shall initiate the process for amending 6VAC35-30, Regulation Governing State Reimbursement of Local Juvenile Residential Facility Costs.

On motion by Jennifer Woolard and seconded by Tito Vilchez, the Board of Juvenile Justice granted the Department of Juvenile Justice authorization to proceed with the filing of a Notice of Intended Regulatory Action (NOIRA) pursuant to §2.2-4007.01 of the Code of Virginia. The NOIRA shall initiate the process for

amending 6VAC35-180, Regulation Governing Mental Health Services Transition Plans for Incarcerated Juveniles.

**REVIEW OF BYLAWS**

James Towey, Legislative and Regulatory Affairs Manager, Department

Pursuant to the bylaws, the Board has the authority to amend the bylaws at any regular meeting as long as there is proper notice. In addition, in accordance with Section 7.01 of the bylaws, the Board is required to perform an annual review of the bylaws to ensure compliance with any amendments that may have been made to the applicable sections of the *Code of Virginia* during the last session.

At the Board's June meeting, the Department briefed the Board on the passage of legislation regarding training standards for resident specialists. The Department sponsored legislation (HB 2438) during the 2019 General Assembly session to transfer the power and duty of establishing training standards for juvenile correctional officers, (known as resident specialists) from the Department of Criminal Justice Services (DCJS) back to the Board. The Board had this responsibility prior to 2012. In 2012, those training standards for juvenile correctional officers were in § 9.1-102, a DCJS section specific to jail officers, local and regional jails, and correctional officers from the Department of Corrections. In 2012, juvenile correctional officers had more things in common with how facilities were operated by jail officers and correctional officers. In 2014, with transformation and implementation of the community treatment model, things started to change. While the resident specialist positions continue to have a security component, they now take more of a therapeutic rehabilitative approach. The training standards were not being updated to fit the new approach. The Department discussed moving this role and responsibility back to the Board from DCJS; the Secretary of Public Safety and Homeland Security and the Governor's Policy Team approved, and legislation was successful.

Pursuant to *Code of Virginia* language, the Board is required to have expertise in juvenile justice in addition to having at least two members with experience in education. The Department believes the Board is the better body to approve training standards because they are familiar with the juvenile justice system. The Department has little in common anymore with jail officers and correctional officers. The Department is in the process of developing training standards that are properly suited to resident specialists. A workgroup was formed, has met twice, and has two meetings set for future dates. The Department anticipates presenting these training standards for the Board's consideration at the March meeting.

The Department is asking the Board to amend the bylaws to reflect this addition to the Board's powers and duties. Article 3, Section 3.01 of the bylaws lists the powers and duties of the Board, so in order to conform with the statutory change, language needs to be added to mirror the statutory language. In addition, a housekeeping measure in Section 2.07 under Quorum makes a technical change to insert the word "with".

On motion duly made by Tyren Frazier and seconded by Tito Vilchez, the Board of Juvenile Justice approved the amendment to the Board of Juvenile Justice Bylaws, Article III, Section 3.01, to conform to the amendments made to the *Code of Virginia* §§ 9.1-102(9) and 66-10 by the 2019 session of the General Assembly of Virginia, to add to the Board's powers and duties that of establishing compulsory minimum

entry-level, in service, and advanced training standards, as well as the time required for completion of such training for persons employed as juvenile correctional officers at a juvenile correctional facility as defined in § 66-25.3. The Board also approved the addition of the word "with" in Article II, 2.07 of said Bylaws.

**VIRGINIA'S STANDARDIZED DISPOSITION MATRIX (SDM)**
Stephanie Garrison, Regional Program Manager, Department

The Department introduced its first risk assessment tool in 2003 called the Detention Alternative Instrument (DAI). It starts with the youth's arrest for an offense in the community. Police officers collaborate with intake officers to make a decision as to whether the youth is eligible for placement in a detention center.

The second assessment tool the Department introduced in 2007 was the YASI (Youth Assessment Screening Instrument). The YASI is an assessment of the youth's risk for reoffending after being placed in the juvenile justice system. YASI also has a case plan component, which guides probation, direct care, and parole services.

The Department now has a risk assessment at adjudication and the hearing stage called the Standardized Disposition Matrix (SDM), which is designed to measure risk, public safety, and offense severity. The tool is intended to guide probation officers' disposition recommendations to the court.

The summary below follows the presentation, which is on page 131 of the Board packet.

**Slide Two:**
For the SDM, the Department underwent an entire system assessment initially conducted by the Annie E. Casey Foundation. They identified some inequities at the point of disposition and invited the National Council on Crime and Delinquency (NCCD) to perform a deeper dive into the Department's disposition data. Disposition data is loaded into BADGE, the Department's main database, and can also pull data from the Supreme Court. That data was analyzed with a sample size of 1,600 cases, and the NCCD identified issues in the Department's system. The issues included decisions made in court recommendations given by probation officers, collaborations between attorneys, and the final decision by the judge. There were inconsistences in dispositions based on geography, on race, and by court service unit. These were subjective decisions. The SDM tool is creating a process of consistency where probation officers are required to perform an assessment by using the SDM. The SDM is a tool in BADGE that probation officers are required to run information through and the system generates a range of disposition options.

**Slide Three and Four:**
The purpose of the SDM is to bring consistency, reliability, and equity. The YASI coincides with the SDM to make risk assessment recommendations and communicate with the SDM.

The design is about objective decision-making and recommending appropriate supervision levels, whether it be no supervision or tiers of supervision. The SDM is about informed decision-making based on an objective tool.

Juveniles with a similar legal history who are before the court for the same exact misdemeanor or felony should be treated the same, no matter where in the Commonwealth they are. Court recommendations should be fair and objective. The Department wants to evaluate internal disposition recommendation practices, be transparent as to the recommendations, improve upon those recommendations, and be fair.

The SDM also provides probation officers and attorneys (defense or Commonwealth's Attorney) an opportunity to collaborate outside court and discuss recommendations regarding the youth's life. The Department encourages probation officers to interface with attorneys. Whether through plea bargains or providing risk level recommendations, the Department wants to ensure that there is an opportunity for discussion. The SDM is not intended to replace the probation officers who are experts on the YASI and case planning.

**Slide Five:**
The slide shows a matrix of how the SDM looks on paper. This matrix was taken from data collected in 2017 and was placed in the matrix by the NCCD. The Department established a workgroup of 32 professionals including the judges from the five regions of the Department, individuals from the community, attorneys, and Department staff, and participated in facilitated discussions.

The cross section of this matrix is set up with the blue side representing YASI levels with low, moderate, and high-risk determinations. Across the top of the matrix in red are the types of offenses. The workgroup discussed the cross sections regarding the level of ranges, and whether they should be changed, added, or deleted. Looking at "Low" in the blue column and "Misdemeanor I" in the red column, the cross-section would be the lowest level of supervision, "Level 1", which is zero. This would be a simple referral. If you looked at "High" in the blue column and "Felony" in the red row, the cross section would indicate "Level 3", which ranges from probation to commitment. The severity changes according to the risk level. The workgroup debated moving ranges.

**Slide Six:**
The slide shows categories of offenses and exclusions in the SDM.

- The Department is excluding status offenders because they have not committed a crime.
- Sex Offenses are excluded because they are a special population on whom, if a risk assessment is completed, generally, their risk would be low, which is a contradiction to the crime. The Department also wants to ensure a clinical assessment is submitted to the court, which drives the disposition and the SDM is not designed for that process.
- The Department has a current procedure in the Community Division that supports the graduated process of addressing non-compliant youth and wanted to ensure the probation officers continue to follow that procedure. Therefore, Technical Violations were excluded.
- Summoned Traffic Offenses are excluded; the probation officers have no contact with that summons. The Department did not want to include offenses that did not involve them directly, and most such offenses do not reach the level of Class 1 misdemeanors.

- Summoned Gaming, Fishing, Wildlife Offenses such as cow tipping, which is an animal cruelty charge. If a petition is filed against a youth for cow tipping, the Department will address it, but for youth who cow tip and get summoned, the Department will not be involved. Violation of local ordinances, curfews, and cases that are transferred to Circuit Court are not addressed in the SDM process.

**Slide Seven:**
Probation officers carry the SDM process from beginning to end.

**Slide Eight:**
The Department's technology unit built the SDM. It generates information from the database to come up with the disposition range.

**Slide Nine:**
If the court did not order a social history, a report can be generated from the SDM, and that recommendation can be given without a social history to the court. For cases where the social history is ordered, this disposition level will be placed in the recommendation section of the social history.

**Slide Ten:**
There are hearings in juvenile courts with adjudications where there is a continuation and disposition. This is the easiest process included in the SDM. Once a youth has been adjudicated, and an order issued for a social history, then the disposition recommendation is written. The courts will decide whether to follow the written recommendation.

**Slide Eleven:**
A more complicated process is the combined hearing. The Department wants to protect the rights of the juvenile and would like this process to take place before adjudication. The process allows a parent and child to volunteer to participate in an assessment interview. The Attorney General's Office has recommended that probation officers inform attorneys that the Department has discussed the assessment interview with the parent and youth before the interview proceeds. The Department drafted a letter that states the interview is voluntary, the Department will not abuse their rights, their attorney has been advised, and the youth is not required to participate. The Department hopes the youth participates because of the benefits of having this interview prior to court. The Attorney General approved both the letter and consent form.

Director Boykin noted this applies only in cases where there is a combined hearing. Some courts adjudicate followed immediately by disposition. Combined hearings are more challenging to ensure youth's rights are protected. It is valuable to have the information available to the court for the disposition.

Richmond juvenile court expedites next-day hearings, which is a combined adjudication and disposition.

The Department paid to customize YASI, which currently has two assessment screens. The Department designed a post-adjudication screen, which removed questions relevant to the current pre-adjudication process. It does not address the offense. With the YASI, historical information is collected (legal history,

family domain) and loaded into the software to develop a risk assessment. The goal is to protect the Sixth Amendment rights of the youth. The SDM was piloted in five court service units, and 85% of parents and youth consented to interviews prior to adjudication. Once the hearing is set, the Department completes the interview, and a report can be generated and filed with the clerk's office. In some instances, attorneys want that report, and the procedure allows for that report to be shared. At the adjudication disposition process, that recommendation is considered.

Board Member Tito Vilchez asked if the SDM replaces the pre-sentence investigation.

Ms. Garrison answered that no, the pre-sentence investigation (social history) will be included in the process, and the wording for the supervision level will be placed in the recommendation section.

Director Boykin followed up by stating that the SDM is an additional tool for sites that do not ask for a social history.

**Slide Twelve:**
There are five supervision levels. Level 1 is no supervision, and includes referrals and reporting of outcomes. Level 1 are youth who commit low-level offenses, are low risk, and need to do community service or anger management. Level 1 has no supervision provided, and no case plans.

**Slide Thirteen:**
Level 2 is a new level for some court service units that include post-disposition case management, which is not supervised probation. At this case management level, the probation officer has monthly contact with the youth and parent that may include community based services and crisis intervention. The YASI identifies areas of need that the probation officer should focus on. Level 2 has no community or risk-based supervision and no rules or case plans. This is an important level.

Chairperson Woolard asked if the lack of violations in this level is because there is no supervision or case plan. This is a connection to services level.

Ms. Garrison responded that at this level, the Department is asking the court to order case management. There can be a noncompliance with case management.

Director Boykin added that probation used to be the default for youth. These are youth who, based on the severity of their charge, do not necessarily need probation but do need services. Hopefully, there will be few situations where a violation is sought and ordered by the court, but that would be the only violation available.

**Slide Fourteen:**
Level 3 is code-driven supervised probation and requires face-to-face contact with the parent and the youth. The frequency of contact is based on the YASI risk level. It includes supervision rules, risk assessment, social history, and a case plan.

**Slide Fifteen:**
Level 4, out-of-home placement, is unique. Probation officers provide case management probation services for youth who are court-ordered to be placed outside of their home in any placement the Department determines to be best. A youth can be sentenced up to 30 days in detention. Youth in post-dispositional programs live in a detention center. There are also local and state funded placements through the Virginia Juvenile Community Crime Control Act (VJCCCA) or the Children Services Act (CSA) and other funding sources. Some parents have private insurance to use for youth placed outside of the home. Probation officers or case managers are required to secure funding. In case management, the manager can be a foster care worker or a probation officer because the Department has youth in both systems. If a youth is placed outside the home, that funding requirement has to be secured before disposition.

**Slide Sixteen:**
Level 5 is commitment. The probation officer is collaborating with direct care staff, and after the youth is released, provides parole supervision. Current placements are at Bon Air Juvenile Correctional Center, Community Placement Programs, and the Department's continuum of residential or group home placements.

**Slide Seventeen:**
The SDM has been in development for four years, and requires stakeholder trust and buy-in. The Department has important information that may help in making a decision about the placement of youth. The SDM matrix gives the Department an opportunity to discuss the appropriate placement with the court service unit.

The Department coordinated a six-month pilot for the SDM in five court service units in the five different regions. Three were rural regions, one region was suburban, and one was an urban court. Out of that pilot, the Department made changes to the SDM procedure and the tool. In June, the Department trained 518 court service unit staff, including probation officers, supervisors, and directors on the draft procedure. In August, the Department began implementation, a phased-in process that will end on December 31. The procedure will become final and begin for all court service units on January 1, 2020.

The "phase in" approach included the five Regional Program Managers providing technical assistance to the 34 court service units, and the requirement was for each court service unit Director to arrange stakeholder meetings to answer questions. Once that meeting is completed, the unit will set an implementation date. Currently, 11 of the 34 court service units have fully implemented the SDM.

Director Boykin noted that the Department had stakeholder representation in the development of the SDM that included judges, prosecutors, defense attorneys, and Department staff, in addition to the assistance of the National Council on Crime and Delinquency and the Annie E. Casey Foundation. The Department also tried to speak to other stakeholder groups to educate them on the SDM. The Department had an opportunity to provide a workshop at the spring judicial conference but could not get on their agenda for the summer conference. The Department talked to its Judicial Liaison Committee, Commonwealth's Attorneys' group, and may be invited to talk with the Commonwealth's Attorneys' Council in December. The Department

continues to have conversations and ensure that individuals and organizations understand the goals of the SDM.

Director Boykin noted that a lot of work went into the creation of the SDM and thanked Ms. Garrison and the team for their hard work. Over time the matrix may change based on what the Department has learned and what works for the young people.

Ms. Garrison said there has been hesitation from the judges because they associate this process with sentencing guidelines. The Department is trying to reassure them of its goal to examine its process and the fairness of the recommendations.

Chairperson Woolard asked if the mechanism for the recommendation ever deviates from the SDM.

Ms. Garrison responded that once the system generates the recommendation, the probation officer clicks a button that sends an email to the supervisor, who will then bring the probation officer into a case staffing meeting. They will discuss the appropriateness of the levels generated. This will allow the probation officer to stay within the range to mitigate down based on the information collected through the YASI and can also aggravate up based on the youth and family.

Chairperson Woolard asked if the research team will be evaluating the SDM as it continues.

Ms. Garrison responded that the research team has set up a database to collect the data from the pilots and has developed queries to put quality assurance measures into the database and in the future performance measures. The Department replicated Florida's performance measures. The evaluation will take place in two or three years.

**DIRECTOR'S COMMENTS**
Valerie P. Boykin, Director, Department

Director Boykin welcomed Mr. Underwood to the Board and indicated that she looks forward to his guidance and support. Director Boykin thanked Ms. Schrad and Dr. Woolard for accepting the invitation to return to the Board.

The Department continues to work on its strategic framework to reduce, reform, replace, and sustain. An area of focus to continue to build is the continuum of services. There are a number of new programs. In July, the Department was able to add more functional family therapy (FFT) to the far western part of the state. The Department currently has multi-systemic therapy (MST) and FFT available in 129 of 133 counties/cities. The other major focus area is trying to reduce our footprint, and our desire to have smaller facilities closer to home. The Department continues to struggle with siting facilities, but still wants to have facilities closer to home and smaller in size. This will allow the Department to focus on high-risk young people who penetrate the system to the deep end that need more therapeutic work. The other major area of focus is to sustain. The Department continues to work on supporting staff by teaching them new skills and helping them develop proficiency.

During the summer, the Department welcomed two new team members. Dr. Lisa Floyd left in July and Dr. Melinda Boone stepped in as the Interim Superintendent of schools in August. School still opened on time. Dr. Boone is a former superintendent of Norfolk City schools and the former superintendent of Worchester, Massachusetts. In September, Linda McWilliams, a long-term DJJ employee who left and went to Maryland to be a Deputy Secretary for community programs and residential services, returned to DJJ to oversee community programs.

The Department hosted a Reentry Conference in September combined with Prison Rape Elimination Act (PREA) training. The Department is required to have PREA training annually, so it made sense to combine efforts. The conference drew over 400 people to Williamsburg for two days of intense and informative training. The Department, along with Virginia State University, DCJS, DOC, and the Petersburg Office of the Community Crime Control Act, sponsored a Racial Ethnic Disparities (RED) conference in early November. That event drew over 200 people in Petersburg. The Department is embracing RED, and the only way to learn and do better is to meet it head on by looking at the data and the practices. One of those practices the Department believes will help is SDM.

In 2010, the Department had over 800 youth committed to state care; currently, we have approximately 350 youth, and of those 350, approximately 200 are at Bon Air, and another 150 are in alternative placements. Part of the overall transformation is to look at alternatives to secure incarceration and find other avenues where youth's needs can be met closer to home. The Department's newest partnership is with Northern Virginia Juvenile Detention Center in Alexandria, which now houses the remainder of the female population. Girls are either housed at Northern Virginia or Merrimac. There are no girls in a juvenile correctional center in Virginia. The population of girls is around 10 in secure care.

The Residential Services Division and the Division of Education hosted a Back to School Family Day in September with over 400 family members in attendance.

The Division of Education introduced the welding and forklift simulators. Currently, seven youths have passed certification in the forklift simulator. The youth learn on a simulator, and leave campus to complete the certification test on a real forklift machine.

The Department sent a team to the Juvenile Detention Alternative Initiative conference in Seattle, and continue to learn about great work happening through the Casey Foundation.

The Department is testing a new positive youth development curriculum. The Department received a training grant and the staff of the 15th Court Service Unit are involved in testing that curriculum. Director Boykin will update the Board on this project at later meetings.

Director Boykin and Statewide Programs Coordinator Beth Stinnett participated in a series of webinars as part of the Casey webinar initiative. The webinar focused on the Department's reinvestment of funds. The General Assembly has allowed the Department to maintain $40 million from the closures of the Reception and Diagnostic Center and Beaumont Juvenile Correctional Center. The Department reinvested that money

to rebuild its continuum of services. This national webinar was a great opportunity for the Department to share that good news. Stephanie Garrison is partnering with Justice System Partners, who provide leadership development to Department staff, and they are also participating in a webinar. The Department has worked with leadership development starting with supervisors. Supervisors touch every staff member who touches every youth/family. The Department's Juvenile Transformation Institute is in class number seven, and has trained 180 staff. In the current cohort, there are 30 employees registered who complete four months of leadership development training and a Capstone related to their work at their home site. The Department will conduct one more cohort, and use a train-the-trainer model for future sessions. This will also be built into the Department's overall training curriculum at the training academy. Reentry Manager Ashaki McNeil will participate in a webinar about reentry conducted by Georgetown University.

## BOARD COMMENTS

There were no Board comments.

## NEXT MEETING

The next Board meeting is scheduled for March 11, at Main Street Centre, 600 East Main Street, Richmond.

## ADJOURNMENT

Chairperson Woolard adjourned the meeting at 12:04 p.m.

## SUMMARY OF DEPARTMENT ACTIONS

### December 9, 2019

**DEPARTMENT CERTIFICATION ACTION –** Extended the certification of The Summit Transitional Living Program to June 8, 2020.
*Pursuant to 6VAC35-20-100 (4.a)*
*4. If the certification audit finds the program or facility in less than 100% compliance with all critical regulatory requirements or less than 90% on all noncritical regulatory requirements or both, and a subsequent status report, completed prior to the certification action, finds less than 100% compliance on all critical regulatory requirements or less than 90% compliance on all noncritical regulatory requirements or both, the program or facility shall be subject to the following actions:*
*a. If there is an acceptable corrective action plan and no conditions or practices exist in the program or facility that pose an immediate and substantial threat to the health, welfare, or safety of the residents, the program's or facility's certification shall be continued for a specified period of time up to one year with a status report completed for review prior to the extension of the certification period.*

**DEPARTMENT CERTIFICATION ACTION -** Certified the 4th District Court Service Unit December 1, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**DEPARTMENT CERTIFICATION ACTION –** Certified the 10th District Court Service Unit until December 1, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**DEPARTMENT CERTIFICATION ACTION –** Certified the 14th Court Service Unit until December 1, 2022 with a status report from Regional Program Manager in June 2020.
*Pursuant to 6VAC35-20-100C.3, if the certification audit finds the program or facility in less than 100% compliance with all critical regulatory requirements or less than 90% on all noncritical regulatory requirements or both, and a subsequent status report, completed prior to the certification action, finds 100% compliance on all critical regulatory requirements and 90% or greater compliance on all noncritical regulatory requirements, the program or facility shall be certified for a specified period of time, up to three years.*

**DEPARTMENT CERTIFICATION ACTION –** Certified the 21th District Court Service Unit until December 1, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

## SUMMARY OF DEPARTMENT ACTIONS

**DEPARTMENT CERTIFICATION ACTION –** Certified the 22nd District Court Service Unit December 1, 2022.

*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**DEPARTMENT CERTIFICATION ACTION –** Certified the 23rd District Court Service Unit December 22, 2022.

*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**Compliance Monitoring Visit**
**Residential Programs**

| | |
|---|---|
| **Program:** | The Summit Transitional Living Program |
| **Date of Visit:** | November 6, 2019 |
| **Type of Visit:** | Announced Monitoring Visit |
| **Administrator:** | Heather Ross |
| **Monitoring Staff:** | Mark Ivey Lewis, Clarice Booker, Learna Harris |

The Summit Transitional Living Program audit was conducted on April 30, 2019 with the following findings:

**6VAC35-41-180 (A). Employee and volunteer background checks. CRITICAL**

**6VAC35-41-1280 (F). Medication**

**6VAC35-41-1280 (H). Medication. CRITICAL**

**6VAC35-41-1280 (J). Medication. CRITICAL**

**6VAC35-41-1280 (M). Medication. CRITICAL**

Department Certification Action was taken on July 30, 2019 and the current certification status of Summit Transitional Living Program was continued until December 8, 2019, with a monitoring report from the Certification Unit.

A monitoring visit was conducted at the Summit Transitional Living Program on November 6, 2019, by Clarice Booker, Learna Harris and Mark Lewis. The visit included the following:

- inspecting the facility
- reviewing three resident case and medical files
- reviewing log book entries
- reviewing one new employee file and three seasoned employee training records
- reviewing a fire inspection reports and the fire drill logbook
- reviewing four Serious Incident Reports
- reviewing regulations missed during the previous audit
- interviewing three residents

The facility was found to be in non-compliance with two regulations:

**6VAC35-41-1280 (G). Medication.**

G. A medication administration record shall be maintained of all medicines received by each resident and shall include:

1. Date the medication was prescribed or most recently refilled;
2. Drug name;
3. Schedule for administration;
4. Strength;
5. Route;
6. Identity of the individual who administered the medication; and
7. Dates the medication was discontinued or changed.

**Finding:**

Two of two Medication Administration Records (MAR) were missing the dates medication was prescribed or refilled. One of two MAR's was missing the route for Bactrim from June 2019 through October 2019.

**Program Response**

**Cause:**

(A) When resident was admitted to Summit from Bon Air, he came with bottled medications and no MAR. Summit staff created MAR based on physician orders but omitted "ordered" date.

(B) Physician order by Dr. Constante was transcribed by program staff *and* by pharmacy on printed MAR's exactly as written, which reads "Sulfamethoxazole-TMP DS (generic for Bactrim DS tablet) Take one tablet twice a day with a full glass of water". The order does not specify "by mouth" and was transcribed, as written. (Please see attached copy of physician order sheet).

**Effect on Program:**

All medications were passed, as ordered; without treatment interruption and there were no medication errors.

**Planned Corrective Action:**

(A) Program Manager or designee will review MAR's upon admission to ensure that all required dates (ordered/refilled) are transcribed onto new MAR's.

(B) Program Manager or designee will review physician orders and contact outpatient providers, as needed, to ensure that all requirements are met on written prescriptions.

**Completion Date:** 11/18/2019

**Person Responsible:** Eric Tyler, Program Manager

**6VAC35-41-1280 (J). Medication. CRITICAL**

J. Medication refusals shall be documented including action taken by staff. The facility shall follow procedures for managing such refusals that shall address:

1. Manner by which medication refusals are documented, and
2. Physician follow-up, as appropriate.

**Finding:**
One medication refusal form reviewed did not include the action taken by staff when the resident refused his medication of Bactrim, Trention Gel, and Sulfamethoxazole. Also there was no documentation for physician follow-up.

## Program Response

**Cause:**
Medication refusals are documented on form created following the previous audit and reviewed at the CAP review date. The Physician Follow-Up section says:
"If Applicable, physician notified:
Physician Name: _____ Date: _____ Time: _____
Recommendations Made: _____"

The Physician Consult form did not include an area for "Standing Orders" and therefore, there was not specific instructions from prescribing outpatient physicians regarding if/how they wanted to be notified of medication refusals.

**Effect on Program:**
Staff were utilizing Refusal Form by documenting refusals but did not have specific instructions regarding whether outpatient/community providers wanted to be notified of refusals and/or any corresponding instructions. Residents continued to follow up with psychiatric provider and outpatient providers, as scheduled and medications/plans for treatment had not been changed by outpatient provider. There were no expressed Standing Orders/instructions provided other than "continue with current medication regimen and treatment plan." There was not any negative effect to resident in this situation. Had resident refusals caused change in affect/mood/rationality, program staff have access to True North Psychiatric providers and would have been able to follow-up for instruction.

**Planned Corrective Action:**
Physician Consult Form will be amended to include a section for "Standing Orders" for any prescriptions/treatments prescribed. Staff will ensure that they are documenting such on the Refusal Form, whenever applicable.

**Completion Date:** 11/22/2019

**Person Responsible:** Heather Rose, Program Director

## Audit Team Observations

The facility looked good and the residents interviewed stated that they loved the program and appreciated the family type atmosphere. The residents spoke very highly of the staff. The program presently has seven residents. The facility had one resident who recently was successfully discharged from the program. Presently there are two more residents who are ready to be successfully discharged.

The administration indicated that the program had a very rough beginning. When the program first started, the facility administration was having to accept most of the referrals made to them

despite the negative results obtained from the clinical interviews, previous history at the JCC and evaluations. Problems continued until DJJ and Intercept met and all agreed that they would have to be much more selective as to who would be placed into the program if they hoped for the program to be successful. The Summit Transitional Living Program has been operating much more smoothly since the meeting, as indicated by the reduction of SIR's and the positive interviews with the facility administration and the residents. Overall the monitoring visit was very positive despite the facility being in non-compliance with the regulations mentioned above. The team was in agreement that since the facilities last audit, the program has improved greatly.

**DEPARTMENT CERTIFICATION ACTION –** Extended the certification of The Summit Transitional Living Program to June 8, 2020.

*Pursuant to 6VAC35-20-100 (4.a)*
*4. If the certification audit finds the program or facility in less than 100% compliance with all critical regulatory requirements or less than 90% on all noncritical regulatory requirements or both, and a subsequent status report, completed prior to the certification action, finds less than 100% compliance on all critical regulatory requirements or less than 90% compliance on all noncritical regulatory requirements or both, the program or facility shall be subject to the following actions:*

*a. If there is an acceptable corrective action plan and no conditions or practices exist in the program or facility that pose an immediate and substantial threat to the health, welfare, or safety of the residents, the program's or facility's certification shall be continued for a specified period of time up to one year with a status report completed for review prior to the extension of the certification period.*

**CERTIFICATION AUDIT REPORT**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

**PROGRAM AUDITED:**
4th District Court Service Unit
150 St. Paul's Blvd, 2nd Floor
Norfolk, Virginia 23510
(757) 664-7601
Theresa McBride, Director
theresa.mcbride@djj.virginia.gov

**AUDIT DATES:**
June 17-18, 2019

**CERTIFICATION ANALYST:**
Mark Ivey Lewis

**CURRENT TERM OF CERTIFICATION:**
December 1, 2016 – November 30, 2019

**REGULATIONS AUDITED:**
6VAC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

**PREVIOUS AUDIT FINDINGS** – June 6-7,2016:
**6VAC35-150-350 (A). Supervision plans for juveniles.**
**6VAC35-150-350 (B) Contacts during juvenile commitment**
**6VAC35-150-420 Supervision plans for juveniles**

**CURRENT AUDIT FINDINGS** – June 17-18, 2019
96.55% Compliance Rating
*One repeated deficiency from previous audit
Number of Deficiencies: Two
**6VAC35-150-336 (A). Social histories.**
***6VAC35-150-420. Contacts during juvenile's commitment.**

**DEPARTMENT CERTIFICATION ACTION** – Certified the 4th District Court Service Unit December 1, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**TEAM MEMBERS:**
Mark Ivey Lewis, Team Leader
Clarice T. Booker, Central Office
Shelia Palmer, Central Office
Deborah Hayes, Central Office
Tracy King, 23-A District CSU (Roanoke City)
Gina Burton, 1st District CSU (Chesapeake)
Marc Crippen, 3rd District CSU (Portsmouth)

**POPULATION SERVED:**
The 4th District Court Service Unit exclusively serves the City of Norfolk.

**PROGRAMS AND SERVICES PROVIDED:**
The 4th District Court Service Unit provides mandated services including:

- Intake Services
- Diagnostic
- Probation & Parole

The Unit interacts with the community in obtaining such services as:

- Pre-disposition Group Home for Boys/Girls
- Pre-disposition Support
- Community Services Board
- Comprehensive Service Act
- Virginia Juvenile Community Crime Control Act (VJCCCA)
- Substance Abuse Assessment and Treatment Group
- Anger Management Group
- Anger Replacement Training Group for youth and parent
- Parenting Groups
- Employment/Vocational Services
- Outreach Detention
- Electronic Monitoring
- Street Law Groups
- Girl Specific Treatment Programs

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**CORRECTIVE ACTION PLAN**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

**FACILITY/PROGRAM:** 4th District Court Service Unit (Norfolk)

**SUBMITTED BY:** Theresa McBride, CSU Director

**CERTIFICATION AUDIT DATES:** June 17-18, 2019

**CERTIFICATION ANALYST:** Mark Ivey Lewis

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

**6VAC35-150-336 (A). Social histories.**
**A. A social history shall be prepared in accordance with approved procedures (i) when ordered by the court, (ii) for each juvenile placed on probation supervision with the unit, (iii) for each juvenile committed to the Department, (iv) for each juvenile placed in a postdispositional detention program for more than 30 days pursuant to § 16.1-284.1 of the Code of Virginia, or (v) upon written request from another unit when accompanied by a court order. Social history reports shall include the following information:**

1. **Identifying and demographic information on the juvenile;**
2. **Current offense and prior court involvement;**
3. **Social, medical, psychological, and educational information about the juvenile;**
4. **Information about the family; and**
5. **Dispositional recommendations, if permitted by the court.**

**Audit Finding: Non-compliant**

**Per approved procedures, the following information was missing in the social histories which were reviewed:**

- **Four of ten social histories reviewed did not include information on the "impact of alcohol or drug use".**

**Program Response**

**Cause:**
In reference to alcohol and drug use impact, the YASI is based upon the last 90 days and the interpretation of the impact reference was misunderstood to be restricted to the reported 90 day period and not to also address historical alcohol and drug usage impact.

**Effect on Program:**
When recent alcohol or drug use was not identified by the YASI, the requirement to address the impact of alcohol and or drug use was overlooked from a historical reference.

**Planned Corrective Action:**
Audit results were immediately shared with all available staff. Supervisors were tasked with identifying all areas of concern, and they submitted their reports to the Director as of June 21, 2019. Refresher trainings on the Social History policy will be conducted at all unit staff meetings, specific to the area of concern. A follow up email from the Director to all staff has been sent as a reminder of the protocol for the Social history checklist and template. A review of social histories completed between June 19 and September 30, 2019 will be conducted by the CSU Director or Deputy Director to monitor compliance with these specific areas of compliance.

**Completion Date:**
October 1, 2019

**Person Responsible:**
CSU Director and or Deputy Director.

**Current Status on October 5, 2019: Compliant**
One social history reviewed included information about the "impact of alcohol or drug use".

**6VAC35-150-420. Contacts during juvenile's commitment.**
**During the period of a juvenile's commitment, a designated staff person shall make contact with the committed juvenile, the juvenile's parents, guardians, or other custodians, and the treatment staff at the juvenile's direct care placement as required by approved procedures. The procedures shall specify when contact must be face-to-face contact and when contacts may be made by video conferencing or by telephone.**

**Audit Finding: Non-compliant**
**Per procedures, the case records and/narratives were missing the following information:**

- **Five of seven case narratives reviewed did not have documentation that required information had been reviewed by the PO with the juvenile during the monthly contact.**
- **Four of seven case records did not document the monthly contact in BADGE as a verbal family progress note.**
- **Three of seven applicable case records reviewed did not have documentation of the**

**PO's monthly contact with the Juvenile Correctional Center (JCC).**

- **Four of nine narratives reviewed were missing documentation that the re-entry advocate had convened a re-entry meeting along with the JCC counselor and PO ninety (90) days prior to release.**
- **Five of nine narratives reviewed did not have documentation that the PO attended the re-entry meeting in person to co-chair with the counselor.**
- **Three of seven narratives did not have documentation that the rules of parole were reviewed and signed by the juvenile prior to being released from the JCC.**
- **Five of nine narratives did not have a summary comment providing case direction and documenting that the review had been completed and approved or modified as indicated in BADGE.**

## Program Response

**Cause:**
Officers failed to follow established procedures as mandated in the 2016 Reentry Manual. The guidance document for Reentry remains in a revision/update status since the formal implementation of the Reentry Manual officially July 1, 2016, with repeated push back for update distribution date. Areas of particular concern regarding the Reentry Manual are the required prescriptive language documentation that often results in duplicated entry with slight variation from the same meeting session. Certification review guidance documents were not initially updated to incorporate the new Reentry procedures, and were subsequently updated February 2, 2017 and again March 19, 2019. BADGE support remains deficient regarding coding purpose for Verbal Family Progress Notes. These aforementioned items are a systemic problem.

Supervisory guidance was compromised during this certification period, as one parole supervisor was newly assigned to parole, and subsequently experienced medical issues cumulating in an extended short term disability claim which remains in progress.

**Effect on Program:**
Changes to the Reentry Manual as suggested following the roll out period, January 1, 2016 to June 30, 2016 remained uncompleted. Anticipatory updates were repeatedly pushed back and remain so. Staff buy-in to the Reentry Manual processes while awaiting updates to the manual was a recurrent frustration to staff.

**Planned Corrective Action:**
Audit results were immediately shared with all available staff. Supervisors were tasked with identifying all areas of concern, and they submitted their reports to the Director as of June 21, 2019. A memorandum addressing all areas of concern will be distributed to all parole officers by June 26, 2019 to include the required corrective action. (See attached copy.) All parole officers will be required to sign off acknowledging receipt of the memorandum. In addition, the areas of concern will be discussed in detail at the next parole unit staffing tentatively set for June 27, 2019. A random review of direct care and parole cases will be conducted between July 1, 2019 and September 30, 2019 by the CSU Director or Deputy Director to monitor compliance with the specific areas of compliance.

**Completion Date:**
October 1, 2019

**Person Responsible:**
CSU Director and or Deputy Director

**Current Status on October 5, 2019: Compliant**
Ten narratives were reviewed and all had the following documentation:

- The required information as outlined in procedure had been reviewed monthly with the juvenile;
- Each of the monthly contacts were being noted as "verbal family progress" in BADGE; and
- A date had been established with the Juvenile Correctional Center for the next contact.

Two of two narratives reviewed had documentation that the JCC counselor, PO and re-entry advocate convened a re-entry meeting 90 days prior to release and the probation officer had attended the re-entry meeting in person.

One applicable narrative reviewed had documentation the parole rules were established and reviewed and a signature was obtained from the juvenile prior to release from the JCC.

One applicable narrative reviewed had a summary comment providing case direction and documenting that the review had been completed and approved or modified as indicated by the supervisor in BADGE.

**CERTIFICATION AUDIT REPORT**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

**PROGRAM AUDITED:**
10th District Court Service Unit
Post Office Box 430
Halifax, VA 24558
(434) 352-8224
Kara Comer, Director
kara.comer@djj.virginia.gov

**AUDIT DATES:**
June 3-4, 2019

**CERTIFICATION ANALYST:**
Shelia L. Palmer

**CURRENT TERM OF CERTIFICATION:**
December 1, 2016 – November 30, 2019

**REGULATIONS AUDITED:**
6VAC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

**PREVIOUS AUDIT FINDINGS –** June 20-21, 2016:
100% Compliance Rating

**CURRENT AUDIT FINDINGS –** June 3-4, 2019:
88.4% Compliance Rating
No repeated deficiencies from previous audit.
Number of deficiencies: Five
**6VAC35-150-350 (A). Supervision plans for juveniles.**
**6VAC35-150-350 (B). Supervision plans for juveniles.**
**6VAC35-150-355. Supervision of juvenile on electronic monitoring.**
**6VAC35-150-410 (A). Commitment information.**
**6VAC35-150-420. Contacts during juvenile's commitment.**

**DEPARTMENT CERTIFICATION ACTION –** Certified the 10th District Court Service Unit until December 1, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**TEAM MEMBERS:**
Shelia L. Palmer, Team Leader
Clarice T. Booker, Central Office
Mark Lewis, Central Office
Learna Harris, Central Office
Jean Cobb, 6th District CSU (Hopewell)
Kevin Heller, 27th District CSU (Pulaski)
Tambrey Fedorko, 21st District CSU (Martinsville)
Dawn Loving, 22nd District CSU (Rocky Mount)

**POPULATION SERVED:**
The 10th District Court Service Unit serve the counties of Appomattox, Buckingham, Charlotte, Cumberland, Halifax, Lunenburg, Mecklenburg, and Prince Edward.

**PROGRAMS AND SERVICES PROVIDED:**
The 10th District Court Service Unit provide the following mandated services:

- Intake Services
- Investigations and Reports
- Domestic Relations
- Probation & Parole

The Unit interacts with the community in obtaining such services as:

- AMI Kids
- Community Services Board
- VJCCCA sponsored services
- Life Skills
- Substance Abuse Education
- Individual therapy
- Sex Offender and Substance Abuse Counseling
- Anger Management Group and Individual Counseling
- Electronic Monitoring

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**CORRECTIVE ACTION PLAN**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTIC**

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|---|---|
| **FACILITY/PROGRAM:** | 10th District Court Service Unit (Appomattox) |
| **SUBMITTED BY:** | Kara Comer, CSU Director |
| **CERTIFICATION AUDIT DATES:** | June 3-4, 2019 |
| **CERTIFICATION ANALYST:** | Shelia L. Palmer |

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

**6VAC35-150-350 (A). Supervision plans for juveniles.**
**A. To provide for the public safety and address the needs of a juvenile and that juvenile's family, a juvenile shall be supervised according to a written individual supervision plan, developed in accordance with approved procedures and timeframes, that describes the range and nature of field and office contact with the juvenile, with the parents or guardians of the juvenile, and with other agencies or providers providing treatment or services.**

**Audit Finding: Non-Compliant**
**Five of nine case files reviewed did not have documentation of the assessment of the juvenile's and or family's motivation for change. Five of nine case files reviewed did not**

**have documentation in the case narrative that the supervision plans were jointly developed and or signed by all parties.**

## Program Response

**Cause:**
Since the last audit period, there have been numerous staff changes to include two new supervisors and four new probation officers in the unit. The director was also promoted from a supervisor during this audit period. These staff changes were a contributing factor to items within the supervision plan being overlooked. The unit's supervision plan is formatted in such a manner as to prompt the staff to insert the motivation for change. Staff failed to specify the juvenile or family's direct motivation and worded it vaguely with one word on many plans. Supervisors failed to catch the shortened version of wording in the plans.

**Effect on Program:**
There is a minimal effect on the program. The documentation of the juvenile's and family's motivation for change was discussed and in the plan. It was not documented; however, in the appropriate way of specifying which person, the juvenile or family, is being discussed. For example, staff would list motivated with the assumption the reader would recognize it meaning for both family and youth. The supervision plans were signed by the parties however, staff did not appropriately document in the case narrative that "the plan was jointly developed and signed by all parties." Without proper documentation of the joint development, it is unknown whether the family and juvenile participated in the plan development.

**Planned Corrective Action:**
The Supervisors will review the supervision plans for compliance with the assessment of the juvenile's and family's motivation for change prior to approval with their signature on the case plan. CSU staff have been made aware of this non-compliance issue through staff meetings and individual meetings with their supervisors. The Director will also randomly review case plans for compliance. The probation officers have been given a template to appropriately document case plan development. This template states: "The supervision plan was jointly developed, discussed, and signed by all parties to include the probation officer, juvenile, and family."

**Completion Date:**
June 24, 2019

**Person Responsible:**
Director, Supervisors, and Probation Officers

**Current Status on September 12, 2019: Compliant**
Two of two case files reviewed documented the assessment of the juvenile's and or family's motivation for change.

One of one case file reviewed documented the entries in the case narratives indicating that the case plans was jointly developed and or signed by all parties.

**6VAC35-150-350 (B). Supervision plans for juveniles.**
**B. In accordance with approved procedures, each written individual supervision plan shall be reviewed (i) with the juvenile and the juvenile's family, and (ii) by a supervisor from both a treatment and a case management perspective to confirm the appropriateness of the plan.**

**Audit Finding: Non-Compliant**
**Three of eight case narratives reviewed did not have documentation that the reassessment using the YASI was completed once every 180 days.**

**Three of eight case narratives reviewed did not have documentation that the reassessment using the YASI was reviewed by the probation supervisor once every 180 days.**

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**Program Response**

**Cause:**
This was an oversight by the supervisors and probation officers.

**Effect on Program:**
Without the most up-to-date YASI, youth are not appropriately assessed at their current risk level. This could affect supervision levels, criminogenic need areas and services provided.
**Planned Corrective Action:**
Staff will complete YASI reassessments every 90 days versus every 180 days. Supervisors will monitor YASI reassessment due dates through community insights and send reminders to staff as necessary. Probation Staff will also monitor their due dates through community insights. Director will also run community insights report monthly to check compliance. A template has been created for probation staff and supervisors. Director has reviewed these requirements with staff and they were given the templates to use.

Probation Officer template: "A YASI re-assessment was completed. There were no changes to the supervision level OR A YASI re-assessment was completed and indicated changes to the risk level. The new risk level is_____."

Supervisor's template: "YASI reassessment was completed on (date). The following change was noted in the dynamic risk classification: (note change or no change). Supervision to proceed at the following level: (note level)."

**Completion Date:**
June 24, 2019

**Person Responsible:**
Supervisors, Probation Officers, and Director

**Current Status on September 12, 2019: Compliant**
Five of five case narratives reviewed documented the reassessment using the YASI was done once every 180 days.

Five of five case narratives reviewed documented the reassessment using the YASI was reviewed by the probation supervisor once every 180 days.

**6VAC35-150-355. Supervision of juvenile on electronic monitoring.**
**When a unit places a juvenile in an electronic monitoring program, use of the program shall be governed by approved procedures that shall provide for criteria for placement in the program, parental involvement, required contacts, consequences for tampering with and violating program requirements, and time limits.**

**Audit Finding: Non-Compliant**
**Three of six electronic monitoring cases reviewed did not have documentation of the length of time the juvenile will be monitored.**

## Program Response

**Cause:**
The CSU did not have a unit wide form for Electronic Monitoring used by the probation officers. The staff had been relying on the provider forms and giving the instructions verbally on the length of time.

**Effect on Program:**
The probation officer was verbally notifying the youth and their parent of the length of time on electronic monitoring. The provider was also verbally notifying the youth of the time they would be on the service. It had not been documented correctly on the forms. This could have raised questions from the client and family regarding their exact date of release from programming.

**Planned Corrective Action:**
Electronic monitoring will only be used as a sanction with supervisor approval. A form has been created that will state the length of time a juvenile will be monitored. Probation Officers, juvenile, family, and supervisor must sign this form prior to services being initiated. Director has reviewed these requirements with staff.

**Completion Date:**
June 24, 2019

**Person Responsible:**
Probation Officers, Supervisors

**Current Status on September 12, 2019: Not Determined**
During the Status Visit period July 1, 2019 – September 11, 2019, there have been no cases of juveniles placed on electronic monitoring

**6VAC35-150-410 (A). Commitment information.**
**A. When a juvenile is committed to the Department, the juvenile may not be transported to the Reception and Diagnostic Center (RDC) until (i) the items and information required by the Code of Virginia and approved procedures have been received by RDC and (ii) the case is accepted by RDC.**

**Audit Finding: Non-Compliant**

**Three of eight commitment letters did not document juveniles who are identified with a disability (i.e. 504 plan or Individual Education Program (IEP).**

**Three of eight commitment letters did not document the names of any known committed juveniles with whom contact with newly committed juvenile may be problematic.**

**Four of eight commitment letters did not document name(s) of any committed families.**

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**Program Response**

**Cause:**
This was an oversight and corrected when issue was recognized by Director in 2018.

**Effect on Program:**
Minimal, as any additional information needed would have been requested by CAP Unit.

**Planned Corrective Action:**
This was corrected with a standard cover letter that is saved on the District Wide X: drive. Staff are aware of where the letter is located. The supervisor and director review and sign the cover letter to ensure all information is accurate.
Following are the items of non-compliance now captured on the revised commitment cover letter:
(1) The youth has been identified with the following disability (i.e., 504 plan or Individualized Education Program (IEP):
(2) Name(s) of any known committed juveniles with whom contact with the newly committed juvenile may be problematic:
(3) Name(s) of any committed family members:

**Completion Date:**
June 10, 2019

**Person Responsible:**
Probation Officer, Supervisor, Director

**Current Status on September 12, 2019: Not Determinable**
There have been no commitments during the Status Review Period July 1, 2019 – September 11, 2019.

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**6VAC35-150-420. Contacts during juvenile's commitment.**
**During the period of a juvenile's commitment, a designated staff person shall make contact with the committed juvenile, the juvenile's parents, guardians, or other custodians, and the treatment staff at the juvenile's direct care placement as required by approved procedures. The procedures shall specify when contact must be face-to-face contact and when contacts may be made by video conferencing or by telephone.**

**Audit Finding: Non-Compliant**
**With Juvenile**

**Five of ten applicable commitment cases files did document the Probation Officer (PO) having monthly contact with the juvenile, either in person, via telephone or via video conferencing.**

**Eight of nine applicable commitment case files did not document all the required information with the juvenile during each monthly contact.**

**With Family**
**Three of eight applicable commitment case did not document the family face to face contact with the parent or legal guardian.**

**With JCC**
**Four of eight applicable commitment cases did not document the PO making the required monthly contacts with the juvenile correctional center counselor (JCC).**

**Seven of eight applicable commitment cases did not have documentation of the date for the following month meeting.**

**Community Supervision Phase**
**Three of eight applicable parole rules reviewed was not signed prior to release.**

**Four of seven applicable parole cases reviewed did not have documentation that the supervisor conducted a case staffing with the assigned PO for all level 3 and 4 parole cases at least every thirty (30) days.**

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## Program Response

**Cause:**
Probation Officers and Supervisors had many new responsibilities to learn after the introduction of the new Re-entry Manual. This led to staff missing some of the new contact requirements. As these areas of non-compliance were discovered in our self-audits, they were corrected.

**Effect on Program:**
There may have been an impact on programming with the staff not having monthly contact with the juvenile. Not having a specific discussion of topics each month could have led to delayed communication amongst all the involved parties. The time period in which the monthly contacts were missed was minimal and occurred when the new procedure came out with this change. Prior to the new manual, monthly juvenile contact was not required. In regards to the monthly contact information not being included, the Probation Officer was having monthly contact with the youth, just not documenting it correctly. Topics of concern were still addressed during the monthly juvenile contact.

With Family: This was also a change in the new reentry manual from monthly telephone contact to face to face contact. Contact was still being made with the parent monthly, just not face to face. Once the responsibilities of the new manual were learned, staff began making face to face monthly contact. Probation officers still maintained monthly contact with family, whether it was in person or over the telephone, still allowing the same information to be relayed and therefore should have had no impact on programing.

With JCC: Again, staff were adjusting to the new reentry manual requirements from being able to have monthly email contact to having monthly telephone or face to face contact. Contacts were still being made, they just were not in the correct manner. Staff were also having monthly meetings even if they were not documenting the following monthly meeting date. There should have been no effect on programming.

Community Supervision Phase: This non-compliance would have an impact if youth were to leave the facility without having the rules signed and they violated those rules. Supervisors were staffing cases with POs monthly but not documenting those case staffing. This is a minimal impact on programming as it was a documentation issue, not a service issue.

**Planned Corrective Action:**
Templates were created in 2018 after review of case files showed non-compliance issues. Staff were given copies of the new templates at that time. Supervisors and Director will randomly review cases through the BADGE case management module to ensure compliance with monthly contacts and follow-up with staff on missing contacts as appropriate. Supervisors and Director will review BADGE community insights module reports for contact compliance monthly and follow-up with staff on any missing contacts as appropriate. Supervisors will review direct care files no later than 72 hours prior to release to ensure rules are reviewed and signed. The Director will monitor Level 4 and Level 3 parole cases for supervisors' entry of case staffing every 30 days. Director has reviewed these requirements with staff.

A template has been created and shared with staff to ensure that staff are documenting the required components during the juvenile monthly contact. The template is as follows:
Family planning and progress on Family domain of CRCP:
Education goals and progress:
Behavioral Adjustments:
Intervention strategies:
Re-entry/parole placement and service needs (e.g. benefits);
Family transportation plan review and update:
Next scheduled monthly contact:

A template has been created and shared with staff to ensure staff are documenting the date for the following monthly meeting with the JCC Counselor. The template is as follows:
Juvenile's progress:
Behavior issues:
Family updates:
Next scheduled monthly contact:

**Completion Date:**
June 24, 2019

**Person Responsible:**
Probation Officers, Supervisors, Director

**Current Status on September 12, 2019: Compliant**
With Juvenile
Six of six applicable commitment cases files did document the Probation Officer (PO) having monthly contact with the juvenile, either in person, via telephone or via video conferencing.

Six of six applicable commitment case files documented all the required information with the juvenile during each monthly contact.

With Family
Six of six applicable commitment cases did document the family face to face contact with the parent or legal guardian.

With JCC
Six of six applicable commitment cases documented the PO making the required monthly contacts with the juvenile correctional center counselor (JCC).

Six of six applicable commitment cases documented the date for the following month meeting.

Community Supervision Phase
Two of two applicable parole rules reviewed were signed prior to release.

Two of two applicable parole cases reviewed did not have documentation that the supervisor conducted a case staffing with the assigned PO for all level 3 and 4 parole cases at least every thirty (30) days.

**CERTIFICATION AUDIT REPORT**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

**PROGRAM AUDITED:**
14th District Court Service Unit (Henrico)
4201 East Parham Road
Richmond, VA 23273
(804) 501-4692
Kathleen Jones, Director
kathleen.jones@djj.virginia.gov

**AUDIT DATES:**
May 29 – 30, 2019

**CERTIFICATION ANALYST:**
Shelia L. Palmer

**CURRENT TERM OF CERTIFICATION:**
December 1, 2016 – November 30, 2019

**REGULATIONS AUDITED:**
6VAC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

**PREVIOUS AUDIT FINDINGS – June 1, 2016:**
98.04% Compliance Rating
Number of Deficiencies: One
**6VAC35-150-336 (B). Social histories.**

**CURRENT AUDIT FINDINGS – May 30, 2019:**
89.1% Compliance Rating
No repeated deficiencies from previous audit.
Number of Deficiencies: Five
**6VAC35-150-336 (A). Social histories.**
**6VAC35-150-350 (A). Supervision plans for juveniles.**
**6VAC35-150-400. Notice of release from supervision.**
**6VAC35-150-410 (A). Commitment information.**
**6VAC35-150-420. Contacts during juvenile's commitment.**

**DEPARTMENT CERTIFICATION ACTION:** Certified the 14th Court Service Unit until December 1, 2022 with a status report from Regional Program Manager in June 2020.
*Pursuant to 6VAC35-20-100C.3, if the certification audit finds the program or facility in less than 100% compliance with all critical regulatory requirements or less than 90% on all noncritical regulatory requirements or both, and a subsequent status report, completed prior to the certification action, finds 100% compliance on all critical regulatory requirements and 90% or greater compliance on all noncritical regulatory requirements, the program or facility shall be certified for a specified period of time, up to three years.*

**TEAM MEMBERS:**
Shelia L. Palmer, Team Leader
Clarice T. Booker, Central Office

Deborah Hayes, Central Office
Mark Lewis, Central Office
Learna Harris, Central Office
John Zamora, 4th District CSU (Norfolk)
Ellen Madison, 8th District CSU (Hampton)
Kara Comer, 10th District CSU (Appomattox)
William Stanley, 12th District CSU (Chesterfield)
Kimberly Russo, 13th District CSU (Richmond)
Thomas Tomlin, 15th District CSU (Fredericksburg)
Cecilia Gomez-Brown, 16th District CSU (Charlottesville)

**POPULATION SERVED:**

The 14th District Court Service Unit serves the County of Henrico.

**PROGRAMS AND SERVICES PROVIDED:**

- Mandated Services:
  - Intake, investigative reports, probation and parole

- Other Services:
  - Children Services Act
  - AMI Kids
  - Mental Health
  - Court Alternative Program (Diversion)
  - Substance Abuse Assessments
  - Multi-Systemic Treatment (MST)
  - Post-Dispositional Program
  - Substance Abuse Education Program
  - Truancy Diversion
  - Fire Setters Program
  - Virginia Center for Restorative Justice
  - VJCCCA
  - Anger Management
  - Detention Outreach
  - Electronic Monitoring
  - Fresh Start
  - Larceny Reduction Program
  - Pearls (Girls Program)
  - STOP

**CORRECTIVE ACTION PLAN**

**TO THE**

**DEPARTMENT OF JUVENILE JUSTICE**

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|---|---|
| **FACILITY/PROGRAM:** | 14th District Court Service Unit (Henrico) |
| **SUBMITTED BY:** | Kathleen Egan Jones, CSU Director |
| **CERTIFICATION AUDIT DATES:** | May 29 -30, 2019 |
| **CERTIFICATION ANALYST:** | Shelia L. Palmer |

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

**6VAC35-150-336 (A). Social histories.**
**A. A social history shall be prepared in accordance with approved procedures (i) when ordered by the court, (ii) for each juvenile placed on probation supervision with the unit, (iii) for each juvenile committed to the Department, (iv) for each juvenile placed in a post dispositional detention program for more than 30 days pursuant to § 16.1-284.1 of the Code of Virginia, or (v) upon written request from another unit when accompanied by a court order. Social history reports shall include the following information:**

1. **Identifying and demographic information on the juvenile;**
2. **Current offense and prior court involvement;**
3. **Social, medical, psychological, and educational information about the juvenile;**
4. **Information about the family; and**
5. **Dispositional recommendations, if permitted by the court.**

**Audit Finding: Non-Compliant**
***Present Offense (s)***
**Five of 10 social histories reviewed did not document previous contacts with CSUs and or other known states.**

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**Program Response**

**Cause:**
With reference to contacts with other CSUs and states, probation staff were not clear about the need to write a statement regarding the lack of charges in other CSUs and other states. If there was no note of additional charges, staff did not explicitly state it. This was especially true with regard to statewide charges. Those charges normally are listed in the table of prior or current charges.

**Effect on Program:**
There was no effect on the program as none of the youth had charges in other localities. It did not affect the YASI or recommendations.

**Planned Corrective Action:**
Retraining of staff and a review of the checklist was completed with staff and supervisors. This occurred at a unit wide meeting, in a leadership meeting, and one on one with staff. Supervisors

also addressed this at their own unit meetings. Additionally, we modified our timeframes for supervisory reviews to allow more time for them to complete a more comprehensive review of the report. Staff now have due dates that are 3 days earlier than the date we originally used. Also, the director is providing additional oversite via reading an increased number of Social History reports. We also plan to utilize an exercise of having all supervisors review the same report for consistency and validity. This activity has been done once but will be ongoing with the leadership staff.

**Completion Date:**
June 20, 2019

**Person Responsible**:
Leadership, director and all staff who complete reports.

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***Community and Peer Relationships***
**Six of 10 social histories reviewed did not document the family and PO's view of the impact of the neighborhood on behavior.**

**Cause:**
Despite ongoing training on the need to provide both the family and the PO's view of the impact of the neighborhood on behavior, staff and supervisors still miss this section or place the statement in the wrong section.

**Effect on Program:**
The effect on the program is that the absence of this information could result in the reader not having a clear picture of the neighborhood in which the youth currently resides and reducing the potential for affecting future negative involvement.

**Planned Corrective Action:**
Retraining of staff and a review of the checklist was completed with staff and supervisors. This was completed at a unit meeting, in a leadership meeting, and one on one with staff. Additionally, we modified our timeframes for supervisory reviews to allow more time for them to complete a more comprehensive review of the report. Staff now have due dates that are 3 days earlier than the date we originally used. Also, the director is providing additional oversite via reading an increased number of Social History reports. We also plan to utilize an exercise of having all supervisors review the same report for consistency and validity. This activity has been done once but will be ongoing with the leadership staff.

**Completion Date:**
June 20, 2019

**Person Responsible:**
Leadership, director and all staff who complete reports.

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*Alcohol and Other Drugs*

**Five of 10 social histories reviewed did not document if the juvenile was under the influence at the time of the present offense.**

**Cause:**

Staff did not understand the need to make a specific statement as to the youth's use of alcohol or substances during the offense. Previous documentation in the reports indicated the youth never used substances. With that notation in the report, probation officers did not believe a specific statement needed to be documented in the report.

**Effect on Program:**

There was no effect on the program, as in general the youth were not involved in substance use. It did not affect the YASI or recommendations.

**Planned Corrective Action:**

Staff were retrained and the checklist was reviewed with staff and supervisors. Staff were advised that regardless of stated usage, there needed to be a specific statement as to usage during the event. Additionally, we modified our timeframes for supervisory reviews to allow more time for them to complete a more comprehensive review of the report. Staff now have due dates that are 3 days earlier than the date we originally used. Also, the director is providing additional oversite via reading an increased number of Social History reports. We also plan to utilize an exercise of having all supervisors review the same report for consistency and validity. This activity has been done once but will be ongoing with the leadership staff.

**Completion Date:**

June 20, 2019

**Person Responsible**:

Leadership, director and all staff who complete reports.

*Pre- and Post-Dispositional Report Requirements*

**Three of seven pre-dispositional social histories reviewed were not completed 45 calendar days from the date of adjudication, if the juvenile is not detained as established by approved procedures.**

**Three of seven pre-dispositional social histories were not filed with the clerk's office 72 hours in advance of the dispositional court date.**

**Cause**:

In the cases of pre-dispositional reports not completed within 45 calendar days, all incidents were a result of not requesting a waiver for the time frame. The late filing of reports was due to probation officers not completing the reports in a timely manner and allowing sufficient time for supervisory review.

**Effect on Program:**

There was little effect on not having the reports completed within 45 days as the closer to the court hearing it is, the more current the information. However, late filing decreases the time that the judiciary and attorneys have to review the report

**Planned Corrective Action:**
The supervisors are now requesting a waiver of the timeframes prior to assigning the case and a folder has been set up on the X drive to retain approved waivers in case the original is misplaced. Time frames were reviewed with staff and the supervisors have decreased the time for completion, which allows more time for supervisory reviews and makes a late filing less likely. Time management continues to be a concern for some staff and training in time management is scheduled.

**Completion Date:**
August 14, 2019

**Person Responsible:**
Director, leadership and OSS Supervisor Sr.

**Current Status on October 17, 2019: Compliant**

**6VAC35-150-350 (A). Supervision plans for juveniles.**
**A. To provide for the public safety and address the needs of a juvenile and that juvenile's family, a juvenile shall be supervised according to a written individual supervision plan, developed in accordance with approved procedures and timeframes, that describes the range and nature of field and office contact with the juvenile, with the parents or guardians of the juvenile, and with other agencies or providers providing treatment or services.**

**Audit Finding: Non-Compliant**
**Three of six applicable case narratives did not include entries indicating that all parties had discussed the supervision plan.**

**Three of six applicable case narratives did not have documentation to indicate that the case plan was either jointly developed, discussed and or signed by all parties.**

## Program Response

**Cause:**
Staff have not always embraced the need to properly document the process for the development and completion of the supervision plans. This was also a concern in our last audit. The plan may contain the signature page with the dates but there was not a subsequent notation in BADGE. The narrative, if in BADGE, may not have been as complete as needed.

**Effect on Program:**
The effect on the program is that when reading the BADGE documentation on cases not appropriately notated it would appear that the youth and family were not part of the plan

development. Their participation is critical to proper case management and overall engagement in the successful completion of the plan.

**Planned Corrective Action**:
Review of the regulation was completed during the June 20 and July 18 staff meetings. Additionally, Ms. Pinkney provided staff with a template to be used with the initial plan development. This was provided to all staff at the July 18 staff meeting and an electronic copy is to be given to all staff prior to July 26, 2019. Supervisors will be reviewing the contents of the plan development in real time as opposed to waiting until the 90-day reviews. The director will be increasing review of BADGE notes to assure appropriate documentation.
**Completion Date:**
July 26, 2019 and on going

**Person Responsible**:
Probation staff, leadership and the director

**Current Status on October 17, 2019: Compliant**
Three of three applicable case narratives included entries indicating that all parties had discussed the supervision plan.

Three of three applicable case narratives documented that the case plan was either jointly developed, discussed and or signed by all parties.

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**6VAC35-150-400. Notice of release from supervision.**
**Notice of release from supervision shall be given in writing to the individual under the supervision of a CSU and to the parents or guardians of juveniles. Such notification shall be appropriately documented in the case record in accordance with approved procedures.**

**Audit Finding: Non-Compliant**
**Three of seven parole case records reviewed did not have a complete and signed certificate of discharge.**

**Three of seven parole case records reviewed did not have a copy of the certificate in the case file within thirty (30) days of release from parole.**

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## Program Response

**Cause**:
In the cases that did not have a complete and signed certificate of discharge and did not have the signed certificate in the file, it was determined that the parole staff did not understand that even at 21 years of age, that requirement needed to be met. Aging out of the system did not release the officer from completing the needed paper work.

**Effect on Program:**
The closed cases were incomplete with regard to the necessary paperwork.

**Planned Corrective Action:**
All parole staff reviewed the regulation. Paperwork was completed after the audit and placed in the file, although it did not meet the 30-day requirement. Going forward all closures regardless of the reason will have a signed certificate of discharge completed and placed in the file within 30 days.

**Completion Date:**
July 1, 2019

**Person Responsible:**
Parole staff to include the supervisor.

**Current Status on October 17, 2019: Compliant**
Five of five parole case records reviewed did have a complete and signed certificate of discharge.

Five of five parole case records reviewed did have a copy of the certificate in the case file within thirty (30) days of release from parole.

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**6VAC35-150-410 (A). Commitment information.**
**A. When a juvenile is committed to the Department, the juvenile may not be transported to the Reception and Diagnostic Center (RDC) until (i) the items and information required by the Code of Virginia and approved procedures have been received by RDC and (ii) the case is accepted by RDC.**

**Audit Finding: Non-Compliant**
**Four of six commitment letters did not document pending court dates.**

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**Program Response**

**Cause:**
Our commitment letters were silent when there was not a pending court date.

**Effect on Program:**
There was limited effect on the program as there were not pending court dates that affected the commitment process.

**Planned Corrective Action:**
A modification made to the commitment letter to note a "hearing" or "no hearing" will correct this area of non-compliance. A drop box will indicate to CAP as well, what court will hear the case.

**Completion Date:** June 6, 2019

**Person Responsible:**
Director, Leadership, probation officers, OSS staff.

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**Three of six commitment cases did not have documentation of immediately notifying the CAP Unit Staff of the packet being posted on the shared drive via email.**

**Cause:**
Supervisors were only noting the packet was sent to the CAP unit and did not specify "who in the CAP unit" was notified.

**Effect on Program:**
There was limited effect on the program as the packets were sent with the notification.

**Planned Corrective Action:**
The regulation was reviewed with the Leadership and a review of the initial commitment process will be done by the forwarding supervisor upon transfer to the parole unit. This will increase the opportunity to correctly note who received the packet.
**Completion Date:**
August 1, 2019

**Person Responsible:**
Director, Leadership, probation officers

**Current Status on October 17, 2019: Non-Compliant**
Two of three commitment letters did not document pending court dates.

Three of three applicable commitment cases did have documentation of immediately notifying the CAP Unit Staff of the packet being posted on the shared drive via email.

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**6VAC35-150-420. Contacts during juvenile's commitment.**
**During the period of a juvenile's commitment, a designated staff person shall make contact with the committed juvenile, the juvenile's parents, guardians, or other custodians, and the treatment staff at the juvenile's direct care placement as required by approved procedures. The procedures shall specify when contact must be face-to-face contact and when contacts may be made by video conferencing or by telephone.**

**Audit Finding: Non-Compliant**

**<u>With Juvenile</u>**
**Three of eight applicable commitment case files did not document the monthly contacts with the juvenile.**

**Five of eight applicable commitment case files did not document all the required information with the juvenile during each monthly contact.**

**Five of eight applicable commitment case files did not document the juvenile's monthly contacts as family progress notes in BADGE.**

**With Family**

**Five of eight applicable commitment case files did not document the contacts in BADGE as Family Progress Reports.**

**With JCC**

**Five of eight applicable commitment cases dates for the following month was not determined.**

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## Program Response

**Cause:**

The re-entry process is very complicated with many parts and an understanding of parole is critical for all staff. Parole staff did not have a good understanding of the parole regulations and coupled with not utilizing the parole check sheet available to staff was problematic. Other causes included not checking the specific boxes in BADGE and not checking available Community Insight reports for contact compliance readily available to staff and supervisors. With respect to dates for subsequent meetings, it was a combination of just not scheduling the dates or not scheduling one due to conflicts with counselor dates. Staff reported being reluctant to set any date, knowing it would need to be changed. Additionally the director did not have a thorough understanding of all the intricacies of parole. Much of my previous efforts were directed at contact compliance and reviewing case plans and efforts with EPICS, and not the specific running record notations

**Effect on Program:**

This had a significant impact on the contact compliance for the parole unit. It could give the appearance that youth were not seen in the facility during their stay and parents were not seen face-to-face. The effect on scheduling subsequent meetings did not seem to have an effect. Meetings were scheduled and there were not issues with missed dates.

**Planned Corrective Action:**

The regulations were reviewed with the parole supervisor and she continues to review the process with her staff. This review continues and all staff are required to use the check sheets to complete their entries. Parole staff will be reviewing their contact compliance reports in Community Insights. The director will be increasing oversight not just on the contact compliance but with running record documentation to ensure the proper format is used. The parole supervisor will be asking the training unit to include our newest staff in the parole basic skills training. Ongoing training in-house will also be provided to the parole staff. Ms. Evans, and others as applicable, will participate in Regional parole meetings.

**Completion Date:**

June 2019 and on going.

**Person Responsible:**

Parole supervisor, parole staff and the director.

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**Community Supervision Phase**

**Three of three applicable parole cases reviewed did not have parole rules which were signed prior to release from the juvenile correctional facility.**

**Three of three applicable parole cases reviewed did not have documentation that the juvenile signed the CRCP prior to the juvenile's release.**

**Cause:**
This appears to be a combination of parole officers not fully understanding the regulation as well as not having the forms with them at the time of the visit. Youth signed the forms when released and arrived at the office on day of release. There is also some confusion as to the need to document in BADGE.

**Effect on Program:**
There could have been a significant impact on the program if the youth absconded prior to signing the rules.

**Planned Corrective Action:** The regulation was reviewed with the parole supervisor and parole staff. Boxes for the county cars were purchased which will contain all needed forms to include rules used. These boxes will be permanently placed in the cars ensuring that the necessary forms will always be available. Staff assigned to the cars will be responsible for ensuring the boxes contained needed supplies.

**Completion Date:**
August 1, 2019

**Person Responsible:**
Parole supervisor, parole officers and the director.

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**Two of five applicable parole case narratives reviewed had documentation that the supervision matrix was changed without any kind of 90-day review.**

**Cause:**
This seems to be a documentation error. Parole staff do not change levels without over sight by the supervisor.

**Effect on Program:**
There could be a significant impact if levels were lowered inappropriately or not increased as needed.

**Planned Corrective Action:**
The regulation was reviewed with the parole supervisor and parole staff.

**Completion Date:**
June 2019

**Person Responsible:**
Parole supervisor, parole staff and the director

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**Four of eight applicable parole case narratives reviewed did not have documentation that the case was reviewed with the parent and or juvenile every 90 days.**
**Three of seven applicable parole case files reviewed did not have documentation that the YASI Re-assessment was conducted once every 180 days.**

**Cause:**
Case management, time management issues, and documentation appear to be the cause. Staff and supervisors are routinely provided with Community Insight reports detailing late reviews and upcoming review dates.

**Effect on Program:**
There is a significant impact on the program as YASI reassessments and plan reviews are critical to our work with parole youth. YASI re-assessments not completed in a timely manner do not give a complete picture of the youth.

**Planned Corrective Action:**
The regulation was reviewed with the parole supervisor and staff. The need to be timely with reviews and YASI re-assessments was discussed at our June and July staff meetings. The need for accurate and timely reviews and contacts were also discussed at our Leadership meeting in July. Staff were reminded of their need to monitor their work and review the plans with families.

**Completion Date:**
July 2019

**Person Responsible:**
Parole supervisor, parole officers and the director.

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**Seven of seven applicable parole cases reviewed did not have documentation that the supervisor conducted a case staffing with the assigned PO for all level 3 and 4 parole cases at least every thirty (30) days.**

**Cause:**
This was a significant oversight by the parole supervisor, despite the fact that she has done these reviews previously. The oversight was also on the director who did not notice the missing reviews.

**Effect on Program:**
There is a significant impact on the program as supervisory oversight is imperative to the case management process.

**Planned Corrective Action:**
The regulation was reviewed with the parole supervisor. In addition, a "white board" was purchased and installed in the parole supervisor's office to provide visual cues of the due dates for parole levels 3 and 4 reviews. Additional review from the director will also be done to ensure continued compliance.

**Completion Date:**
June 2019

**Person Responsible:**
Parole supervisor and the director

**Current Status on October 17, 2019: Compliant**
With Juvenile - **Not Determinable**
There were no applicable commitment cases during the status review period of July 1, 2019 – October 16, 2019

With Family – **Not Determinable**
There were no applicable commitment cases during the status review period of July 1, 2019 – October 16, 2019

With JCC – **Not Determinable**
There were no applicable commitment cases during the status review period of July 1, 2019 – October 16, 2019

Community Supervision Phase - **Compliant**
One of four applicable parole cases reviewed did not have parole rules which were signed prior to release from the juvenile correctional facility.

Four of four applicable parole cases reviewed documented that the juvenile signed the CRCP prior to the juvenile's release.

Three of three applicable parole case narratives reviewed documented that the supervision matrix was changed with a 90-day review.

Four of four applicable parole case narratives reviewed did not have documentation that the case was reviewed with the parent and or juvenile every 90 days.

Three of seven applicable parole case files reviewed documented that the YASI Re-assessment was conducted once every 180 days.

Supervisor Responsibilities - **Compliant**
Two of eight applicable parole cases reviewed did not have documentation that the supervisor conducted a case staffing with the assigned PO for all level 3 and 4 parole cases at least every thirty (30) days.

**CERTIFICATION AUDIT REPORT**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

**PROGRAM AUDITED:**
21st District Court Service Unit
3160 Kings Mountain Road
Martinsville, VA 24112
(276) 634-4865
Barry K. Meeks, Director
barry.meeks@djj.virginia.gov

**AUDIT DATES:**
June 3-4, 2019

**CERTIFICATION ANALYST:**
Shelia L. Palmer

**CURRENT TERM OF CERTIFICATION:**
December 1, 2016 – November 30, 2019

**REGULATIONS AUDITED:**
6VAC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

**PREVIOUS AUDIT FINDINGS** - June 13-14, 2016
100% Compliance Rating

**CURRENT AUDIT FINDINGS** – June 3-4, 2019:
93.2% Compliance Rating
**6VAC35-150-300 (B). Predispositionally placed juvenile.**
**6VAC35-150-410 (A). Commitment information.**
**6VAC35-150-420. Contacts during juvenile's commitment.**

**DEPARTMENT CERTIFICATION ACTION** – Certified the 21st District Court Service Unit until December 1, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**TEAM MEMBERS:**
Shelia L. Palmer, Team Leader
Clarice T. Booker, Central Office
Mark Lewis, Central Office
Aileen Lewis, 10th District CSU (Appomattox)
Elaine Lassiter, 20-W District CSU (Warrenton)
Kevin Downs, 28th District CSU (Abingdon)
Robert Hiatt, 27th District CSU (Pulaski)

**POPULATION SERVED:**
The 21st District Court Service Unit serve Henry and Patrick Counties and the City of Martinsville.

**PROGRAMS AND SERVICES PROVIDED:**
- Intake Services

- Investigations and Reports
- Domestic Relations
- Probation & Parole

The Unit interacts with the community in obtaining such services as:

- Outreach/Electronic Monitoring
- Residential Group Home
- Education Based Program which addresses:
  - Anger Management
  - Self-Esteem
  - Substance Abuse
  - Focus on Youth
  - Piedmont Community Service Board
  - Family Preservation Services

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**CORRECTIVE ACTION PLAN**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

| | |
|---|---|
| **FACILITY/PROGRAM:** | 21st District Court Service Unit (Martinsville) |
| **SUBMITTED BY:** | Barry Kevin Meeks, CSU Director |
| **CERTIFICATION AUDIT DATES:** | June 3-4, 2019 |
| **CERTIFICATION ANALYST:** | Shelia L. Palmer |

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

**6VAC35-150-300 (B). Predispositionally placed juvenile.**
**B. The case of each predispositionally placed juvenile shall be reviewed at least every 10 days in accordance with approved procedures to determine whether there has been a material change sufficient to warrant recommending a change in placement.**

**Audit Finding: Non-Compliant**
**Two of three case records reviewed did not have documentation that the juvenile placed in detention was reviewed by the supervisor once every 10 days.**

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**Program Response**

**Cause:**
The staff who was designated with this responsibility allowed the timeframe for review to be exceeded by one day in each case. When I reviewed the audit results the individual was adamant

the detention reviews were done weekly. I reminded the staff this requirement was a ten-day requirement and simply doing them each week may not necessarily result in compliance with the minimum standard.

**Effect on Program:**
Missing the review timeframe in these cases had no effect on the youth's placement. In both cases there was no material change in the youth's circumstance which would have warranted a change in placement.

**Planned Corrective Action:**
The standard has been reviewed with the individual who was tasked with this assignment and they fully understand the requirement is every 10 days and not weekly. Additionally, while neither the minimum standard nor the procedure require this process to be performed by a supervisor, I have made the decision to reassign these duties to the Henry County Supervisor. The individual serving in this capacity previously will continue to serve as backup and assist to ensure this task is completed on Thursday of every week. Therefore, these reviews shall occur every 7 days which will provide us with a buffer for the 10-day requirement. Both of these individuals will have an automatic google calendar reminder to prompt them to perform this task.

**Completion Date:**
Implementation of the corrective action plan will begin as soon as possible but no later than July 1, 2019.

**Person Responsible:** B. Kevin Meeks, Unit Director

**Current Status on September 11, 2019: Compliant**
Four of four applicable case records reviewed documented the juvenile placed in detention was reviewed by the supervisor once every 10 days.

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**6VAC35-150-410 (A). Commitment information.**
**A. When a juvenile is committed to the Department, the juvenile may not be transported to the Reception and Diagnostic Center (RDC) until (i) the items and information required by the Code of Virginia and approved procedures have been received by RDC and (ii) the case is accepted by RDC.**

**Audit Finding: Non-Compliant**
**Two of four commitment letters did not have documentation of juveniles who are identified with a disability (i.e. 504 plan or individual Education Program (IEP). Two of four commitment cases did not have documentation of any committed family members.**

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**Program Response**

**Cause:**
The staff incorrectly assumed if the youth did not have a documented disability (i.e. 504 plan or Individual Education Program) or no committed family members then the issue did not need to be addressed in the cover letter. The staff was fully informed and had the information but neglected to simply say the issues were not applicable.

**Effect on Program:**
This had no effect on the delivery of services or educational planning for the youth at the facility. The complete school records were available in the commitment package even though the letter failed to have complete information.

**Planned Corrective Action:**
Staff has been counseled that information which is not applicable must still be addressed in the commitment letter and documented as such. Additionally, The Unit has prepared a commitment letter template which specifically numbers and lists each requirement in 6VAC35-150-410(A), including the above stated deficiencies.

**Completion Date:**
Implementation of the corrective action plan will begin by July 1, 2019.

**Person Responsible:**
B. Kevin Meeks, Unit Director

**Current Status on September 11, 2019: Not Determined**
There were no applicable commitment cases during the status review period of July 15, 2019 – September 11, 2019.

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**6VAC35-150-420. Contacts during juvenile's commitment.**
**During the period of a juvenile's commitment, a designated staff person shall make contact with the committed juvenile, the juvenile's parents, guardians, or other custodians, and the treatment staff at the juvenile's direct care placement as required by approved procedures. The procedures shall specify when contact must be face-to-face contact and when contacts may be made by video conferencing or by telephone.**

**Audit Finding: Non-Compliant**
**<u>With Juvenile</u>**
**Three of three applicable commitment case files did not document all the required information with the juvenile during each monthly contact.**

**Two of three applicable commitment case files did not document the monthly contacts in BADGE as a verbal family progress note.**

**<u>With Family</u>**
**One of two applicable commitment case files did not document all the required information with the family during each monthly contact.**

**One of two applicable commitment case files did not document the contacts in BADGE as Family Progress Reports.**

**<u>With JCC</u>**
**One of two applicable commitment cases dates for the following month was not determined.**

**<u>Supervisor Responsibilities</u>**
**Two of five applicable parole cases reviewed did not have documentation that the**

**supervisor conducted a case staffing with the assigned PO for all level 3 and 4 parole cases at least every thirty (30) days.**

## Program Response

**Cause:**
The complexity of the Re-entry manual and more specifically the outlined requirements in 6VAC35-150-420 are so numerous and detailed properly documenting all this information is very difficult without some type of checklist or template to organize the information. It is my belief the PO's have a very thorough understanding of these cases, ask the appropriate questions and know the required information. I failed to give them the tools necessary to organize and document this detailed and complex requirement.

**Effect on Program:**
After reviewing the cases I do not believe the missing documentation had any impact on the case or service delivery to the youth and family. Often this information was documented elsewhere in the file.

**Planned Corrective Action:**
The Unit plans to correct the above mentioned discrepancies in two ways. 1). The Unit will develop a comprehensive checklist which outlines every single requirement (and associated documentation requirement) in the Re-entry Manual from the time of commitment up until their release from parole. 2). The Unit will develop a word template which lists and covers every single contact requirement with the youth, family and JCC staff. These templates will ensure the P.O. covers all requirements (A – F and A – H). This can be saved on the computer of each Parole Officer who can use the guide as their contact narrative and copy and paste it into BADGE. The above mentioned Re-entry checklist will include the requirements of the Supervisor. I have counseled the supervisors on this issue.

**Completion Date:**
July 15, 2019 (this is a complex document which will require more time to develop).

**Person Responsible:**
B. Kevin Meeks, Unit Director

**Current Status on September 11, 2019: Compliant**
With Juvenile
One of one commitment case file documented all the required information with the juvenile during each monthly contact.

One of one commitment case file documented the monthly contacts in BADGE as a verbal family progress note.

With Family
One of one applicable commitment case file documented all the required information with the family during each monthly contact.

One of one applicable commitment case file documented the contacts in BADGE as Family Progress Reports.

With JCC
One of one applicable commitment case dates for the following month were determined.

Supervisor Responsibilities
One of one applicable parole case reviewed documented that the supervisor conducted a case staffing with the assigned PO for all level 3 and 4 parole cases at least every thirty (30) days.

**CERTIFICATION AUDIT REPORT**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

**PROGRAM AUDITED:**
22nd District Court Service Unit
275 South Main Street, Suite 531
Rocky Mount, VA 24151
(757) 926-3676
Joyce Green, Director
joyce.green@djj.virginia.gov

**AUDIT DATES:**
June 5-6, 2019

**CERTIFICATION ANALYST:**
Mark Ivey Lewis

**CURRENT TERM OF CERTIFICATION:**
December 1, 2016 – November 30, 2019

**REGULATIONS AUDITED:**
6AC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

**PREVIOUS AUDIT FINDINGS – February 22, 2017:**
**6VAC35-150-336 (A). Social History**
**6VAC35-150-410 (A). Commitment information.**

**CURRENT AUDIT FINDINGS – June 6, 2019:**
90.90% Compliance Rating
Two repeated deficiencies from previous audit.
Number of deficiencies: Five
***6VAC35-150-336 (A). Social histories.**
**6VAC35-150-350 (A). Supervision plans for juveniles.**
***6VAC35-150-410 (A). Commitment information.**
**6VAC35-150-415. Supervision of juvenile in direct care.**
**6VAC35-150-420. Contacts during juvenile's commitment.**

**DEPARTMENT CERTIFICATION ACTION –** Certified the 22nd District Court Service Unit December 1, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**TEAM MEMBERS:**
Mark Ivey Lewis, Team Leader
Clarice Booker, Central Office
Shelia Palmer, Central Office
Shelia Halsey, 23rd District CSU (Salem)
Kimberly Keller, 31st District CSU (Manassas)

Amy Johnson, 28th District CSU (Abingdon)

**POPULATION SERVED:**

The 22nd District Court Service Unit serve the City of Danville, Franklin County and Pittsylvania County.

**PROGRAMS AND SERVICES PROVIDED:**

The 22nd District Court Service Unit provides mandated services including:

- Intake Services
- Diagnostic (Investigation and Reports)
- Probation supervision
- Supervision Cases
    - Probation
    - Parole
    - Diversion

The Unit interacts with the community in obtaining such services as:

- **Post-dispositional Program**
    - Roanoke Valley Juvenile Detention Center for juveniles in Franklin County
    - W.W. Moore Juvenile Detention Center for juvenile in the City of Danville and in Pittsylvania County
- **VJCCCA Programs**
    - City of Danville
        - Outreach Detention
        - Electronic Monitoring
        - Anger Management Services
    - Franklin County
        - Electronic Monitoring
    - Pittsylvania County
        - Electronic Monitoring
        - Outreach Detention
        - Anger Management
- **Other Primary Referrals**
    - Job Training
    - Sex Offender Treatment
    - Mentoring
    - Psychological Evaluation
    - Group Home and Residential Placement
    - Intensive Care Coordination
    - Individual Counseling
    - Parent Aide Services
    - In Home Counseling

**CORRECTIVE ACTION PLAN**
**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

**FACILITY/PROGRAM:** 22nd District Court Service Unit (Rocky Mount)

**SUBMITTED BY:** Joyce Green, CSU Director

**CERTIFICATION AUDIT DATES:** June 5-6, 2019

**CERTIFICATION ANALYST:** Mark Ivey Lewis

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

**6VAC35-150-336 (A). Social histories.**
**A. A social history shall be prepared in accordance with approved procedures (i) when ordered by the court, (ii) for each juvenile placed on probation supervision with the unit, (iii) for each juvenile committed to the Department, (iv) for each juvenile placed in a post-dispositional detention program for more than 30 days pursuant to § 16.1-284.1 of the Code of Virginia, or (v) upon written request from another unit when accompanied by a court order. Social history reports shall include the following information:**

1. **Identifying and demographic information on the juvenile;**
2. **Current offense and prior court involvement;**
3. **Social, medical, psychological, and educational information about the juvenile;**
4. **Information about the family; and**
5. **Dispositional recommendations, if permitted by the court.**

**Audit Finding: Non-Compliant**
**Per approved procedures, the following information was either missing or was placed in the wrong section of the social histories which were reviewed:**

- **Some sections in four of ten social histories reviewed did not include the standard Social History Template.**
- **Four of ten social histories reviewed did not include information on the "impact of alcohol or drug use".**

**Program Response**

**Cause:**
Probation Officers and Supervisors did not consistently use the template & checklist given by DJJ to complete Social Histories.

**Effect on Program:**

There is no long term or major effect to the program in the two areas the District was cited for non-compliance. Changes to the template were made to accommodate the Court in not grouping petitions together before addressing probable cause and other information when there are multiple offenses. One PO failed to address DOB/AGE appropriately when answering DOB/AGE. The PO added the word "AGE." Staff also separated the YASI Generated information from the enhance information by adding a section entailed "Other Source" instead of blending the YASI generated & enhanced information together. In the four reports that did not address the impact of alcohol or drug use, staff failed to make a statement either when there was no impact when youth were not impacted alcohol or drug use.

**Planned Corrective Action:**
The Probation Officers and Supervisors were resent the email from Kenneth Davis on March 15, 2017 on Social Histories Document with the social history template, checklist & updated FAQ. They were resent this email on 6/12/19. On 6/14/19, at a districtwide staff meeting, these audit findings (non-compliance areas and areas of concerns) were discussed. All Probation Officers and Supervisors were instructed not to modify the template in any way and to use the checklist consistently to ensure that all the required information is captured in the report in the right section. The Supervisors will meet with the Probation Officers individually to discuss the areas of non-compliance and areas of concerns. The Supervisors will also attach the signed checklist to each completed Social History placed in the file. The Director will conduct random review of at least two social histories each month to ensure compliance.

**Completion Date:**
June 24, 2019

**Person Responsible:**
All Probation Officers that complete Social Histories, Supervisors and Director Green are responsible for ensuring compliance.

**Current Status on October 3, 2019: Compliant**
Ten of ten social histories reviewed used the standard social history template and they included information about the "impact of alcohol or drug use".

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**6VAC35-150-350 (A). Supervision plans for juveniles.**
**A. To provide for the public safety and address the needs of a juvenile and that juvenile's family, a juvenile shall be supervised according to a written individual supervision plan, developed in accordance with approved procedures and timeframes, that describes the range and nature of field and office contact with the juvenile, with the parents or guardians of the juvenile, and with other agencies or providers providing treatment or services.**

**Audit Finding: Non-Compliant**
**Per procedures, the supervision plans were missing the following information:**

- **Three of four case records reviewed did not have documentation that supervision plans were discussed within 45 days after disposition with the juvenile and/or parents.**

- **Two of four case narratives reviewed did not indicate that the case plan was jointly developed by the probation officer, juvenile and family.**

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## Program Response

**Cause:**
Probation staff not consistently adhering to Procedure 9324 in regards to documenting that the PO discussed the supervision plans within 45 days with both the juvenile & parent. Staff went beyond the 45 days by a day or two or did not review it with both parties.

**Effect on Program:**
There is no long term or major effect to the program in the areas the District was cited for non-compliance. The plans were developed in the required timeframes, but not reviewed according to policy.

**Planned Corrective Action:**
On June 14, 2019, the Director & Supervisors met with the staff of the 22nd District and reviewed the audit finding. Staff were given templates to use when developing a Probation Supervision Case Plan, reviewing the Probation Supervision Case Plan and conducting a YASI reassessment. A local practice was drafted to assist in ensuring the plans are completed on time. The local practice adjusted the completion of the Probation Supervision Case Plan, the Probation Supervision Case Review, and the YASI Reassessment to earlier dates than the DJJ procedure. The Supervisors will be required to assess the completion of the Supervision Plan according to policy two weeks before statewide procedure to ensure compliance. (See the attached local written practice dated July 1, 2019.

**Completion Date:**
July 1, 2019

**Person Responsible:**
The Probation Officers, Supervisors & Director Green are responsible to ensure compliance.

**Current Status on October 3, 2019: Compliant**
Ten probation records were reviewed:

- They all had documentation that the supervision plan was discussed with the juvenile and parents within 45 days after disposition.
- The case narrative indicated the case plan was jointly developed by the probation officer, juvenile and family.

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**6VAC35-150-410 (A). Commitment information.**
**A. When a juvenile is committed to the Department, the juvenile may not be transported to the Reception and Diagnostic Center (RDC) until (i) the items and information required by**

**the Code of Virginia and approved procedures have been received by RDC and (ii) the case is accepted by RDC.**

**Audit Finding: Non-Compliant**
**Five of nine case records reviewed did not have documentation for some of the Central Admission and Placement (CAP) unit staff being notified of the packet's posting on the shared drive via email.**

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## Program Response

**Cause:**
Staff was unaware that the Re-entry procedure required that the CAP Manager (Demetria Clayton) needed to be notified through email that a commitment packet was posted on the shared drive. It should be noted an email was sent to three other CAP personnel, notifying that the commitment packet was on the shared drive.

**Effect on Program:**
There is no long term or major effect to the program in this area. All commitment packets submitted to the CAP Unit was received in a timely fashion.

**Planned Corrective Action:**
The commitment email template was updated to include the CAP Manager Demetria Clayton as well as the other CAP staff. This template was saved to the district shared drive on 6/19/19. A copy of the template was emailed to appropriate staff who complete the task of notifying the CAP unit that a commitment packet has been downloaded to the S-drive on 6/14/19. Staff was advised by email to discard the old template and to use the new one on 6/19/19.

**Completion Date:**
June 19, 2019

**Person Responsible:**
The Probation Officers, Supervisors & Director Green are responsible to ensure compliance.

**Current Status on October 3, 2019: Compliant**
Two or two commitment packets reviewed had an e-mail notifying the CAP unit staff in the master file room, both counselor supervisors, and the CAP manager of the commitment packets being posted on the shared drive.

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**6VAC35-150-415. Supervision of juvenile in direct care.**
**For a juvenile placed in direct care, the probation or parole officer shall, in accordance with approved procedures, do the following:**

1. **Develop and implement a family involvement plan.**
2. **Develop a parole supervision plan.**
    a. **For a juvenile indeterminately committed to the Department pursuant to subsection A (14) of § 16.1-278.8 and § 16.1-272 of the Code of Virginia, CSU**

**staff shall complete a parole supervision plan in accordance with approved procedure.**

**b. For a juvenile determinately committed to the Department pursuant to subdivision A (17) of § 16.1-278.8 or §§ 16.1-285.1 or 16.1-272 of the Code of Virginia, a parole supervision plan shall be prepared for all serious offender judicial review hearings as required by law and in accordance with approved procedures.**

**3. Send a report on the family's progress toward planned goals of the family involvement plan to the facility at which the juvenile is housed.**

**Audit Finding: Non-Compliant**
**Seven of ten case records reviewed did not have documentation that a family involvement plan (Family Domain Cover Sheet of the CRCP) had been developed and implemented.**

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**Program Response**

**Cause:**
Parole Staff was unware that the Family Domain Cover Sheet of the CRCP needed to be printed and placed in the file. The plan was completed as required, but the cover sheet was not printed for the file.

**Effect on Program:**
There is no long term or major effect to the program in the area the District was cited for non-compliance.

**Planned Corrective Action:**
A districtwide staff meeting was held on 6/14/19 to review the audit finding. The Supervisors and Director met separately with all staff that does direct care and parole supervision on 6/14/19. We reviewed all the audit findings that dealt with commitment and re-entry. They were instructed to print the coversheet and include it in the commitment packet to ensure compliance.

**Completion Date:**
June 14, 2019

**Person Responsible:**
Parole Staff with oversight by the Supervisors

**Current Status on October 3, 2019: Compliant**
One applicable case record reviewed had documentation that a family involvement plan (Family Domain Coversheet of the CRCP) has been developed and implemented

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**6VAC35-150-420. Contacts during juvenile's commitment.**
**During the period of a juvenile's commitment, a designated staff person shall make contact with the committed juvenile, the juvenile's parents, guardians, or other custodians, and the treatment staff at the juvenile's direct care placement as required by approved**

**procedures. The procedures shall specify when contact must be face-to-face contact and when contacts may be made by video conferencing or by telephone.**

**Audit Finding: Non-Compliant**
**Per procedures, the case records and/narratives were missing the following information:**

- **Three of six case records reviewed had documentation that the probation officer did not attend the re-entry meeting in person.**
- **Three of seven CRCP reviewed had not been signed by the juvenile prior to their release from the facility.**
- **Five of seven applicable case records reviewed did not have documentation that the case staffing had been conducted every 30 days.**
- **Six of eight narratives reviewed did not have documentation that the PO was having contact with the juvenile once a month.**
- **Seven of nine case records reviewed did not have documentation that certain information required by procedures was being reviewed with the juvenile during each monthly contact.**
- **Five of seven case records did not document the monthly contact in BADGE as a verbal family progress note.**
- **Four of nine applicable case records reviewed did not have documentation of the PO's monthly contact with the Juvenile Correctional Center (JCC).**
- **Eight of eight applicable case records reviewed did not have documentation that a date had been established for the next monthly contact with the JCC.**

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## Program Response

**Cause:**
The Parole Officer in the Danville branch Office was not able to keep up with the direct care/re-entry requirements and timeframes. This was learned during the Supervisory Reviews of cases. The deficits were brought to the staff's attention. A voluntary change in position was made and a different person assumed the duties of direct care/re-entry in February 2019. Also, the Supervisor failed to code the monthly case staffing with appropriate code staffing when level III & IV parole cases. Supervisor should have used the code 43 also along with the Parole Supervision code under the purpose of contact.

**Effect on Program:**
The effect was moderate in that re-entry procedures were not consistently followed. Staff was overall completing re-entry tasks & had regular contact with the juvenile, but not according to the re-entry procedures & timeframes. Juveniles were not seen in person for the re-entry meetings due to staff utilizing video contacts during re-entry meetings. Staff also did not consistently adhere to timeframes when completing procedures such as signing CRCP prior to release. The CRCP was developed prior to release and signed when the juveniles returned to the community. The Supervisor failed to code the monthly case staffing appropriately. Staff did review all the required information consistently during monthly contact with the juvenile and the juvenile's parent/guardian as well as setting the next contact with the JCC after each monthly contact.

**Planned Corrective Action:**

As stated above, there was personnel transfer of direct care/parole duties in February 2019. A districtwide staff meeting was held on 6/14/19 to review the audit finding. The Supervisors and Director met separately with all staff that perform direct care and parole supervision duties on 6/14/19. We reviewed all the audit findings that dealt with commitment and re-entry. Each staff verbalized an understanding of the areas of non-compliance and what needed to be done to ensure compliance to include timeframes. A template was created and distributed to the Parole staff that included all the information that is required by procedure to be reviewed monthly with the juvenile. A second template was created with the all required information to be reviewed with the parent/guardian monthly during a face-to-face contact. The CSU Director will conduct random reviews of at least 30% of parole cases each quarter to ensure compliance. The Director, Supervisors and all staff with direct care & parole cases will restart the quarterly district re-entry meetings starting in July 2019. The Re-entry Manual will be reviewed along with any new re-try procedures. Staff will conduct a self-audit on January 16, 2020 of the district cases.

**Completion Date:**
August 14, 2019

**Person Responsible:**
The Probation Officers, Supervisors & Director Green are responsible to ensure compliance.

**Current Status on October 3, 2019: Compliant**
Seven narratives were reviewed and all had the following documentation:

- The probation officer had contact with the juvenile once a month
- The required information from procedure had been reviewed monthly with the juvenile
- Each of the monthly contacts were being noted as "verbal family progress" in BADGE
- The probation officer was having either face to face or verbal contact with the juvenile correctional center on a monthly basis
- A date had been established with the Juvenile Correctional Center for the next contact

One case record reviewed had documentation that the probation officer had attended the re-entry meeting in person.

One case file reviewed had documentation that the supervisor had conducted a monthly case staffing review for the parolee who was on level 3 and 4.

There were no applicable releases from direct care to parole during the status period between July 1, 2019 and October 1, 2019 so it could not be determined if a resident had signed his CRCP prior to being released from the facility.

**CERTIFICATION AUDIT REPORT**

**TO THE**

**DEPARTMENT OF JUVENILE JUSTICE**

**PROGRAM AUDITED:**
23rd District Court Service Unit
400 East Main Street
Salem, Virginia, 24153
(540) 283-3183
Carolyn M. Minix, Director
carolyn.minix@djj.virginia.gov

**AUDIT DATES:**
July 23-24, 2019

**CERTIFICATION ANALYST:**
Shelia L. Palmer

**CURRENT TERM OF CERTIFICATION:**
December 22, 2016 - December 21, 2019

**REGULATIONS AUDITED:**
6VAC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

**PREVIOUS AUDIT FINDINGS – February 27, 2017**
95.2% Compliance Rating
Number of Deficiencies: Two
**6VAC35-150-110 (D). Volunteers and Interns.**
**6VAC35-150-336 (A). Social histories.**

**CURRENT AUDIT FINDINGS – July 24, 2019:**
97% Compliance Rating
*One repeat deficiency from previous audit.
Number of deficiencies: One
***6VAC35-150-336 (A). Social histories.**

**DEPARTMENT CERTIFICATION ACTION –** Certified the 23rd District Court Service Unit December 22, 2022.
*Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.*

**TEAM MEMBERS:**
Shelia L. Palmer, Team Leader
Clarice T. Booker, Central Office
Mark Lewis, Central Office
Lloyd Merchant, 24th District CSU (Roanoke)
Rachel Moore, 22nd District CSU (Rocky Mount)
Robert Hiatt, 27th District CSU (Pulaski)
Sarah Pendleton-Quinones, 16th District CSU (Charlottesville)

**POPULATION SERVED:**
The 23rd District Court Service Unit serve Roanoke County, the Town of Vinton and City of Salem.

**PROGRAMS AND SERVICES PROVIDED:**
Mandated Services:

- Intake, Investigative Reports, Domestic Relations, Probation, Parole

Other Services:

- Utilizes comprehensive services to provide:
- Blue Ridge Behavioral Health Care (CSB)
- Roanoke County Department of Social Services
- Individual and family counseling services
- 294 funded services
- Surveillance services
- VJCCCA services
- Diversion
- Substance Abuse Services
- Family Assessment and Planning Team
- Brambleton Assessment and Counseling Center, LLC
- TAP, Total Action Against Poverty
- CSA services, Intercept, Family Preservation, EBA referrals
- AMI referrals

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**CORRECTIVE ACTION PLAN**

**TO THE**
**DEPARTMENT OF JUVENILE JUSTICE**

| | |
|---|---|
| **FACILITY/PROGRAM:** | 23rd District Court Service Unit (Salem) |
| **SUBMITTED BY:** | Carolyn Minix, CSU Director |
| **CERTIFICATION AUDIT DATES:** | July 23-24, 2019 |
| **CERTIFICATION ANALYST:** | Shelia L. Palmer |

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

**6VAC35-150-336 (A). Social histories.**
**A. A social history shall be prepared in accordance with approved procedures (i) when ordered by the court, (ii) for each juvenile placed on probation supervision with the unit,**

**(iii) for each juvenile committed to the Department, (iv) for each juvenile placed in a postdispositional detention program for more than 30 days pursuant to § 16.1-284.1 of the Code of Virginia, or (v) upon written request from another unit when accompanied by a court order. Social history reports shall include the following information:**

1. **Identifying and demographic information on the juvenile;**
2. **Current offense and prior court involvement;**
3. **Social, medical, psychological, and educational information about the juvenile;**
4. **Information about the family; and**
5. **Dispositional recommendations, if permitted by the court.**

**Audit Finding: Non-Compliant**
**Mental Health**
**Four of five applicable social histories reviewed did not document the impact of any form of abuse physical, emotional, mental, and or sexual.**

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## Program Response

**Cause:**
Mental Health: After reviewing outcomes of the certification audit with Probation Officer's, the perception was that since the information was already in the body of the "Mental Health" section, it was not necessary to repeat it; in the way of how any reported abuse impacted the youth. In addition, the Probation Supervisor admits oversight while reviewing the social history for this specific statement.

**Effect on Program:**
Did not allow the youth to express his concerns of how the abuse impacted them. Along with the possibility of additional treatment or intervention needs that could be addressed and provided to the youth and family.

**Planned Corrective Action:**
Probation Supervisor met with each Probation Officer on 7/24/19 to review audit outcomes and explain why addressing the Mental Health area of the social history is imperative to meeting the needs of each youth (and family) that we serve. She discussed the social histories that were reviewed during the certification audit. In addition, on 7/29/19 a team meeting took place where she discussed the importance of compliance with DJJ regulations and the social history template. On 7/30/19, each Probation Officer was given the social history template with "the bubble wording" highlighted; indicating what is expected in each section of the social history.
On 7/30/19 the Director met individually and as a team to review the importance of allowing the youth to express his feelings about how any form abuse could impact them, following the DJJ/SH template and discussing abuse in both the Mental Health and Family sections of the SH.

The Supervisor will: in the future, for all social histories, specifically review the Mental Health section to ensure that if a child discloses abuse, that it is discussed and the youth has the opportunity to share how this abuse has impacted them.

The Director will: conduct random reviews of social histories, a minimum of one per month, to ensure that the Mental Health area is properly documented if a youth discloses abuse of any type.
**Completion Date:**
July 31, 2019

**Person Responsible:**
Director Minix, Supervisor Walker

**Current Status as of October 24, 2019: Not Determined**
One of one applicable social history report completed during the Status Visit period July 1 2019 – October 16, 2019 there was no documentation of any form of abuse physical, emotional, mental, and or sexual.

# Spit and Bite Guards

Mark Murphy
Health Services Unit Director

March 11, 2020

Virginia Department of Juvenile Justice

## Staff Health and Safety

- Saliva can contain as many as 50 different types of bacteria and close to 100,000,000 microbes per ml.
- Bacterial transfer from saliva occurs for:
  - Streptococcus pyogenes
  - Strep throat
  - Necrotizing fasciitis
  - Septicemia
  - Toxic shock syndrome
  - Rheumatic fever
  - Scarlet fever
  - Meningococcal invasive disease (Meningitis)
  - Treponema pallidum (Syphilis)

2

## Staff Health and Safety

- Saliva also contains viruses that can be transferred between people.
  - Herpesvirus
  - Epstein-Barr (Mono)
  - Human papillomaviruses
  - Hepatitis B

3

## Staff Health and Safety

- Saliva also can be used to convey other material:
  - Blood
  - Feces
- This opens up the risk of HIV and Hepatitis C transmission.

4

## Bites

Human bites

- Pressure damage to skin, tendon, and bones
- Tetanus
- Infection
  - Travels along tendons and lymph systems
  - Infection can cause permanent damage, septic arthritis
  - Necrotizing fasciitis
  - Amputation (7-20% for MCP Joint infection)

5

## Youth in Restraint

- Most youth involved in these restraints have emerging Borderline Personality (BPD) traits.
- Persons with BPD and adolescents both seek and test the limits.
- Often will resist de-escalation until they find the limits.
- Spitting is a way that is used to prolong conflict in restraint.

6

# The Use of Spit Guards in Juvenile Detention

Presented By

The Virginia Juvenile Detention Association

March 11, 2020

## WHAT IS IT?

A protective device designed for the purpose of preventing the spread of communicable disease and blood borne pathogens when exposed to bites, spit or blood.

## USED BY

- Law Enforcement
- Jails
- Secure Juvenile Facilities
- Hospitals

## IS SPITTING CONSIDERED ASSAULT?

- *United States v. Frizzi*, 491 F.2d 1281 (1st Cir. 1974) ("We do not think it could be ruled that spitting in the face is not forcible assault, or, more exactly, a battery . . . . Although minor, it is an application of force to the body of the victim, a bodily contact intentionally highly offensive.")
- *Ray v. United States*, 575 A.2d 1196 (D.C. Ct. App. 1990) (noting that "the injury resulting from or threatened by an assault may be extremely slight," the court ruled that "we find ourselves in full agreement with courts in other jurisdictions which have held that spitting on another person is indeed an assault")
- *People v. Terry*, 553 N.W.2d 23 (Mich. Ct. App. 1996) ("Because spitting upon a person is a battery, which is a consummated assault, spitting falls within the prohibitions of the [assault] statute.")

## IS SPITTING CONSIDERED ASSAULT?

- *Com. v. Cohen*, 771 N.E.2d 176 (Mass. Ct. App. 2002) (finding it "self-evident" that spitting on a person is an assault and joining "other jurisdictions holding that an intentional and unconsented spitting on another constitutes a criminal battery"
- *Gilbert v. Com.*, 608 S.E.2d 509 (Va. Ct. App. 2005) (finding sufficient evidence of assault based on spitting: "In spitting on Officer Fletcher, Gilbert committed an act that involved physical contact and was deeply offensive. Thus, it constituted an infliction of bodily harm.")
- *United States v. Lewellyn*, 481 F.3d 695 (9th Cir. 2007) ("[I]ntentionally spitting on another person is an offensive touching that rises to the level of simple assault under the theory of assault as an attempted or completed battery.")

## PURPOSE AND USE

- Managing combative residents is one of the most dangerous and stressful situations faced by staff.
- Residents occasionally enter detention from court or directly from the community in a combative state (most often due to intoxication or under the influence of controlled substances), and program staff with no established relationship to the detainee must accept custody and manage them in their current state.

## PURPOSE AND USE

- Staff who are subjected to exposure from bites, spit or blood are at high risk of contracting a blood borne pathogen such as HIV or Hepatitis.
- Testing can take weeks and be very stressful for the employee.
- Treatments can be costly and may require time off from the job.

## PURPOSE AND USE

- Residents with a history of spitting or biting when in an agitated state are likely to repeat this behavior.
- Residents have been known to intentionally bite their tongues or checks to cause bleeding in order to spit blood at staff.

## PURPOSE AND USE

- Being spit on can evoke strong reactions from even the most seasoned and controlled staff.
- Spit/bite guards are specifically designed for the purpose of prevention and known to be safe and effective.

## PURPOSE AND USE

- As with any protective equipment, a spit guard may not be available in the instance when needed but prohibiting them increases risk of harm to staff and other residents.
- Without a properly designed piece of equipment, options for managing a resident who is actively spitting or biting resort to some form of physical control which can perpetuate the aggression and potentially cause injury to the staff or resident.
- Staff may use something not designed for this purpose as a barrier, such as a shirt, towel, or blanket, which could be extremely harmful.

## PURPOSE AND USE

- Attempts to prevent a combative resident from spitting by restricting or re-directing the head during a restraint makes staff for more susceptible to a bite which is equally, if not more, dangerous and increases the risk of injury to the resident.

## PURPOSE AND USE

- Protective equipment designed specifically for the prevention of spitting or biting is designed with mesh fabric that offers the following:
  - No restrictions to breathing
  - No choking hazard
  - Restricts fluids from exiting the guard
  - Limits ability to bite
  - Reduces the need for physical force to prevent spitting and biting

## ALTERNATIVE SPIT GUARD PROVISIONS PROPOSED FOR INCLUSION IN JCC REGULATION

**6VAC35-71-10. Definitions.**

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Protective device" means an approved device placed on a portion of a resident's body to protect the resident or staff from injury.

"Spit guard" means a protective device designed for the purpose of preventing the spread of communicable diseases as a result of spitting or biting.

**6VAC35-71-1180. Mechanical restraints and protective devices.**

A. Mechanical restraints and protective devices may be used for the following purposes, subject to the restrictions enumerated in this section: (i) to control residents whose behavior poses an imminent risk to the safety of the resident, staff, or others; (ii) for purposes of controlled movement, either from one area of the facility to another or to a destination outside the facility; or (iii) to address emergencies.

B. A JCC that uses mechanical restraints or protective devices shall observe the following general requirements:

1. Mechanical restraints and protective devices shall be used only for as long as necessary to address the purposes established in subsection A. Once the imminent risk to safety has been abated, the resident has reached the intended destination within the facility or has returned to the facility from a destination offsite, or the emergency has been resolved, the mechanical restraint or protective device must be removed.

2. The superintendent or the superintendent's designee shall be notified immediately upon using mechanical restraints or protective devices in an emergency;

3. Facility staff shall not use mechanical restraints or protective devices as a punishment or a sanction;

4. Residents shall not be restrained to a fixed object or restrained in an unnatural position.

5. A mental health clinician or other qualifying licensed medical professional may order termination of a mechanical restraint or protective device at any time upon determining that the item poses a health risk.

6. Each use of a mechanical restraint or protective device, except when used to transport a resident or during video court hearing proceedings, shall be recorded in the resident's case record and in the daily housing unit log;

7. A written system of accountability shall be in place to ensure routine and emergency distribution of mechanical restraints and protective devices; and

8. All staff who are authorized to use mechanical restraints or protective devices shall receive training in such use in accordance with 6VAC35-71-160 and 6VAC35-71-170, as applicable; and only trained staff shall use mechanical restraints or protective devices.

C. A juvenile correctional center that uses a mechanical restraint to control a resident whose behavior poses a safety risk in accordance with subdivision (A)(i) of this section shall notify a qualified health care professional and a mental health clinician or qualified mental health professional before continuing to use the restraint, and, if applicable, the accompanying protective device if the imminent risk has been abated, but 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. This may include instances in which the resident verbally expresses the intent to continue the actions that required the restraint.

D. Juvenile correctional center staff may not use a protective device unless the use is in connection with a restraint and shall remove the device when the resident is released from the restraint.

E. In addition to the requirements enumerated in subsections A through D of this section, juvenile correctional center staff that use a spit guard to control resident behavior shall observe the following requirements:

1. Staff may not use a spit guard unless it possesses the following characteristics:
    a. The spit guard's design may not inhibit the resident's ability to breathe;
    b. The spit guard must be constructed to allow for visibility;
    c. The spit guard must be manufactured and sold specifically for the prevention of biting or spitting

2. The spit guard may be used only on a resident who: (i) previously has bitten or spit on a person at the facility, or (ii) in the course of a current restraint, threatens or attempts to spit on or bite or actually spits on or bites a staff member;

3. The spit guard must be applied in a manner that will not inhibit the resident's ability to breathe;

4. While the spit guard remains in place, staff shall provide for the resident's reasonable comfort and ensure the resident's access to water and meals, as applicable;

5. Staff must employ constant supervision of the resident while the spit guard remains in place to observe whether the resident exhibits signs of respiratory distress. If any sign of respiratory distress is observed, staff shall take immediate action to prevent injury and to notify supervisory staff;

6. Staff may not use a spit guard on a resident who is unconscious, vomiting, or in obvious need of medical attention.

# DEPARTMENT OF JUVENILE JUSTICE
# REGULATORY UPDATE

**March 11, 2020**

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**CURRENT ACTIONS:**

**6VAC35-170** **Minimum Standards for Research Involving Human Subjects or Records of the Department of Juvenile Justice**

Stage: (Fast-Track Process)

Status: This chapter was last amended effective December 1, 2016. This regulatory action seeks minor amendments to the process for requesting and approving requests for data and human research proposals. The fast-track action is currently under review by the Office of the Attorney General (OAG).

Next step: Once the OAG completes its review, the action will advance to the Department of Planning and Budget (DPB). DPB will determine whether the action is appropriate for the fast-track process and prepare a policy analysis and Economic Impact Analysis (EIA).

**6VAC35-71** **Regulation Governing Juvenile Correctional Centers**

Stage: Proposed (Standard Regulatory Process).

Status: This regulation became effective on January 1, 2014. This action involves a comprehensive review of the regulatory requirements. The Notice of Intended Regulatory Action (NOIRA) was published in the *Virginia Register* on October 3, 2016. At the NOIRA stage, no public comments were submitted. Now in the Proposed Stage, the action has been approved by DPB, the Secretary of Public Safety and Homeland Security (SPSHS), and the Governor's Office. The Proposed action was published in the *Virginia Register of Regulations* on September 30, 2019 and the 60-day public comment period ended on November 29, 2019.

Next step: The department will need to advance the action to the Final Stage of the process through the Virginia Regulatory Town Hall on or before May 27, 2020.

**6VAC35-101** **Regulation Governing Juvenile Secure Detention Centers**

Stage: Proposed (Standard Regulatory Process)

Status: This regulation became effective on January 1, 2014. This action involves a comprehensive review of the regulatory requirements. The NOIRA was published in the *Virginia Register* on October 17, 2016. At the NOIRA Stage, no public comments were submitted. The action was submitted through the Proposed Stage on September 3, 2019 and is currently being reviewed by the OAG.

Next step: DPB will complete an EIA and policy analysis.

**6VAC35-30** **Regulation Governing State Reimbursement of Local Juvenile Residential Facility Costs**

Stage: NOIRA (Standard Regulatory Process)

Status: This regulation was last amended effective July 1, 2011. This action involves a comprehensive overhaul of the process localities follow to obtain state reimbursement for local facility construction and renovation projects. The NOIRA has undergone review by DPB and the SPSHS, and currently is under review in the Governor's office.

Next step: Once the Governor's office completes its review, the action will be published in the *Virginia Register of Regulations*, followed by a 30-day public comment period.

6VAC35-180 **Regulations Governing Mental Health Services Transition Plans for Incarcerated Juveniles**

Stage: NOIRA (Standard Regulatory Process)

Status: This regulation became effective January 1, 2008 and has never been amended. This action involves a comprehensive overhaul of the regulatory requirements to ensure the continued provision of post-release services for incarcerated juveniles with a substance abuse, mental health, or other therapeutic need. The NOIRA has undergone review by DPB and the SPSHS, and currently is under review in the Governor's office.

Next step: Once the Governor's office completes its review, the action will be published in the *Virginia Register of Regulations*, followed by a 30-day public comment period.

Valerie P. Boykin
Director

# COMMONWEALTH OF VIRGINIA

*Department of Juvenile Justice*

P.O. Box 1110
Richmond, VA 23218
(804) 371.0700
Fax: (804) 371.6497
www.djj.virginia.gov

**TO:** State Board of Juvenile Justice

**FROM:** Virginia Department of Juvenile Justice

**SUBJECT:** Request Authorization to Submit Amendments to the Regulation Governing Juvenile Correctional Centers (6VAC35-71) to the Final Stage of the Regulatory Process

**DATE** March 11, 2020

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## I. SUMMARY OF ACTION REQUESTED

The Department of Juvenile Justice (the department) respectfully requests the State Board of Juvenile Justice (board) to authorize amendments to the Regulation Governing Juvenile Correctional Centers (6VAC35-71) for advancement to the Final stage of the regulatory process pursuant to the Administrative Process Act set forth in § 2.2-4000 et seq. of the Code of Virginia. The proposed amendments are intended to impact the Bon Air Juvenile Correctional Center, as well as any juvenile correctional centers that may be constructed in the Commonwealth in the future. These amendments also will apply to any future privately operated juvenile correctional center.

The department respectfully requests the board to approve the submission of amendments to the Regulation Governing Juvenile Correctional Centers for advancement to the Final Stage of the regulatory process.

## II. BACKGROUND OF THE REVIEWS

Pursuant to § 66-10 of the Code of Virginia, the board has the authority to promulgate regulations "necessary to carry out the provisions of this title and other laws of the Commonwealth administered by the Director or the Department." This includes the authority to adopt regulations governing the operation of juvenile correctional centers. The department assists the board by facilitating the review of existing regulations and submitting them to the board for evaluation and approval.

In June 2016, the board authorized the submission of a Notice of Intended Regulatory Action (NOIRA) to initiate the regulatory process for a comprehensive review of this regulation. The NOIRA completed Executive Branch review in September 2016, followed by a 30-day public comment period ending on November 2, 2016, which yielded no public comments. Contemporaneously, the department convened a committee with representatives

from its Division of Operations and its Health Services, Certification, Training, and Policy units to review the existing regulation and propose amendments.

In November 2017 and January 2018, the board authorized submission of specific proposed amendments for advancement to the Proposed Stage of the regulatory process. The amendments were submitted to the Virginia Regulatory Town Hall where they underwent Executive Branch review, before being published in the Virginia Register of Regulations in September 2019. After a 60-day public comment period that yielded only one set of comments from the disAbility Law Center of Virginia (dLCV), the department conducted a final review of the regulation and is recommending additional amendments based on this review.

## III. BACKGROUND OF PROPOSED CHANGES

*Improper Incorporation by Reference*: Effective January 1, 2016, pursuant to 1VAC7-10-140, state agencies may not incorporate their own documents into a regulation by reference unless the agency establishes the documents or circumstances are highly unusual. The JCC regulations currently contain numerous provisions requiring staff in a juvenile correctional center to comply with certain directives "in accordance with written procedures" (or some other variation). When the department's certification unit assesses compliance for these provisions, the unit looks to determine that the facility has complied with the regulatory directive, as well as the applicable written procedure. Because the department has not demonstrated that its procedures are unique and highly unusual, these references violate 1VAC7-10-140 and should be removed. As part of its review, the reconvened committee consulted each applicable procedure currently incorporated by reference into the regulation to determine whether any of the provisions contained in those procedures should be included expressly in the regulation. The committee determined that most of the applicable written procedures were operational in nature and not appropriate for inclusion in a regulation; therefore, the committee recommended striking each such reference. The committee recommended similar amendments to remove many references to written procedures that outlined specific, detailed requirements. In sum, the committee recommended striking references to written procedures in 27 separate sections including: §§ 10, 30, 50, 60, 70, 75, 110, 270, 420, 470, 480, 530, 545, 560, 570, 610, 690, 720, 745, 747, 765, 815, 820, 1030, 1050, 1060, 1070, 1110, and 1140.

*Mechanical Restraint, Protective Devices, and Mechanical Restraint Chair Provisions*:
Regulations currently in effect for JDCs and JCCs regarding mechanical restraints are very similar in content and contain few restrictions on the use of such devices. Both chapters prohibit the use of mechanical restraints (including the restraint chair) as a punishment or sanction, require staff authorized to use restraints to receive training in their use, and prohibit mechanical restraint use by any staff who have not received adequate training. Under existing regulations, written procedures shall govern the use of mechanical restraints and must specify the conditions under which mechanical restraints may be used.

Recognizing the health and safety repercussions if these devices are applied improperly or negligently, the board asked the department to recommend options for additional limitations and restrictions on the use of mechanical restraints with particular emphasis on the mechanical restraint chair. A workgroup consisting of representatives from the JCC and several JDC superintendents suggested additional restrictions on the use of these devices, and at its May 2019 meeting, the board approved these proposed amendments for incorporation into the Regulations Governing Juvenile Secure Detention Centers (6VAC35-101). Because proposed amendments to the JCC regulation were moving through the Executive Branch review process, the department agreed to incorporate any proposed amendments regarding mechanical restraints into the JCC regulatory action after the public comment period of the Proposed Stage.

This proposal amends Section 10 to incorporate the mechanical restraint-related definitions approved by the board in May (*mechanical restraint, mechanical restraint chair,* and *protective device).* Additionally, the proposal amends Sections 1180 and 1190 and adds new sections 1195, 1203, 1204, 1206, 1207, and 1208 to incorporate the proposed amendments to the JDC regulation as approved by the board in May 2019. Thus, much of the language conveyed as modified language, represented in red text that has been underlined or stricken through, has already been approved by the board. The summaries contained in Parts IV through the end of this memo are limited to a discussion on amendments made after the board meeting in May 2019.

## IV. SUMMARY OF SUBSTANTIVE RECOMMENDATIONS – SIGNIFICANT IMPACT

The department proposes the following substantive changes, which may have a significant impact on facility operations, residents, or staff in juvenile correctional centers.

Definition of direct care staff – Section 10

Under Section 840 of this chapter, at least one direct care employee must be present and responsible for the supervision of every eight residents during resident waking hours. Section 10 defines a direct care employee as one whose primary job responsibilities include: (i) maintaining resident safety, care, and well-being; (ii) implementing the structured program of care and the behavior management program; and (iii) maintaining facility security. Only staff who meet this definition can satisfy the staffing ratio requirements.

In January 2019, the department made a minor change to its security staff classification by retitling the security specialist position and modifying expectations regarding duties. Before that time, the position responsibilities included maintaining the security of the facility, conducting perimeter checks, operating the central control center, and conducting searches at the security entrance. Security specialists primarily served a security function and did not meet the definition of direct care staff. The position, now referred to as "resident specialist" (RS) must fulfill all of the security-related functions previously required of security specialists. In addition, now the position is responsible for temporarily assuming the posts of direct care staff and providing coverage in individual housing units when there is a shortage of resident specialist I and II direct care staff on the units. Although the new RS position receives the same volume and content of training mandated for direct care staff and shares the same job responsibilities as other direct care staff, they do not meet the technical direct care staff definition because their **primary** job responsibilities continue to center on security.

> ***Proposal***: The proposal expands the definition of "direct care staff" to include these newly titled RS positions. The new definition requires such security employees to receive initial and annual training in these areas to carry out their expanded duties.

Definition of room confinement – Section 10 and related provisions

The board-adopted amendments require JCCs to follow numerous regulatory requirements before placing residents in room confinement. Section 10 defines room confinement as the involuntary placement of a resident in his room or other designated room, together with additional restrictions. Timeout periods are expressly excluded from the definition. The committee believed this carve-out would ensure that timeout periods would not be subject to the same restrictions and conditions as room confinement. The committee has since identified several additional scenarios necessitating temporary confinement in order to enable staff to safely and seamlessly execute duties within housing units. These exceptions include room confinement for the purpose of: (i) enabling residents to shower, (ii) conducting facility counts, and (iii) executing shift changes. The committee agreed that many of

the conditions and parameters placed on room confinement would not fit in the context of temporary confinement periods for these purposes.

***Proposal***: The proposal explicitly excludes from the definition of room confinement, confinement for the purposes addressed above. The proposal also strikes the language identifying the permissible purposes for room confinement because those purposes are addressed in Section 1140.

Room confinement – Section 1140

- ***Release from confinement (subsection A)***: The board-adopted amendments require certain information be included in written procedures governing room confinement, including the necessary steps to release the resident to a less restrictive setting once the threat necessitating confinement is abated. Under the department's current procedures, there is no incremental approach for releasing residents from confinement to a less restrictive setting. Rather, a resident who is ready for release is released into the general population.

  ***Proposal***: The proposal acknowledges this practice by requiring the written procedures to address the steps needed to release the resident **from room confinement**, rather than to a less restrictive setting. Conforming amendments are made in subsection D of this section.

- ***Exhibiting self-injurious behavior while confined (subsection B)***: The board-approved amendments address the process for responding to residents exhibiting self-injurious behavior while confined. Staff must take appropriate action in response and monitor the resident according to established protocols, which may include constant supervision. The committee had concerns with this vague language and recommended amendments to the regulation to delineate staff expectations more clearly.

  ***Proposal***: The proposal requires that staff take appropriate action in response to the behavior to prevent further injury and to notify supervisory staff, and adjust the frequency of the face-to-face checks as needed.

- ***Permitted justification for room confinement (subsection C)***: The board-adopted amendments allow room confinement only: (i) if a resident's actions threaten facility security or the safety and security of residents, staff or others in the facility; or (ii) to prevent damage to property committed with the intent of fashioning an object that may threaten facility security or the safety of others in the facility. The committee was concerned that this provision was too narrow and would prevent the department from using confinement to address a resident who has lost control and is destroying property, but for purposes other than fashioning a threatening device or object.

  ***Proposal***: The proposal expands the property damage justification to allow room confinement as a means of preventing any damage to real or personal property if such damage would threaten facility security or the security of others in the facility.

- ***Approximating opportunities of residents in general population (subsection E)***: The board-adopted amendments require staff to provide confined residents with the same opportunities as other residents on the unit including as much time out of their rooms as security considerations permit.

***Proposal***: The proposal modifies this language to outline the resident's rights while confined (e.g., the right to receive applicable medical and mental health treatment, education, daily nutrition, and daily opportunities for bathing).

- ***Room confinement exceeding five days; case management review process***: Under the board-adopted amendments, room confinement periods that exceed five days must undergo a case management review process that involves: 1) review by a facility-level review committee (Institutional Classification Review Committee or ICRC) at its next scheduled meeting immediately upon expiration of the five-day period; and 2) referral to the division-level review committee (Central Classification Review Committee or CCRC) if the facility-level committee determines the resident should remain confined. Upon such referral, the CCRC must review the confinement at its next scheduled meeting immediately following the ICRC review. Per the board-approved amendments, additional recurring reviews shall continue according to the same schedule until one of the committees recommends the resident's release from confinement. The Deputy Director of Residential Services may reduce the frequency of or waive the division level reviews in accordance with written procedures.

  The dLCV recommends adding a requirement directing both review committees to complete their case management reviews within two business days to ensure that residents are not being confined to their rooms for longer than necessary.

  ***Proposal***: The department believes it would be logistically impossible to conduct both reviews within two business days. The earliest point at which the department can convene the division-level committee is within seven business days following the referral. The proposal modifies the language to require the division-level review to occur within seven business days after the referral. The proposal also requires the Deputy Director of Residential Services to provide a rationale for waiving the division-level reviews and to document the rationale in the resident's record.

- ***Delayed effective date (subsection M)***: Though not immediately apparent from the placeholder language in subsection M of the board-adopted amendments, the department intended to delay implementing the provisions related to room confinement until January 1 of the first January that falls at least nine months after the other regulatory provisions of this action take effect. The dLCV discourages a delayed implementation date and recommends that the department implement these provisions as early as possible due to the detrimental physical and mental health effects of room confinement.

  ***Proposal***: The proposal strikes the delayed implementation placeholder language. All of the proposed regulatory amendments, including those involving room confinement, will take effect on the same date.

<u>Definition of juvenile correctional center (§10) and new Applicability section (§15)</u>

The current regulation defines "juvenile correctional center" to include public or private facilities operated by or under contract with DJJ that provide 'round-the-clock' care to residents committed to DJJ. The board-approved amendments exclude from this definition facilities that operate alternative direct care placement programs. This amendment sought to prevent juvenile detention centers operating alternative direct care programs and other entities not customarily considered juvenile correctional centers from the reach of these regulations. Since the board approved this language, however, the committee has determined that narrowing the definition of juvenile

correctional center in this manner may unintentionally invalidate the department's placement of serious offenders in juvenile detention centers operating community placement programs (CPPs).

Additionally, the current regulation contains five provisions that apply exclusively to juvenile boot camp programs. Currently, no such programs are operating in the Commonwealth, and when these programs were in operation, their participants consisted largely of youth under DJJ court service unit supervision, rather than committed youth. These programs are starkly different from juvenile correctional centers in terms of programming and operations and arguably, should be addressed in a separate chapter.

> ***Proposal***: The proposal strikes the exclusionary language in the definition and adds a new applicability section (§ 15) that makes this chapter apply exclusively to state-operated juvenile correctional centers and juvenile correctional centers governed by the Private Juvenile Corrections Management Act (66-25.3 *et seq.)*, both of which are currently governed by this chapter. The proposal excludes from this chapter juvenile boot camps and locally, regionally, or privately operated alternative direct care programs. The proposal also repeals the boot-camp related provisions (§§ 1230-1270) and creates a new chapter under which these provisions will fall:

Boot camp, program description (*replacing Section 1270 with 6VAC35-73-40)*

The current regulation requires boot camps to write out and maintain their program descriptions, which must address incentives and sanctions, the length of the program, and other specific issues. Per recommendation of the dLCV, boot camps should operate as therapeutic communities in the same manner as juvenile correctional centers under Section 735 of the regulations. While the department supports the concept of considering a youth's therapeutic needs for all programming, the boot camp facilities were not intended to operate as therapeutic communities.

> ***Proposal***: The proposal adds a provision to the new 6VAC35-73-40 requiring the boot camp's program description to specify that programming for boot camps must consider each participant's therapeutic needs.

Grievance definition and grievances – Sections 10, 80

The board-approved amendments direct DJJ to have a grievance procedure that, among other things, requires staff to review emergency grievances immediately and to provide a resolution no later than eight hours after the review. The regulation does not define the term "emergency grievance." The dLCV observed that this section fails to establish a deadline for reviewing and resolving non-emergency grievances.

> ***Proposal***: Rather than referring to emergency grievances, the proposal adds explanatory language making the 8-hour requirement applicable to grievances that pose an immediate risk of harm to a resident. The proposal sets the deadline for addressing, correcting, or referring other, non-emergency grievances to external organizations at 30 business days after receipt of the grievance.

Lockdown definition – Section 10

As originally amended, the action adds a definition for lockdown to describe instances in which all or some residents are restricted to their housing units or areas within their housing units or within the JCC for one of several specifically enumerated purposes, including relieving temporary tensions within the facility and conducting a facility search for missing tools or other contraband.

***Proposal***: Per recommendation of the dLCV, the proposal narrows the definition of lockdown to apply only for purposes of relieving **severe** tensions within the facility that may threaten or critically affect staff or residents or threaten public safety. The proposal also strikes the reference to missing tools and security contraband, as lockdowns are not limited to these types of searches.

Searches of residents – Section 480

Under the board-approved amendments, staff may conduct patdown, frisk, and strip searches of residents, as well as visual inspections of a resident's body cavity. Although there are exceptions in exigent circumstances that potentially threaten the resident's health, generally, if staff determine that a manual or instrumental search of a resident's body cavity is necessary, the resident must be transported to a local medical facility. The proposed amendments do not place any restrictions on staff when those exigent circumstances demand a manual or instrumental cavity search.

***Proposal***: The proposal limits the staff who may conduct onsite instrumental and manual body cavity searches in such exigent circumstances to include only qualified medical professionals.

Weapons – Section 510

Currently, weapons, including firearms, are not permitted on the premises unless authorized by written procedures, the director, or the director's designee. Written procedures govern possession, use, or storage of authorized firearms and other weapons.

***Proposal:*** The proposal removes the reference to written procedures and provides that law enforcement officers may bring such weapons on the premises if secured in a locked cabinet or their vehicle's trunk, or if the department has requested law enforcement intervention in an emergency. The proposal also allows the director to permit such weapons on the premises.

Transportation – Section 540

The board-approved amendments require the JCC to follow written safety and security procedures governing transportation and directs the facility to have written procedures requiring staff who transport residents to maintain and verify a valid driver's license and notify the superintendent of any change in their driver's license status.

***Proposal***: The proposal directs such staff to complete related required training. Additionally, consistent with failed legislation introduced in 2019, the proposal directs staff to convey pertinent written information to any party transporting a resident off campus that will alert the transporter to the resident's medical or mental health status and related concerns that might jeopardize the resident's safety. Finally, staff must provide the transporter with whatever medication the resident may need to take during transport or while offsite.

Showers – Section 610

Currently, JCCs must provide residents with an opportunity to shower daily, except where written procedures allow an exception to maintain facility security or to manage maladaptive behavior. These cases must be approved by the superintendent, his designee, or a mental health professional. Current regulation also allows the board to approve an exception.

***Proposal***: The proposal removes the board's authority to approve an exception. The board's broad regulatory and variance authority enable it to amend or temporarily suspend the application of a regulation,

rendering this exception unnecessary. Moreover, if the facility has a compelling need to deprive a resident of his daily opportunity to shower, obtaining approval from the board may present logistical challenges. The committee recommends replacing this language with a broader exception applicable when there is a documented emergency.

Monitoring residents placed in mechanical restraints – Section 1190

The board-approved amendments require staff, whenever they place a resident in mechanical restraints to: (i) provide for his reasonable comfort and ensure access to water meals, and toilet, (ii) check the resident, face -to-face at least every 15 minutes; and (iii) attempt verbal engagement with the resident during each such check. Additionally, during these checks, the board-approved proposed amendments require a health-trained staff member to monitor the resident for signs of circulation and for injuries despite the fact that DJJ does not use health-trained staff in its JCCs. In addition to these provisions, to prevent blood clots, the board-approved amendments require staff to allow residents restrained for two or more hours to exercise their limbs for at least 10 minutes every two hours. Each of these monitoring requirements likely will present logistical challenges for mechanically-restrained residents being transported offsite.

Finally, the board-approved amendments address the mandated response when a mechanically-restrained resident exhibits self-injurious behavior during restraint. Staff must take appropriate action in response to the behavior and monitor the resident in accordance with established protocols, which may include constant supervision. The committee raised concerns with this vague language and recommended that the regulation include more details regarding the expectations of staff in responding to self-injurious behaviors.

***Proposal***: The proposal replaces health-trained staff with staff, thus allowing direct care or other staff to monitor the resident for circulation and injuries during the checks at 15-minute intervals, and requires medical staff to conduct a formalized, thorough check of the resident at least once every two hours while the resident remains in mechanical restraints. This proposal is consistent with best practices regarding mechanical restraint use. The proposal also provides an exception from each of these monitoring provisions for mechanically restrained residents being transported off campus. As for self-injuring mechanically restrained residents, the proposal requires that they take appropriate action in response to the behavior to prevent further injury and to notify supervisory staff and adjust the frequency of the face-to-face checks if needed.

Mechanical restraint chair; general provisions - Section 1203

Among the numerous checks placed on the JDC's authority to use a restraint chair, the board-approved amendments require direct care staff, immediately after placing a resident in the chair, to notify the health authority to assess the resident's health condition, determine whether the restraint is contraindicated, and advise whether the resident should be in a medical or mental health unit for emergency involuntary treatment. According to the department's Health Services Unit, DJJ's health authority is not the appropriate party to conduct these assessments or to make these determinations. Instead, the Health Authority's role should be limited to ensuring that the resident is assessed for any contraindications to the restraint chair and that a mental health clinician conducts a subsequent assessment to determine whether the resident should be transferred to a medical or mental health unit. The juvenile correctional center has nursing staff on hand that are able to provide an immediate assessment of the resident; therefore, DJJ recommends that the initial assessment occur **before** the resident is placed in the chair. Finally, the board-approved amendments direct staff to debrief after releasing the resident.

***Proposal***: The proposal adopts the committee's recommendation requiring the health authority **or his designee** to ensure that the medical and mental health assessment regarding contraindications be conducted **before** placing the resident in the chair and requiring immediate notification to the health authority or designee upon placement. The health authority, in turn, must ensure that a subsequent assessment is conducted by a mental health clinician to determine whether the resident requires transfer. Finally, the proposal modifies the debriefing requirement to clarify that the debriefing must include staff involved in the chair use, as well as supervisory staff, and that the debriefing must occur after **each use of the restraint chair**, rather than after releasing the resident from the restraint. The department believes that this amendment allows staff more flexibility regarding the timing for conducting the debriefing.

Mechanical restraint chair use for purposes other than controlled movement; conditions for use – Section 1205
Subsection D of this section directs staff to ensure that if a resident is placed in a restraint chair for any purpose other than for controlled movement, a health-trained staff member must monitor the resident for signs of circulation and injuries. This provision is inconsistent with the department's current practices, as the existing JCC does not have health-trained staff.

***Proposal***: The proposal replaces "health-trained staff" with a "licensed medical provider," as the individual required to monitor the resident as part of the checks occurring at 15-minute intervals.

## V. SUMMARY OF SUBSTANTIVE RECOMMENDATIONS – MODERATE IMPACT

Incident reports – Section 60
Currently, certain serious incidents must be reported to the director, the resident's parent or legal guardian, and the supervising court service unit within 24 hours of the incident and in accordance with written procedures. Serious illnesses, incidents, injuries, and accidents, as well as escapes and all other incidents required in written procedures are subject to this reporting requirement.

***Proposal***: To comply with the provisions of 1VAC7-10-140, the proposal removes the reference to written procedures and limits the categories of incidents that are subject to the incident reporting requirements in this chapter to those currently enumerated in the regulation. The proposal also expands the list to include any mechanical restraint chair, regardless of the duration or purpose of the placement. Finally, the proposal directs DJJ to establish written procedures identifying additional "serious incidents" subject to this reporting requirement that will govern the incident reporting process and to make such procedures accessible to staff. This language will give DJJ the discretion to identify additional reportable incidents, but the facility will not be under any regulatory requirement to report such additional incidents.

Smoking prohibitions – Section 400
The board-adopted amendments prohibit residents from using, possessing, purchasing, or distributing tobacco and nicotine vapor products. Staff, contractors, and interns may not use these products in any area of the premises.

***Proposal***: The proposal seeks to expand the list of prohibited items to include alternative nicotine vapor products, CBD oil, or any other substance prohibited by state or federal law.

Emergency and evacuation procedures – Section 460
The proposal eliminates an inconsistency in the regulation. Section 60 currently requires the JCC to report to the director or his designee, the parent or legal guardian, and the supervising court service unit within 24 hours of the

incident, fires, group disturbances, hostage situations, riots, and other emergencies, as mandated in written procedures. Section 460, however, requires the facility to report these emergencies to the director or designee, parents or legal guardians, and board no later than 72 hours after stabilizing the incident.

> ***Proposal***: The proposal conforms Section 460 to the incident reporting requirements in Section 60. Additionally, it clarifies that the parents or legal guardians of all residents, whether or not the emergency affects the resident, must be notified under this provision.

Visitation—Section 580

The board-approved amendments mandate that JCC visitors receive occasional opportunities to view the resident's housing unit or room and to interact with staff, unless impracticable or hazardous to safety or security.

> ***Proposal***: The proposal strikes this entire provision as inappropriate for a regulation.

Resident transfer between and within JCCs—Section 710

Currently, if JCC staff transfer a resident to a more restrictive unit or program within the JCC or between JCCs, staff must provide the resident with due process safeguards before the transfer. The dLCV recommends that DJJ document these safeguards in writing and provide the resident with a copy at orientation and before transfer.

> ***Proposal***: The proposal adopts the dLCV's recommendation, but clarifies that this section is applicable to resident reassignments (suggesting permanency), rather than transfers (suggesting a resident's temporary transfer, perhaps for safety or other purposes).

Discharge—Section 720

The current regulation requires JCC staff to follow written procedures in discharging residents. JCC staff must include a comprehensive discharge summary in the case record for indeterminately committed residents not released by court order, as well as documentation that staff discussed the discharge with the resident, the parent or legal guardian, and the CSU. For residents serving a determinate commitment or discharged pursuant to a court order, the case record must contain only a copy of the court order. The committee maintains that there is no justification for relaxing the documentation and information storage requirements for indeterminately committed residents.

> ***Proposal***: In addition to striking the reference to written procedures, the proposal makes the documentation requirements that currently apply to residents serving an indeterminate commitment applicable to all residents discharged from direct care. The case records of residents who served a determinate commitment or were discharged by court order must also continue to include a copy of the court order.

Hospitalization and other outside medical treatment of residents – Section 1060

Currently, when a resident needs medical attention off campus, staff must transport the resident safely and in accordance with applicable security procedures applied consistent with the severity of the medical condition. With the exception of residents under the Psychiatric Inpatient Treatment of Minors Act, staff must escort and supervise these residents until they make other appropriate security arrangements. Facility staff must notify the parent or legal guardian (as appropriate and applicable) of this off-campus medical visit as soon as practicable.

***Proposal***: The proposal replaces the directive to comply with security procedures when such residents are transported off campus with a mandate that such transportation comply with 6VAC35-71-540 (*establishing rules for residents transported offsite by non-DJJ staff; establishing licensure and training conditions for staff responsible for conducting the transport; and limiting DJJ staff who are authorized to supervise residents during routine and emergency transportation, etc)*. The proposal requires any exceptions to these rules be applied in accordance with the resident's medical condition. Finally, the proposal directs the facility, where applicable, to notify the parent or legal guardian of the resident's offsite health care visit in accordance with the incident reporting notification requirements established in Section 60 (e.g., within 24 hours of the incident), rather than "as soon as practicable."

Disciplinary process – Section 1110

As part of the formal disciplinary process that staff must follow when residents are alleged to have violated a rule that cannot be resolved informally, staff must conduct a disciplinary hearing. Staff must document the hearing and retain a record for six months.

***Proposal***: The proposal extends the required record retention period from six months to three years to align with the time needed to demonstrate compliance during a certification audit, as provided in 6VAC35-71-30.

Timeout – Sections 10 and 1120

Pursuant to the board-approved amendments, facilities that use timeout must implement written procedures that allow placement in timeout only after less restrictive alternatives have been applied. Timeout is defined in Section 10 as a behavior management technique program component designed to reduce or eliminate problematic behavior by having staff require a resident to move to a location away from a source of reinforcement for 60 minutes or until the behavior subsides, whichever occurs first. Because by definition timeout periods are limited to 60 minutes, and because residents need not serve timeout behind a locked door, the committee believes that timeout periods already constitute one of the least restrictive alternatives. The board-approved amendments also prohibit the use of timeout to address chargeable offenses as designated in procedures or aggressive behaviors.

***Proposal***: The proposal makes the following amendments:

- Changes the definition in Section 10 by striking the "program component" language as timeouts are not a current component of the department's behavior management program. The proposal clarifies the timeout definition by adding the qualifier "minor" to convey that timeout is intended to address minor problematic behavior. The proposal makes additional technical changes to the definition.
- Strikes the limitation directing staff to apply other, less restrictive alternatives before using timeout;
- Strikes the prohibition on using timeout to address chargeable offenses to avoid conflicting with the incorporation by reference issue and allows timeouts only to address minor inappropriate or problematic behavior, consistent with the language in the timeout definition.

## VI. SUMMARY OF SUBSTANTIVE RECOMMENDATIONS – MINOR IMPACT

Reporting criminal activity: The proposal makes the duty to notify appropriate agencies of suspected staff or resident criminal violations applicable to the superintendent **or his designee**.

Organizational communications – Section 110

The board-approved amendments require the assistant superintendent and community managers in the JCC to visit the housing units under their jurisdiction regularly and frequently. Additionally, DJJ must establish written procedures governing these visits that specify the required duration, activities to be observed, and process for documenting such visits. DLCV recommends adding a requirement that such procedures also address the frequency of these visits.

> ***Proposal***: The workgroup determined that prescribing the specific duration, frequency, documentation methods, and activities of these visits, even in written procedures, is far too prescriptive and may reduce staff flexibility and negate the intended purpose of these meetings. Instead, the proposal's broader language directs DJJ to have rules regarding these visits in its written procedures, without specifying the subject matter of those rules.

Background checks – Section 140

Currently, individuals employed in a JCC and certain contractors must undergo a host of background checks before working in the JCC. An exception allows employees to be hired pending the results of the fingerprint checks if all the other applicable background checks have been completed. The current regulation and board-approved language improperly references the wrong section and subsections regarding this requirement. The proposal corrects this error.

Required initial training – Section 160

In order to reflect a requirement for training on procedures regarding the disciplinary process set out in Section 1110, the proposal adds the disciplinary process as a required topic of training for direct care and direct supervision employees.

The proposal also corrects language in subsection E of this provision, as adopted by the board, that requires medication administrators to either complete a medication management training program or be **certified** by the Commonwealth before they may administer medication. The Commonwealth serves as the licensing authority for these individuals; therefore the term, "certified," is not the proper terminology.

Maintenance of records – Section 260

The current regulation requires staff to follow written procedures to keep case records and health care records up-to-date and uniform.

> ***Proposal***: The proposal removes this requirement in its entirety, as the directive is more appropriate as a written procedure. In order to comply with 1VAC7-10-140, the proposal also requires DJJ to have procedures in place for maintaining and managing case records in JCCs.

Space utilization – Section 410

The current regulation requires the provision of a designated visiting area in each JCC that allows for informal communication and opportunities for physical contact between residents and visitors in accordance with written procedures. Although primarily operational in nature, the written procedures allow only limited, monitored physical contact between residents and visitors.

> ***Proposal***: The proposal replaces the reference to written procedures with a requirement that the opportunities for physical contact be limited and monitored.

Animals on the premises – Section 440
The proposal makes a minor amendment to clarify that animals maintained on the premises must be kept a reasonable distance from eating and food preparation areas and a safe distance from water supplies. The proposal inadvertently removed eating areas from this list.

Prohibited actions – Section 550
The proposal removes as unnecessary discrimination in violation of executive orders from the list of actions staff may not take in their interactions with residents. State agencies must comply with executive orders in place, even in the absence of conforming regulatory language.

Resident mail – Section 560
The proposal replaces the director/designee with the superintendent/designee as the individual authorized to allow staff to read incoming or outgoing resident mail upon determining that there is a reasonable belief that the security of the facility is threatened. The proposal makes additional amendments for clarification.

Telephone calls – Section 570
Rather than permitting telephone calls in accordance with written procedures, the proposal directs staff to allow residents to call immediate family members or natural supports according to a flexible schedule based on facility security needs and other scheduled activities. The proposal also cross-references Section 590, which addresses resident contacts with legal representatives.

Visitation – Section 580
The board-adopted amendments prohibit facility staff from subjecting visits from immediate family members and natural supports to unreasonable limitations and allows for limitations only as authorized in written procedures, applicable regulations, or court order. The proposal removes the restriction on unreasonably limiting visitation for these parties and instead allows the facility to limit these visits only if documented and based on the need for facility security and order and the behavior of individual residents and visitors.

Residents' funds – Section 670
The proposal revives the current regulatory language that permits a resident's funds to be used for his benefit and removes the specific references to activities, services, or goods for the resident. The proposal also clarifies that if the resident's funds are used to pay non court-ordered or non-judicial-ordered restitution for damaged property or personal injury, such damage or injury must have resulted from an institutional incident.

Resident personal possessions – Section 690
The current regulation sets forth the process for handling unauthorized items the resident has on his person when he arrives at the facility. Currently, among other requirements, staff must discard contraband in accordance with written procedures. The committee believes the scope of the directive to dispose of such items is narrow and applies solely to illegal contraband items and that such illegal items should not have been addressed in a regulatory section involving residents' personal possessions. Therefore, the committee recommends striking this reference. The proposal makes additional amendments to reflect applicable statutory language.

Resident transfer between and within JCCs – Section 710
As originally amended, the regulation requires JCCs to provide the resident with due process safeguards prior to transferring him to a more restrictive unit or program within the JCC or between JCCs. The dLCV recommends

requiring these safeguards to be documented in writing and given to the resident, both during orientation and before transfer.

Family engagement – Section 765

The proposal makes modifications to the newly adopted family engagement section of the regulation by removing the requirement that written procedures specify the number of weekly telephone calls JCC staff must allow a resident to make, in favor of a requirement that staff comply with Section 570 (*requiring JCC staff to allow residents to call family members and natural supports, giving staff flexibility to schedule these calls based on security and scheduled activities, and complying with Section 590 regarding phone calls with legal counsel).* The proposal also relaxes the duties of facility staff to plan events and activities that include family members.

Staff supervision of residents – Section 820

The proposal makes a minor edit to correct an improper reference to security series staff in subdivision F(2). Before direct supervision staff may be alone with a resident outside the active supervision of a direct care employee, the staff must complete certain agency-approved training. The provision applies to direct supervision staff outside the active supervision of direct care, rather than security employees.

Staffing pattern – Section 830

The proposal adds a new subsection D that incorporates language from an existing variance authorizing security employees to supervise residents outside the presence of direct care staff in the infirmary or nurse's station without conflicting with ratio requirements contained in this section. To the extent that there are security employees who do not meet the definition of direct care staff as defined in Section 10, this provision allows JCC staff to supervise residents outside the presence of direct care staff.

Emergency medical services – Section 1050

Currently, staff must respond to medical or dental emergencies in accordance with written procedures. The proposal removes this provision and replaces it with language requiring such staff to respond within the scope of their training and certification. This is consistent with language elsewhere in the regulation.

Medication – Section 1070

Under subsection K of the current regulation, staff shall follow applicable laws and regulations when disposing or storing unused, expired, and discontinued medications. The proposal expands this provision to apply to medical implements (e.g., syringes), in addition to discontinued medications.

Release physical – Section 1080:

The proposal makes a minor amendment to remove the requirement that a qualified health care practitioner be operating under the supervision of a physician before the practitioner may conduct a resident's release physical. Pursuant to regulations promulgated by the Board of Health Professions, some practitioners can qualify for independent practice. Striking this supervision requirement leaves the issue properly in the hands of the Board of Health Professions.

## VII. OTHER DEFINITIONAL CHANGES, CLARIFICATIONS, AND TECHNICAL AMENDMENTS

Definitions

- Case record (§10): The proposal strikes "record" as a possible synonymous term for "case record" because the regulation's use of the term "record" extends to other records, such as criminal records and background records. Conforming changes are made throughout the chapter.
- Natural support: The proposal modifies the board-adopted definition of natural support to require that such association be approved by the department and makes additional technical amendments.
- Timeout: The committee recommends removing the reference to a program component in the timeout definition because timeout currently is not a component of the department's behavior management program.
- Vulnerable population: The definition removes the examples of factors that could signify a resident's vulnerable status in order to prevent the assumption that such factors are necessarily indicative of a vulnerable status. The amendments move these factors to Section 555.

Reorganizing provisions

In order that all the "restraint" provisions are grouped together, the proposal repeals Section 1130 (physical restraints) and places it in a new Section 1175 that immediately precedes the provisions addressing mechanical restraints. Amendments are made to Section 1175 to eliminate duplicative language and provide additional clarification. Conforming changes are made to other sections of this chapter.

Medical References

The proposal replaces references to "physician" throughout the regulation with "licensed physician" and, where authorization is granted or a duty is imposed upon a physician in this chapter, expands the authorization or duty so that it also includes "licensed medical providers (i.e., physician assistants and nurses), consistent with accepted medical practices. Such changes are made to §§ 185, 550, 960, 1040, 1070, and 1080. The proposal also adds the "licensed" qualifier to "health care provider" references.

The proposal replaces references to medical records with health care records where the intent is to capture the entire compilation of health-related records, including medical, dental, and behavioral health records. The proposal adds a new definition for health care to effectuate this intent. Amendments are being proposed to the following sections: (§§ 260, 550, 710, 990, and 1020).

The Virginia legislature recently amended the statutory definition for "qualified mental health professional" so that the term captures a broader category of mental health professionals. Because the most recent statutory definition encompasses individuals who are not clinicians, the workgroup recommends establishing a new term for individuals employed in the mental health field who are responsible for conducting assessments and making other determinations related to a resident's mental health needs. The workgroup established a new term, "mental health clinician," defined in Section 10, to include licensed clinicians who assess, diagnose, treat, plan, implement treatment, and provide similar clinical counseling services, or licensed-eligible clinicians being supervised by such mental health clinicians. The proposal replaces references to "qualified mental health professional," with "mental health clinician" in §§ 545, 630, 805, and 1140.

Employees versus staff

The proposal makes several technical amendments including replacing references to direct care staff, direct supervision staff, and security staff with direct care, direct supervision, and security **employees** (§§ 10, 220, 320, 500, 540, 745, 820, and 830).

Technical changes:

The proposal makes technical changes to the following sections to conform to the requirements in the Style Manual: §§ 10, 220, 545, 680, 820, 1070, and 1110.

The proposal makes several changes to simplify language and clarify concepts, including amendments to the following sections: §§ 10 and 820.

Because a JCC is an entity and not a person, the workgroup has recommended replacing certain personifying references to JCCs or facilities with "the JCC administration" or "JCC staff". Such amendments are set out in §§ 30, 60, 90, 120, 140, 180, 280, 290, 410, 420, 430, 450, 460, 480, 520, 530, 540, 555, 630, 660, 680, 690, 700,735, 740, 745, 765, 770, 820, 880, 890, 1050, 1070, and 1110.

**DEPARTMENT (BOARD) OF JUVENILE JUSTICE**
**Periodic Review of Regulation Governing Juvenile Correctional Centers**

## CHAPTER 71 (6VAC35-71)

Part I
General Provisions

### 6VAC35-71-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Active supervision" or "actively supervise" means ~~a method~~ the act of resident supervision in which a direct care employee is (i) actively patrolling and frequently viewing the areas in which residents are present a minimum of once every 15 minutes and (ii) close enough in proximity to the resident to provide a quick response should an incident occur.

"Annual" means within 13 months of the previous event or occurrence.

"Assistant superintendent" means the individual who provides regular assistance and support to the superintendent in the management and operation of a juvenile correctional center.

"Aversive stimuli" means physical forces, such as sound, electricity, heat, cold, light, water, or noise, or substances, such as hot pepper, pepper sauce, or pepper spray, measurable in duration and intensity that when applied to a resident are noxious or painful to the resident.

"Behavior management" means the principles and methods employed to help a resident achieve positive behavior and to address and correct a resident's inappropriate behavior in a constructive and safe manner that emphasizes ~~in accordance with written procedures governing~~ program expectations, treatment goals, resident and staff safety and security, and the resident's individual service plan.

"Board" means the Board of Juvenile Justice.

~~"Boot camp" means a short-term secure or nonsecure juvenile residential program that includes aspects of basic military training and that utilizes a form of military-style discipline whereby employees are authorized to respond to minor institutional offenses by imposing immediate sanctions that may require the performance of some physical activity based on the program's written procedures.~~

"Case record" ~~or "record"~~ means the collection of written ~~or electronic~~ information regarding a resident and the resident's family, if applicable~~, maintained in accordance with written procedures~~.

"Community manager" means the individual who supervises, coordinates, and directs an assigned group of staff in multiple housing units and who oversees the schedules, programs, and services for assigned housing units within a juvenile correctional center.

"Contraband" means ~~any~~ an item possessed by or accessible to a resident or found within a juvenile correctional center or on its premises that (i) is prohibited by statute, regulation, or department procedure; (ii) is not acquired through approved channels or in prescribed amounts; or (iii) may jeopardize the safety and security of the juvenile correctional center or individual residents.

"Contractor" means an individual who has entered into a legal agreement to provide services on a recurring basis to a juvenile correctional center.

"Department" means the Department of Juvenile Justice.

"Direct care" means the ~~time~~ period during which a resident who is committed to the department pursuant to § 16.1-272 or 16.1-285.1, or ~~subsection~~ subdivision A 14 ~~or A 17~~ of

§ 16.1-278.8 of the Code of Virginia is under the supervision of staff in a juvenile correctional center operated by or under contract with the department.

"Direct care ~~staff~~ employee" means ~~the~~ an ~~staff~~ employee whose primary job responsibilities are ~~for~~ (i) maintaining the safety, care, and well-being of residents; (ii) implementing the structured program of care and the behavior management program; and (iii) maintaining the security of the facility. For purposes of this chapter, the term "direct care employee" shall include a security employee assigned, either on a primary or as-needed basis, to perform the duties of subdivisions (i) through (iii) of this definition and who is required to receive initial and annual training in these areas in order to carry out the responsibilities in subdivisions (i) through (iii) of this definition.

"Direct supervision" or "directly supervise" means ~~the act of working with residents who are not in the presence of direct care staff. Staff members who provide direct supervision are responsible for maintaining the safety, care, and well-being of the residents in addition to providing services or performing the primary responsibilities of that position~~ ~~a method of resident supervision in which~~ the act of a direct supervision employee ~~is authorized to provide~~providing services to a resident while direct care ~~staff~~ employees are not within close proximity and do not have direct and continuous visual observation of or the ability to hear any sounds or words spoken by the resident.

"Direct supervision employee" means a staff member who is responsible for maintaining the safety, care, and well-being of the residents in addition to providing services or performing the primary responsibilities of that position and who is authorized to directly supervise residents.

"Director" means the Director of the Department ~~of Juvenile Justice~~.

"Emergency" means a sudden, generally unexpected occurrence or set of circumstances demanding immediate action such as a fire, chemical release, loss of utilities, natural disaster, ~~taking of hostages~~ hostage situation, major ~~disturbances~~ disturbance, escape, ~~and~~ or bomb ~~threats~~ threat. ~~Emergency~~ For purposes of this definition, "emergency" does not include regularly scheduled employee time off or other situations that reasonably could be ~~reasonably~~ anticipated.

"Gender identity" means a person's internal sense of being male or female, regardless of the person's sex assigned at birth.

"Grievance" means a written communication by a resident on a department-approved form that reports a condition or situation that relates to department procedure and that presents a risk of hardship or harm to a resident ~~and relates to department procedure~~.

~~"Health care record" means the complete record of medical screening and examination information and ongoing records of medical and ancillary service delivery, including but not limited to all findings, diagnoses, treatments, dispositions, prescriptions, and their administration.~~

"Health care record" means the complete record of all health care services provided to a resident, including medical, dental, orthodontic, mental health, family planning, obstetrical, gynecological, health education, and other ancillary records.

"Health care services" means those actions, preventative and therapeutic, taken for the physical and mental well-being of a resident. Health care services include medical, dental, orthodontic, mental health, family planning, obstetrical, gynecological, health education, and other ancillary services.

"Health ~~-~~trained personnel" means an individual who is trained ~~by a licensed health care provider to perform specific duties, such as administering health care screenings, reviewing screening forms for necessary follow-up care, preparing residents and records for sick call, and assisting in the implementation of certain medical orders~~ and appropriately supervised to carry out specific duties with regard to the administration of health care.

"Housing unit" means the space in a juvenile correctional center in which a particular group of residents resides, which comprises sleeping areas, bath and toilet facilities, and a living room or

its equivalent for use by the residents. Depending upon its design, a building may contain one or several separate housing units.

"Human research" means any systematic investigation, including research development, testing, and evaluation utilizing human subjects that is designed to develop or contribute to generalized knowledge. Human research shall not be deemed to include research exempt from federal research regulation pursuant to 45 CFR 46.101(b).

"Immediate family member" means a resident's parent or legal guardian, step-parent, grandparent, spouse, child, sibling, and step-sibling.

"Individual service plan" ~~or "service plan"~~ means a written plan of action developed, revised as necessary, and reviewed at specified intervals~~,~~ to meet the needs of a resident. ~~The individual service plan specifies (i) measurable short-term and long-term goals; (ii) the objectives, strategies, and time frames for reaching the goals; and (iii) the individuals responsible for carrying out the plan.~~

"Juvenile correctional center," "JCC," or "facility" means a public or private facility, operated by or under contract with the ~~Department of Juvenile Justice~~ department, where ~~24-hour per day~~ care is provided to residents under the direct care of the department 24 hours a day, seven days a week. ~~For purposes of this chapter, "juvenile correctional center" does not include any facility at which a direct care alternative placement program is operated~~.

~~"Living unit" means the space in a juvenile correctional center in which a particular group of residents resides that contains sleeping areas, bath and toilet facilities, and a living room or its equivalent for use by the residents. Depending upon its design, a building may contain one living unit or several separate living units.~~

"Legal mail" means a written communication that is sent to or received from a designated class of correspondents~~, as defined in written procedures,~~ which shall include any court, legal counsel, administrator of the grievance system, the department, or the regulatory authority.

"Lockdown" means the restriction of all or a group of residents to their housing unit, an area within their housing unit, or another area within a JCC for the purpose of (i) relieving temporary, tensions within the facility that may threaten or critically affect staff or residents or present a risk to public safety; (ii) conducting a facility search for ~~missing tools or other security~~ contraband; (iii) responding to an imminent threat to the security and control of the facility or to the safety of staff, residents, or the public; or (iv) responding to other unexpected circumstances that threaten the safe operation of the facility, such as a loss of electricity, a critical shortage of staff, or an emergency.

"Mechanical restraint" means ~~the use of~~ an approved mechanical device that involuntarily restricts the freedom of movement or voluntary functioning of a limb or portion of an individual's body as a means of controlling his physical activities when the individual being restricted does not have the ability to remove the device. For purposes of this ~~definition~~chapter, mechanical restraints ~~are limited to~~shall include ~~handcuffs, handcuff covers, leather restraints,~~ flex-cuffs, handcuffs, leather restraints, ~~waist chains,~~ leg irons, restraining belts and straps, ~~helmets, spit guards~~ and waist chains~~, anti-mutilation gloves, and restraint chairs~~.

"Mechanical restraint chair" means an approved chair used to restrict the freedom of movement or voluntary functioning of a portion of an individual's body as a means of controlling his physical activities while the individual is seated and either stationary or being transported.

"Medical record" means the complete record of medical screening and examination information and ongoing records of medical and ancillary service delivery, including all findings, diagnoses, treatments, dispositions, prescriptions, and their administration.

"Medication incident" means any one of the following errors made in administering a medication to a resident: (i) a resident is given incorrect medication; (ii) medication is administered

to the incorrect resident; (iii) an incorrect dosage is administered; (iv) medication is administered at the wrong time or not at all; or (v) the medication is administered through an improper method. For purposes of this regulation, a medication incident does not include a resident's refusal of appropriately offered medication.

"Mental health clinician" means a clinician licensed to provide assessment, diagnosis, treatment planning, treatment implementation, and similar clinical counseling services, or a licensed-eligible clinician under supervision of a licensed mental health clinician.

"Natural support" means a department-approved personal association and pro-social relationship typically developed in the community that enhances the quality and security of life for a resident and that is expected to provide post-release support, including an extended family member, person serving as a mentor, or representative from a community organization~~, or other person in the community with whom a resident has developed a relationship that enhances the resident's quality and security of life and who is expected to provide post-release support~~.

"On duty" means the period ~~of time, during~~ of an employee's scheduled work hours~~,~~ during which the employee is responsible for the ~~direct~~ supervision of one or more residents in the performance of that employee's ~~position's~~ position duties.

"Parent" or "legal guardian" means (i) a biological or adoptive parent who has legal custody of a resident, including either parent if custody is shared under a joint decree or agreement; (ii) a biological or adoptive parent with whom a resident regularly resides; (iii) a person judicially appointed as a legal guardian of a resident; or (iv) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption, or otherwise by operation of law.

"Physical restraint" means the application of behavior intervention techniques involving a physical intervention to prevent an individual from moving all or part of his body.

"Premises" means the tracts of land within the secure perimeter on which any part of a juvenile correctional center is located ~~and any buildings on such tracts of land~~.

"Protective device" means an approved device placed on a portion of a resident's body to protect the resident or staff from injury.

~~"Reception and Diagnostic Center" or "RDC" means the juvenile correctional center that serves as the central intake facility for all individuals committed to the department. The Reception and Diagnostic Center's primary function is to orient, evaluate, and classify each resident before being assigned to a juvenile correctional center or alternative placement.~~

"Regulatory authority" means the board, or the department if designated by the board.

"Resident" means an individual, ~~either a minor or an adult~~regardless of age, who is committed to the department and resides in a juvenile correctional center.

"Rest day" means a period of not less than 24 consecutive hours during which the direct care ~~staff person~~ employee has no responsibility to perform duties related to employment at the JCC or with the department.

"Room confinement" means the involuntary placement of an individual resident in the resident's room or other designated room~~, except during normal sleeping hours,~~ and the imposition of additional restrictions ~~for the purpose of (i) ensuring the safety of the resident, staff, or others within the facility; (ii) ensuring the security of the facility; or (iii) protecting property within the facility~~. For purposes of this ~~regulation~~chapter, room confinement shall not include (i) any timeout period; (ii) confinement during normal sleeping hours; (iii) confinement for purposes of allowing residents within a housing unit to shower safely; (iv) confinement for purposes of conducting facility counts; (v) confinement during shift changes; or (vi) ~~or any~~ confinement resulting from a lockdown.

"Rules of conduct" means a ~~listing~~ list of a juvenile correctional center's rules or regulations that is maintained to inform residents and others of the behavioral expectations of the behavior management program, ~~about~~ behaviors that are not permitted, and ~~about~~ the ~~sanctions~~ consequences that may be applied when impermissible behaviors occur.

"Security ~~staff~~employee" means an ~~staff~~ employee who ~~are~~ is responsible for maintaining the safety, care, and well-being of residents and the safety and security of the facility.

"Sick call" means the evaluation and treatment of a resident in a clinical setting, either onsite or offsite, by a qualified health care professional.

"Spit guard" means a protective device designed for the purpose of preventing the spread of communicable diseases as a result of spitting or biting.

"Superintendent" means the individual who ~~has the responsibility~~is responsible for the ~~on-site~~ onsite management and operation of a juvenile correctional center on a regular basis.

"Timeout" means a systematic behavior management technique ~~program component~~ designed to reduce or eliminate minor inappropriate or problematic behavior by having staff require a resident to move to a specific location that is away from a source of reinforcement ~~for the earlier of a period not to exceed 60 minutes or~~ until the problem behavior has subsided, not to exceed 60 minutes.

"Volunteer" or "intern" means ~~any~~ an individual or group under the direction and authority of the juvenile correctional center who ~~of their own free will~~ voluntarily provides goods and services without competitive compensation.

"Vulnerable population" means a resident or group of residents who has been determined by designated JCC staff to be reasonably likely to be exposed to the possibility of being attacked or harmed, either physically or emotionally~~, due to factors such as the resident's age, height, size, English proficiency, sexual orientation, gender nonconformity, history of being bullied, or history of self-injurious behavior~~.

"Written" means the required information is communicated in writing~~. Such writing may be available~~ in either hard copy or in electronic form.

**6VAC35-71-15. Applicability.**

This chapter applies exclusively to: (i) state operated juvenile correctional centers and (ii) privately operated juvenile correctional centers governed by the Juvenile Corrections Private Management Act (§ 66-25.3 et seq. of the Code of Virginia). Parts I through VIII apply to state operated and privately operated facilities. Part IX applies solely to privately operated juvenile correctional centers. Provisions governing juvenile boot camps and locally, regionally, or privately operated alternative direct care programs for juveniles are not included in this chapter.

**6VAC35-71-30. Certification.**

A. The JCC administration shall maintain a current certification demonstrating compliance with the provisions of the ~~Regulations~~ Regulation Governing the Monitoring, Approval, and Certification of Juvenile Justice Programs and Facilities (6VAC35-20).

B. The JCC administration shall demonstrate compliance with this chapter, other applicable regulations issued by the board, and applicable statutes and regulations ~~as interpreted by the assessment and compliance measures approved in accordance with board regulations or department procedures~~.

C. Documentation necessary to demonstrate compliance with this chapter shall be maintained for a minimum of three years.

D. The current certificate shall be posted at all times in a place conspicuous to the public.

**6VAC35-71-50. Variances and waivers.**

A. Board action may be requested by the ~~superintendent~~ director or the director's designee to relieve a JCC from having to meet or develop a plan of action for the requirements of a specific section or subsection of this regulation, provided the section or subsection is a noncritical regulatory requirement. The variance request may be granted either permanently or for a determined period of time, as provided in the ~~Regulations~~ Regulation Governing the Monitoring, Approval, and Certification of Juvenile Justice Programs and Facilities (6VAC35-20) ~~and in accordance with written procedures~~.

B. A variance may not be implemented prior to approval of the board.

C. If the superintendent has submitted a variance request to the director or the director's designee concerning a noncritical regulatory requirement and board action has been requested formally by the director or the director's designee, the director may but is not required to grant a waiver temporarily excusing the facility from meeting the requirements of a specific section or subsection of this regulation. The waiver shall be subject to the requirements in 6VAC35-20-93.

**6VAC35-71-60. ~~Serious incident~~ Incident reports.**

A. The following events shall be reported to the director or the director's designee as soon as practicable, but no later than 24 hours after the incident~~, and in accordance with written department procedures to the director or his designee~~:

1. ~~Any~~ A serious illness, incident, injury, or accident involving the serious injury of a resident;

2. ~~Any~~ A resident's absence from the facility without permission; ~~and~~

~~3. All other situations required by written procedures.~~ and

3. The facility's use of the mechanical restraint chair, regardless of the purpose or duration of use.

B. As appropriate and applicable, ~~the~~ facility staff shall, as soon as practicable, but no later than 24 hours after the incident, ~~and in accordance with written procedures,~~ report the incidents listed in subsection A of this section to (i) the parent or legal guardian and (ii) the supervising court service unit or agency.

C. Any incident involving the death of a resident shall be reported to the individuals specified in subsections A and B of this section without undue delay.

D. ~~The facility~~Facility staff shall prepare and maintain a written report of the events listed in subsections A and C of this section ~~which~~ that shall contain the following information:

1. The date and time the incident occurred;

2. A brief description of the incident;

3. The action taken as a result of the incident;

4. The name of the person who completed the report;

5. The name or identifying information of the person who made the report to the supervising agency and to the parent or legal guardian; and

6. The name ~~or identifying information of the person~~ of any law-enforcement agency or local department of social services to ~~whom~~ which the report was made~~, including any law enforcement or child protective service personnel~~.

E. The department shall establish written procedures that address any additional serious incidents that must be reported, the process for notifying the parties identified in subsection B of this section, and the steps for completing and submitting the written report required in subsection D. The JCC administration shall ensure the written procedures are accessible to JCC staff.

~~E~~F. The resident's case record shall contain a written reference (i) that an incident occurred and (ii) of all applicable reporting.

~~F~~G. In addition to the requirements of this section, any suspected child abuse and neglect shall be governed by 6VAC35-71-70 ~~(suspected child abuse or neglect)~~.

**6VAC35-71-70. Suspected child abuse or neglect.**

A. When there is reason to suspect that a resident is an abused or neglected child, the matter shall be reported immediately to the local department of social services or to the Virginia Department of Social Services toll-free child abuse and neglect hotline as required by § 63.2-1509 of the Code of Virginia ~~and in accordance with written procedures~~.

B. Any case of suspected child abuse or neglect occurring at ~~the~~ a JCC, occurring ~~on~~ during a ~~JCC-sponsored~~ JCC-sponsored event or excursion~~,~~ or involving JCC staff shall be reported within 24 hours~~, in accordance with written procedures,~~ to (i) the director or ~~his~~ the director's designee, (ii) the supervising court ~~services~~ service unit, and (iii) the resident's parent or legal guardian, as appropriate and applicable.

C. When a case of suspected child abuse or neglect is reported ~~to child protective services~~ in accordance with subsection A of this section, a record shall be maintained at the facility that contains the following information:

1. The date and time the suspected abuse or neglect occurred;
2. A brief description of the suspected abuse or neglect;
3. ~~Action~~ The action taken as a result of the suspected abuse or neglect; and
4. The name or identifying information of the person to whom the report was made at the local ~~child protective services unit~~ department of social services.

D. The resident's case record shall contain a written reference that a report was made.

E. Written procedures shall be accessible to staff regarding the following:

1. Handling accusations of child abuse or neglect, including those made against staff;
2. Reporting, consistent with requirements of the Code of Virginia, and documenting suspected cases of child abuse or neglect to the local child protective services unit;
3. Cooperating during any investigation; and
4. Measures to be taken to ensure the safety of the resident and the staff.

**6VAC35-71-75. Reporting criminal activity.**

A. Staff shall be required to report to the superintendent or the superintendent's designee all known criminal activity alleged to have been committed by residents or staff, including ~~but not limited to any~~ physical abuse, sexual abuse, or sexual harassment of residents~~, to the superintendent or designee~~.

B. ~~The~~ ~~In accordance with written procedures, the~~ The superintendent or the superintendent's designee~~, in accordance with written procedures,~~ shall notify the appropriate persons or agencies, including law enforcement and the local department of social services division of child protective services, if applicable and appropriate, of suspected criminal violations by residents or staff.

C. The JCC superintendent and applicable staff shall assist and cooperate with the investigation of ~~any such~~ these complaints and allegations ~~as necessary~~ subject to restrictions in federal or state law.

**6VAC35-71-80. Grievance procedure.**

A. ~~The superintendent or the superintendent's designee shall ensure the facility's compliance with the department's grievance procedure~~. The department shall have a grievance procedure in place that ~~shall~~ provides for the following:

1. Resident participation in the grievance process, with assistance from staff upon request;

2. Investigation of the grievance by an impartial and objective ~~person~~ employee who is not the subject of the grievance;

3. Documented~~, timely~~ responses to all grievances with the supporting reasons for the decision;

4. At least one level of appeal;

5. Administrative review of grievances;

6. Protection of residents from retaliation or the threat of retaliation for filing a grievance; and

7. Immediate review of ~~emergency~~ grievances that pose an immediate risk of ~~hardship or~~ harm to a resident, with resolution as soon as practicable but no later than eight hours after the initial review, and review and resolution of all other grievances as soon as practicable but no later than 30 business days after receipt of the grievance. For purposes of this subdivision, a grievance may be deemed resolved once the issue has been addressed or corrected by facility staff or referred to an external organizational unit.

B. Residents shall be oriented to the grievance procedure in an age ~~or~~ and developmentally appropriate manner.

C. The grievance procedure shall be (i) written in clear and simple language, (ii) posted in an area accessible to residents, and (iii) ~~posted~~ available in an area easily accessible to parents and legal guardians.

D. Staff shall assist and work cooperatively with other employees in facilitating the grievance process.

**6VAC35-71-90. ~~Resident advisory committee~~ Student government association.**

~~Each~~ A. ~~A~~ The JCC administration~~, except RDC,~~ shall ~~have a resident advisory committee~~ maintain a student government association that ~~(i)~~ is representative of the facility's population and ~~(ii) shall meet monthly with the superintendent or designees during which time the residents shall be given the opportunity to raise matters of concern to the residents and the opportunity to have input into planning, problem-solving, and decision-making in areas of the residential program that affect their lives~~ that is organized to (i) provide leadership, development opportunities, and opportunities for civic participation and engagement for residents and (ii) allow for resident communication with facility and agency leadership.

B. The student government association shall develop a constitution and bylaws that shall govern the operation of the organization and provide for an election process for student government association officers and representatives.

C. Representatives from the student government association shall meet with the superintendent or the superintendent's designee at least once per month, during which time the representatives shall be given the opportunity to raise matters that concern the residents and to have input into planning, problem-solving, and decision-making in areas of the residential program that affect their lives.

D. In addition to the monthly meetings with the superintendent or the superintendent's designee, the JCC administration shall provide regular opportunities for the student government association to meet as a body and with the residents they represent.

E. The facility administration shall maintain a current copy of the constitution and bylaws required in subsection B of this section that shall be posted in each housing unit. During orientation, the residents shall receive an overview of the student government association, the constitution, and the bylaws.

## Part II
## Administrative and Personnel

### 6VAC35-71-110. Organizational communications.

A. The superintendent or the superintendent's designee shall meet, at least monthly, with all facility department heads and key staff members.

B. ~~The superintendent or the assistant superintendent, chief of security, treatment program supervisor, or counseling supervisor, if designated by the superintendent, shall visit the living units and activity areas at least weekly~~ In order to encourage ~~informal~~ contact with employees and residents, ~~and to~~ observe ~~informally~~ the facility's living and working conditions, and enhance the efficacy and success of the therapeutic community within each housing unit, the JCC administration shall ~~ensure that the~~ establish written procedures that require the assistant superintendent and the community manager assigned to each specific housing unit ~~shall~~ to make regular, consistent, and frequent visits to each housing unit under their jurisdiction. The written procedures also shall provide rules regarding these visits ~~, in accordance with written procedures established pursuant to subsection D of this section~~.

C. The superintendent shall ~~make such visits, at a minimum, one time~~ visit every housing unit and activity area at least once per month.

~~D. The JCC shall establish written procedures governing the visits required in subsection B of this section that shall specify the required duration of each visit, the information and activities that should be observed, and the manner in which the visits shall be documented.~~

### 6VAC35-71-120. Community relationships.

~~Each~~ The JCC administration shall designate a community liaison and, if appropriate, a community advisory committee ~~that serves~~ to serve as a link between the facility and the community~~, which~~. The community advisory committee may include facility neighbors, local law enforcement, and local government officials.

### 6VAC35-71-140. Background checks.

A. Except as provided in subsection B of this section, all persons who (i) accept a position of employment or (ii) provide contractual services directly to a resident on a regular basis and will be alone with a resident in the performance of their duties in a JCC shall undergo the following background checks, in accordance with § 63.2-1726 of the Code of Virginia, to ~~ascertain~~ determine whether there are criminal acts or other circumstances that would be detrimental to the safety of residents in the JCC:

1. A reference check;
2. A criminal history record check;
3. Fingerprint checks with the Virginia State Police and Federal Bureau of Investigation (FBI);
4. A central registry check with Child Protective Services; and
5. A driving record check, if applicable to the individual's job duties.

B. ~~To~~ In order to minimize vacancy time~~,~~ when the fingerprint checks required by subdivision A 3 of this section have been requested, employees may be hired, pending the results of the fingerprint checks, provided:

1. All ~~of the~~ other applicable components of this ~~subsection~~ ~~section~~ subsection A have been completed;

2. The JCC provides the applicant ~~is given~~ with written notice that continued employment is contingent on the fingerprint check results as required by subdivision A 3 of this section; and

3. Employees hired under this exception shall not be allowed to be alone with residents and may work with residents only when the residents are under the direct or active supervision of staff whose background checks have been completed until ~~such time as~~ all the requirements of this section are ~~completed~~ satisfied.

C. ~~Documentation~~ The JCC administration shall retain documentation of compliance with this section ~~shall be retained~~.

D. Written procedures shall provide for the supervision of nonemployee persons, who are not subject to the provisions of this section ~~who~~ and have contact with residents.

**6VAC35-71-160. Required initial training.**

A. ~~Each employee~~ JCC employees shall complete initial, ~~comprehensive~~ agency-approved training that is specific to the individual's occupational class~~, is based on the needs of the population served, and ensures that the individual has the competencies to perform the position responsibilities. Contractors shall receive training required to perform their position responsibilities in a correctional environment~~.

B. Direct care ~~staff and~~ employees ~~responsible for the direct supervision of residents shall~~ and security employees, before ~~that employee is~~ being responsible for ~~the direct supervision of~~ supervising a resident, shall complete at least 120 hours of training, which shall include training in the following areas:

~~1. Emergency preparedness and response;~~

~~2.~~ 1. First aid and cardiopulmonary resuscitation, unless the individual is currently certified, with certification required as applicable to their duties;

2. Recognition of signs and symptoms and knowledge of actions required in a medical emergency;

3. The ~~facility's~~ department's behavior management program, as provided in 6VAC35-71-745, including the requirements for sustaining a therapeutic community environment, as required in 6VAC35-71-735. At a minimum, this training shall address (i) the components and basic principles of the behavior management program; (ii) the principles, definitions, and expectations governing a therapeutic community environment; (iii) the main tenets of the department's graduated incentive system; and (iv) the tools available to address noncompliance;

4. The residents' rules of conduct, ~~and~~ the rationale for the rules, and the disciplinary process in accordance with 6VAC35-71-1110;

5. The ~~facility's~~ department's behavior interventions, ~~with restraint training required as~~ including, if applicable to ~~their~~ the individual's duties, training in the use of physical restraints, ~~and~~ mechanical restraints and protective devices, and the mechanical restraint chair, as provided in 6VAC35-71-~~1130~~ 1175, ~~and~~ 6VAC35-71-1180, and 6VAC35-71-1203;

6. Emergency preparedness and response, as provided in 6VAC35-71-460;

7. Standard precautions, as provided in 6VAC35-71-1000;

~~6.~~ 8. Child abuse and neglect;

~~7.~~ 9. Mandatory reporting;

10. Residents' rights, including the prohibited actions provided for in 6VAC35-71-550;

~~8.~~ 11. Maintaining appropriate professional relationships;

~~9.~~ 12. Appropriate interaction among staff and residents;

~~10.~~ 13. Suicide prevention, as provided in 6VAC35-71-805;

~~11. Residents' rights, including but not limited to the prohibited actions provided for in 6VAC35-71-550 (prohibited actions);~~

~~12. Standard precautions;~~

~~13. Recognition of signs and symptoms and knowledge of actions required in medical emergencies;~~

14. Adolescent development;

15. Procedures applicable to the employees' ~~position~~ positions and consistent with their work profiles; and

16. Other topics as required by the department and any applicable state or federal statutes or regulations.

~~C. Administrative and managerial staff shall receive at least 40 hours of training during their first year of employment. Clerical and support staff shall receive at least 16 hours of training.~~

~~D. Employees who administer medication shall, prior to such administration, successfully complete a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medication.~~

~~E. Employees providing medical services shall be trained in tuberculosis control practices.~~

C. Direct supervision employees shall complete an initial 80 hours of agency-approved training inclusive of the topics enumerated in subsection B of this section before being responsible for the direct supervision of a resident and an additional 40 hours of agency-approved training before the completion of their first year of employment.

D. Employees providing medical services shall complete the following training:

1. An initial 40 hours of agency-approved training, inclusive of (i) tuberculosis control practices and (ii) the topics enumerated in subdivisions B 5 through B 16 of this section before they may work directly with a resident; and

2. An additional 80 hours of agency-approved training before the expiration of their first year of employment.

E. Employees who administer medication shall, prior to administration and in accordance with the provisions of § 54.1-3408 of the Code of Virginia, successfully complete a medication management training program approved by the Board of Nursing or be ~~certified~~ licensed by the Commonwealth of Virginia to administer medication.

F. Administrative and managerial staff shall receive at least 40 hours of training during their first year of employment. Clerical and support staff shall receive at least 16 hours of training.

~~F. When~~ G. If an individual is employed by contract to provide services for which licensure by a professional organization is required, documentation of current licensure shall constitute compliance with this section.

~~G.~~ H. Volunteers and interns shall be trained in accordance with 6VAC35-71-240 ~~(volunteer and intern orientation and training)~~.

I. The department shall develop written procedures that clearly delineate the positions falling under each category identified in this section.

**6VAC35-71-170. Retraining.**

A. Each employee shall complete retraining that is specific to the individual's occupational class and the position's job description~~,~~ and that addresses any professional development needs.

1. Direct care ~~staff and~~ employees ~~who provide~~, security employees, direct supervision ~~of the residents~~ employees, and employees providing medical services shall complete 40 hours of training annually, inclusive of the requirements of this section.

2. Administrative and managerial staff shall receive at least 40 hours of training annually.

3. Clerical and support staff shall receive at least 16 hours of training annually.

~~4. Contractors shall receive retraining as required to perform their position responsibilities in the correctional environment.~~

B. All staff shall complete an annual training refresher on the facility's emergency preparedness and response plan and procedures.

C. All direct care ~~staff and~~ employees ~~who provide~~, security employees, and direct supervision ~~of the residents~~ employees shall complete annual refresher ~~re~~training in the following areas:

1. The department's behavior management program and the requirements for sustaining a therapeutic community environment, as required in accordance with 6VAC35-71-160 B 3;

2. Suicide prevention;

~~2.~~ 3. Maintaining appropriate professional relationships;

~~3.~~ 4. Appropriate interaction among staff and residents;

~~4.~~ 5. Child abuse and neglect;

~~5.~~ 6. Mandatory reporting;

~~6.~~ 7. Resident rights, including ~~but not limited to~~ the prohibited actions provided for in 6VAC35-71-550 ~~(prohibited actions)~~;

~~7.~~ 8. Standard precautions; and

~~8. Behavior management techniques; and~~

9. Other topics as required by the department and any applicable state or federal statutes or regulations.

D. All employees providing medical services shall complete annual retraining in the topics enumerated in subdivisions C 2 through C 9 of this section.

~~D.~~ E. All direct care ~~staff~~ employees, security employees, and direct supervision employees shall receive training sufficient to maintain a current certification in first aid and cardiopulmonary resuscitation.

~~E.~~ F. Employees who administer medication shall complete annual refresher training on the administration of medication, which shall, ~~at a minimum,~~ include, at a minimum, a review of the components required in 6VAC35-71-1070.

~~F. When~~ G. If an individual is employed by contract to provide services for which licensure by a professional organization is required, documentation of the individual's current licensure shall constitute compliance with this section.

~~G.~~ H. All staff approved to apply physical restraints as provided for in 6VAC35-71-~~1130~~ 1175 ~~(physical restraint)~~ shall be trained as needed to maintain the applicable current certification.

~~H.~~ I. All staff approved to apply mechanical restraints, protective devices, or ~~-~~ the mechanical restraint chair shall be retrained annually as required by 6VAC35-71-1180 and 6VAC35-71-1203 ~~(mechanical restraints)~~.

~~I.~~ J. Staff who have not timely completed required retraining shall not be allowed to have direct care or direct supervision responsibilities pending completion of the retraining requirements.

**6VAC35-71-180. Code of ethics.**

A The facility administration shall make available to all employees a written set of rules describing acceptable standards of conduct for all employees ~~shall be available to all employees~~.

**6VAC35-71-185. Employee tuberculosis screening and follow-up.**

A. On or before the ~~employee's~~ individual's start date at the facility and at least annually thereafter each (i) employee and (ii) contractor who provides services directly to residents on a regular basis shall submit the results of a tuberculosis screening assessment that is no older than 30 days. The documentation shall indicate the screening results as to whether there is an absence of tuberculosis in a communicable form.

B. Each (i) employee~~,~~ and (ii) contractor who provides services directly to residents on a regular basis shall submit evidence of an annual evaluation of freedom from tuberculosis in a communicable form.

C. ~~Employees~~ Each (i) employee and (ii) contractor who provides services directly to residents on a regular basis shall undergo a subsequent tuberculosis screening or evaluation, as applicable, in the following circumstances:

1. The employee or contractor comes into contact with a known case of infectious tuberculosis; or

2. The employee or contractor develops chronic respiratory symptoms of three ~~weeks~~ weeks' duration.

D. Employees and contractors providing services directly to residents on a regular basis, who are suspected of having tuberculosis in a communicable form shall not be permitted to return to work or have contact with staff or residents until a physician or ~~health trained personnel~~licensed medical provider has determined that the individual does not have tuberculosis in a communicable form.

E. Any active case of tuberculosis developed by an employee or a resident shall be reported to the local health department in accordance with the requirements of the ~~Virginia~~ State Board of Health Regulations for Disease Reporting and Control (12VAC5-90).

F. Documentation of any screening results shall be retained in a manner that maintains the confidentiality of information.

G. The detection, diagnosis, prophylaxis, and treatment of pulmonary tuberculosis shall be performed ~~consistent~~ in accordance with the current ~~requirements~~ recommendations of the Virginia Department of Health's Division of Tuberculosis Prevention and Control and the federal Department of Health and Human Services Centers for Disease Control and Prevention.

**6VAC35-71-220. Selection and duties of volunteers and interns.**

A. ~~Any~~ A JCC that uses volunteers or interns shall implement written procedures governing their selection and use. ~~Such~~ The procedures shall provide for the evaluation of persons and organizations in the community who wish to associate with the residents.

B. Volunteers and interns shall have qualifications appropriate for the services provided.

C. The responsibilities of interns and individuals who volunteer on a regular basis shall be ~~clearly~~ defined clearly in writing.

D. Volunteers and interns may not be responsible for the duties of direct care or direct supervision ~~staff~~employees, nor. ~~In no event~~ may a volunteer or intern be authorized to be alone with residents.

**6VAC35-71-260. Maintenance of case records.**

A. A separate written ~~or automated~~ case record shall be maintained for each resident, which shall include all correspondence and documents received by the JCC relating to the care of that resident and documentation of all case management services provided.

B. Separate ~~health care medical~~ health care records, including behavioral health records, as applicable, ~~and medical records~~ and medical records~~,~~ shall be kept on each resident. ~~Health care~~Health care ~~Medical~~ records shall be maintained in accordance with 6VAC35-71-1020 ~~(residents' health records)~~ and applicable statutes and regulations. Behavioral ~~health care medical~~ health records may be kept separately from other ~~medical~~ health care records.

C. ~~Each case record Case records and health care record medical records shall be kept up to date and in a uniform manner in accordance with written procedures.~~ Case records shall be released only in accordance with §§ 16.1-300 and 16.1-309.1 of the Code of Virginia and applicable state and federal laws and regulations.

D. The department shall have written procedures in place for the maintenance and management of case records in juvenile correctional centers. The procedures for ~~management of residents'~~ managing resident written records~~, written and automated,~~ shall ~~describe~~ address confidentiality, accessibility, security, and retention of records pertaining to residents, including:

1. Access, duplication, dissemination, and ~~acquiring~~ acquisition of information only to persons legally authorized according to federal and state laws;

2. Security measures to protect records from loss, unauthorized alteration, inadvertent or unauthorized access, disclosure of information, and transportation of records between service sites; and

3. Designation of the person responsible for records management.

E. Active and closed records shall be kept in secure locations or compartments that are accessible only to authorized employees and ~~are~~ shall be protected from unauthorized access, fire, and flood.

F. Each resident's written case and ~~health care~~ ~~medical~~ health care records shall be stored separately subsequent to the resident's discharge in accordance with applicable statutes and regulations.

G. Residents' inactive records shall be retained as required by The Library of Virginia.

**6VAC35-71-270. Face sheet.**

A. At the time of admission, each resident's record shall include, at a minimum, a completed face sheet that contains the following: (i) the resident's full name, last known residence, birth date, birthplace, sex, gender identity, race, social security number or other unique identifier, religious preference, and admission date; and (ii) the names, addresses, and telephone numbers of the resident's legal guardians, supervising agency, emergency contacts, and parents, if appropriate.

B. The face sheet shall be updated when changes occur and maintained as a part of the resident's record ~~in accordance with written procedures~~.

Part III
Physical Environment

**6VAC35-71-280. Buildings and inspections.**

A. All newly constructed buildings, major renovations to buildings, and temporary structures shall be inspected and approved by the appropriate building officials. There shall be a valid, current certificate of occupancy available at each JCC that documents this approval.

B. A current copy of the facility's annual inspection by fire prevention authorities indicating that all buildings and equipment are maintained in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-51) shall be maintained. If the fire prevention authorities have failed to ~~timely~~ inspect the facility's buildings and equipment, the facility administration shall maintain documentation of ~~its~~ the request to schedule the annual inspection, as well as documentation of any necessary follow-up. ~~For this subsection, the definition of annual shall be defined by the Virginia Department of Fire Programs, State Fire Marshal's Office.~~

C. The facility administration shall maintain a current copy of ~~its~~ the facility's compliance with annual inspection and approval by an independent, outside source in accordance with state and local inspection laws, regulations, and ordinances, of the following:

1. General sanitation;
2. The sewage disposal system, if applicable;
3. The water supply, if applicable;
4. Food service operations; and
5. Swimming pools, if applicable.

**6VAC35-71-290. Equipment and systems inspections and maintenance.**

A. All safety, emergency, and communications equipment and systems shall be inspected, tested, and maintained by designated staff in accordance with the manufacturer's recommendations or instruction manuals or, absent ~~such~~ these requirements, in accordance with a schedule that is approved by the superintendent.

1. The facility administration shall maintain a listing of all safety, emergency, and communications equipment and systems and the schedule established for inspections and testing.

2. Testing of ~~such~~ equipment and systems shall~~, at a minimum,~~ be conducted, at a minimum, quarterly.

B. Whenever safety, emergency, ~~and~~ or communications equipment or ~~a system is found to be~~ systems are determined defective, immediate steps shall be taken to rectify the situation and to repair, remove, or replace the defective equipment or systems.

**6VAC35-71-320. Lighting.**

A. Sleeping and activity areas shall provide natural lighting.

B. All areas within buildings shall be lighted for safety, and the lighting shall be sufficient for the activities being performed.

C. Night lighting shall be sufficient to observe residents.

D. Operable flashlights or battery-powered lanterns shall be accessible to each security ~~staff~~ employee and direct care ~~staff~~ employee on duty.

E. Outside entrances and parking areas shall be lighted.

**6VAC35-71-360. Sleeping areas.**

A. ~~Male~~ Generally, male and female residents shall have separate sleeping areas; however, nothing in this chapter shall preclude a facility from making a placement decision based upon a case-by-case analysis, as required in 6VAC35-71-555, of whether a placement would ensure a resident's health and safety or present management or security problems.

B. Beds in all facilities or sleeping areas established, constructed, or structurally modified after July 1, 1981, shall be at least three feet apart at the head, foot, and sides; and ~~double-decker~~bunk beds in such facilities shall be at least five feet apart at the head, foot, and sides. Facilities or sleeping areas established, constructed, or structurally modified before July 1, 1981, shall have a bed placement plan approved by the director or the director's designee.

C. Mattresses shall be fire retardant as evidenced by documentation from the manufacturer, except in buildings equipped with an automated sprinkler system as required by the Virginia Uniform Statewide Building Code (13VAC5-63).

D. Sleeping quarters established, constructed, or structurally modified after July 1, 1981, shall have:

1. At least 80 square feet of floor area in a bedroom accommodating one person;

2. At least 60 square feet of floor area per person in rooms accommodating two or more persons; and

3. Ceilings with a primary height at least 7-1/2 feet in height exclusive of protrusions, duct work, or dormers.

**6VAC35-71-400. Smoking, vaping, and other prohibitions.**

Residents shall be prohibited from using, possessing, purchasing, or distributing: (i) ~~any~~ tobacco products, ~~or~~ nicotine vapor products or alternative nicotine vapor products as defined in § 18.2-31.2 of the Code of Virginia; (ii) cannabidiol oil or THC-A as defined in § 54.1-3408 of the Code of Virginia; and (iii) any other substance that is prohibited by state or federal law. ~~Tobacco products, including cigarettes, cigars, pipes, and bidis, smokeless tobacco, such as chewing tobacco or snuff, shall and vapor products, such as electronic cigarettes, electronic cigars, electronic cigarillo, electronic pipes, or similar products or devices.~~ These products may not be used by staff, contractors, interns, or visitors in any ~~areas of the facility or its~~ area on the premises ~~where residents may see or smell the tobacco product~~.

**6VAC35-71-410. Space utilization.**

A. ~~Each~~ The JCC administration shall provide for the following:

1. An indoor recreation area with appropriate recreation materials;

2. An outdoor recreation area with appropriate recreation materials;

3. Kitchen facilities and equipment for the preparation and service of meals;

4. A dining area equipped with tables and seating;

5. Space and equipment for laundry, if laundry is done on site;

6. ~~Space~~ Storage space for ~~the storage of~~ items such as first aid equipment, household supplies, recreational equipment, and other materials;

7. A designated visiting area that permits informal communication and opportunities for limited, monitored physical contact between residents and visitors~~, including opportunity for physical contact in accordance with written procedures~~;

8. Space for administrative activities, including~~, as appropriate to the program,~~ confidential conversations and the storage of records and materials; and

9. A central medical ~~room~~ area with medical examination ~~facilities~~ rooms or other spaces designated to ensure privacy of care and equipped in consultation with the health authority.

B. If a school program is operated at the facility, school classrooms shall be designed in consultation with appropriate education authorities to comply with applicable state and local requirements.

C. Spaces or areas may be ~~interchangeably~~ utilized ~~interchangeably~~ for multiple purposes but shall be in functional condition for the designated purpose.

**6VAC35-71-420. Kitchen operation and safety.**

A. ~~Each facility~~The facility administration shall have a food service operation maintenance plan that addresses the following: (i) food sanitation and safety procedures; (ii) the inspection of ~~all~~ food service, preparation, and dining areas and equipment; (iii) a requirement for sanitary and temperature-controlled storage facilities for food; and (iv) the monitoring of refrigerator and water temperatures.

B. The facility administration shall ~~follow~~ have written procedures governing access to all areas where food or utensils are stored and the inventory and control of culinary equipment to which residents reasonably may be expected to have access.

C. Walk-in refrigerators and freezers shall be equipped to permit emergency exits.

D. Bleach or another sanitizing agent approved by the ~~federal~~ U.S. Environmental Protection Agency to destroy bacteria shall be used in laundering table and kitchen linens.

**6VAC35-71-430. Maintenance of the buildings and grounds.**

A. The interior and exterior of all buildings and grounds shall be safe, maintained, and reasonably free of clutter and rubbish. This ~~includes but is not limited to~~ requirement applies to all areas of the facility and to items within the facility, including (i) required locks, mechanical devices, indoor and outdoor equipment, and furnishings; and (ii) all areas where residents, staff, and visitors may reasonably be expected to have access.

B. All buildings shall be reasonably free of stale, musty, or foul odors.

C. Each facility shall have a written plan to control pests and vermin. Buildings shall be kept reasonably free of flies, roaches, rats, and other vermin. ~~Any condition~~ Conditions conducive to harboring or breeding insects, rodents, or other vermin shall be eliminated immediately. ~~Each~~ The facility administration shall document efforts to eliminate ~~such~~ these conditions, as applicable.

**6VAC35-71-440. Animals on the premises.**

A. Animals maintained on the premises shall be ~~housed~~:

1. ~~Housed~~ Kept ~~at a~~ reasonable distance from ~~sleeping, living, eating, and~~ eating and food preparation areas as well as a safe distance from water supplies~~.~~;

~~B. Animals maintained on the premises shall be tested~~ 2. Tested, inoculated, and licensed as required by law~~.~~; and

3. Provided with clean sleeping areas and adequate food and water.

~~C.~~ B. The premises shall be kept reasonably free of stray domestic animals.

~~D. Pets shall be provided with clean sleeping areas and adequate food and water.~~

## Part IV
## Safety and Security

**6VAC35-71-450. Fire Prevention Plan.**

~~Each~~ The JCC administration shall develop and implement a fire prevention plan that provides for an adequate fire protection service.

**6VAC35-71-460. Emergency and evacuation procedures.**

A. Each JCC shall have a written emergency preparedness and response plan. ~~The plan,~~ which shall address:

1. Documentation of contact with the local emergency coordinator to determine (i) local disaster risks; (ii) communitywide plans to address different disasters and emergency situations; and (iii) assistance, if any, that the local emergency management office will provide to the facility in an emergency;

2. Analysis of the facility's capabilities and potential hazards, including natural disasters, severe weather, fire, flooding, workplace violence or terrorism, missing persons, severe injuries, or other emergencies that would disrupt the normal course of service delivery;

3. Written emergency management procedures outlining specific responsibilities for (i) provision of administrative direction and management of response activities; (ii) coordination of logistics during the emergency; (iii) communications; (iv) life safety of employees, contractors, interns, volunteers, visitors, and residents; (v) property protection; (vi) community outreach; and (vii) recovery and restoration;

4. Written emergency response procedures for (i) assessing the situation; (ii) protecting residents, employees, contractors, interns, volunteers, visitors, equipment, and vital records; and (iii) restoring services shall address:

a. Communicating with employees, contractors, and community responders;

b. Warning and ~~notification of~~ notifying residents;

c. Providing emergency access to secure areas and opening locked doors;

d. Requiring fire and emergency keys that are instantly identifiable by sight and touch;

e. Conducting evacuations to emergency shelters or alternative sites and accounting for all residents;

f. Relocating residents, if necessary;

g. Notifying parents and legal guardians, as applicable and appropriate;

h. Alerting emergency personnel and sounding alarms;

i. Locating and shutting off utilities when necessary; and

j. Providing for a planned, personalized means of effective ~~egress~~ evacuation for ~~residents~~ individuals who use wheelchairs, crutches, canes, or ~~other mechanical devices for assistance in walking~~ require other special accommodations.

5. Supporting documents that would be needed in an emergency, including emergency call lists, building and site maps necessary to shut off utilities, designated ~~escape~~ evacuation routes, and ~~list~~ lists of major resources such as local emergency shelters; and

6. Schedule for testing the implementation of the plan and conducting emergency preparedness drills.

B. All employees shall be trained to ensure they are prepared to implement the emergency preparedness plan in the event of an emergency. ~~Such~~ The training shall ~~include~~ be conducted in accordance with 6VAC35-71-160 and 6VAC35-71-170 and shall outline the employees' responsibilities for:

1. Alerting emergency personnel and sounding alarms;
2. Implementing evacuation procedures, including evacuation of ~~residents with~~ individuals who require special ~~needs (i.e., deaf, blind, nonambulatory)~~ accommodations;
3. Using, maintaining, and operating emergency equipment;
4. Accessing emergency information for residents including medical information; and
5. Utilizing community support services.

C. Contractors ~~and~~, volunteers, and interns shall be oriented in their responsibilities in implementing the evacuation plan in the event of an emergency. ~~Such orientation~~ Orientation shall be in accordance with the requirements of 6VAC35-71-150 ~~(required initial orientation)~~, 6VAC35-71-160 ~~(required initial training)~~, and 6VAC35-71-240 ~~(volunteer and intern orientation and training)~~.

D. ~~The~~ A The JCC administration shall document the review of the emergency preparedness plan annually and make necessary revisions. ~~Such~~ The revisions shall be communicated to employees, contractors, volunteers, ~~and~~ interns, and residents and shall be incorporated into (i) training for employees, contractors, interns, and volunteers; and (ii) orientation of residents to services.

E. ~~In the event of~~If a disaster, fire, emergency, or ~~any~~ other condition that may jeopardize the health, safety and welfare of residents occurs, the facility administration shall take appropriate action to protect the health, safety and welfare of the residents and to remedy the conditions as soon as possible.

F. ~~In the event of~~If a disaster, fire, emergency, or ~~any~~ other condition that may jeopardize the health, safety, and welfare of residents occurs, ~~the~~ facility staff ~~should~~ first shall respond and stabilize the disaster or emergency. ~~After~~ Once ~~the disaster or emergency is~~ stabilized, ~~the~~ facility staff shall (i) report the disaster or emergency and the conditions at the facility to (a) the parents or legal guardians of all residents, ~~and (b)~~ the director or ~~his~~ the director's designee, ~~of the conditions at the facility~~ and the applicable court service units in accordance with 6VAC35-71-60. A report also shall be made to the~~(ii) report the disaster or emergency to the~~ regulatory authority within the same time frame, ~~. Such The reporting shall be made as soon as possible but no later than 72 hours after the incident is stabilized~~.

G. Floor plans showing primary and secondary means of emergency exiting shall be posted on each floor in locations where they ~~can~~ are easily ~~be seen by~~ visible to employees and residents.

H. The responsibilities of the residents in implementing the emergency and evacuation procedures shall be communicated to all residents within seven days following admission or within seven days of a substantive change in the procedures.

I. ~~At~~ The facility administration shall conduct at least one evacuation drill ~~(the simulation of the facility's emergency procedures) shall be conducted~~ to simulate ~~its~~ the facility's evacuation procedures each month in each building occupied by residents. During any three consecutive calendar months, at least one evacuation drill shall be conducted during each shift.

J. A record shall be maintained for each evacuation drill and shall include the following:

1. ~~Buildings~~ The buildings in which the drill was conducted;
2. ~~Date~~ The date and time of the drill;
3. ~~Amount~~ The amount of time taken to evacuate the buildings; ~~and~~
4. ~~Specific~~ The specific problems encountered, if applicable;

5. The staff tasks completed, including head counts and practice in notifying emergency authorities; and

6. The name of the staff members responsible for conducting and documenting the drill and preparing the record.

K. ~~Each~~ ~~A~~ The JCC administration shall ~~assign~~ designate at least one employee who shall ensure that all requirements regarding the emergency preparedness and response plan and the evacuation drill program are met.

**6VAC35-71-470. Security Procedures.**

Each JCC shall ~~follow~~ have written security procedures in place related to the following:

1. Post orders or shift duties for each security post;
2. Population count;
3. A control center that integrates all external and internal security functions and communications, is secured from residents' access, and is staffed 24 hours a day;
4. Control of the perimeter;
5. Actions to be taken regarding any escapes or absences without permission;
6. Searches of the buildings, premises, and persons; and
7. The control, detection, and disposition of contraband.

**6VAC35-71-480. Searches of residents.**

A. A JCC may conduct a search of a resident only for the purposes of maintaining facility security and controlling contraband ~~and only in a manner that~~while, to the greatest extent possible, ~~protects~~ protecting the dignity of the resident.

B. Staff in the JCC shall adhere to the following requirements when conducting searches of residents. ~~Written procedures shall govern searches of residents,~~ including patdowns and frisk searches, strip searches, and body cavity searches~~, and shall include the following~~:

~~1. Searches of residents' persons shall be conducted only for the purposes of maintaining facility security and controlling contraband while protecting the dignity of the resident.~~

~~2.~~ 1. Searches ~~are~~ shall be conducted only by personnel who have received the required training and are authorized to conduct ~~such~~ searches.

~~3.~~ 2. The resident shall not be touched any more than is necessary to conduct the search.

3. ~~The facility~~Facility staff shall not search or physically examine a transgender or intersex resident solely for the purpose of determining the resident's genital status.

~~B.~~ ~~C. Patdown and frisk searches shall be conducted by personnel of the same sex as the resident being searched, except in emergencies in accordance with written procedures~~.

~~C.~~ ~~D~~C. Strip searches and visual inspections of the vagina and anal cavity areas shall be ~~subject to the following:~~ conducted with a staff witness, ~~and~~ in an area that ensures privacy ~~in accordance with written procedures.~~.

~~1. The search shall be performed by personnel of the same sex as the resident being searched;~~

~~2. The search shall be conducted in an area that ensures privacy; and~~

~~3. Any witness to the search shall be of the same sex as the resident.~~

~~D. Manual and~~ ~~E~~D. Except in exigent circumstances creating a potential threat to the health of a resident, if it is determined that a manual or instrumental ~~searches~~ search of the anal cavity

or vagina is necessary, the resident shall be transported to a local medical facility. In exigent circumstances that create a potential threat to the health of a resident, manual or instrumental searches of the anal cavity or vagina shall be conducted by a qualified medical professional. ~~in accordance with written procedures, not including medical examinations or procedures conducted by medical personnel for medical purposes, shall be:~~

~~1. Performed only with the written authorization of the facility administrator or by a court order;~~

~~2. Conducted by a qualified medical professional;~~

~~3. Witnessed by personnel of the same sex as the resident; and~~

~~4. Fully documented in the resident's medical file~~.

**6VAC35-71-490. Communications systems.**

A. There shall be at least one continuously operable, nonpay telephone accessible to staff in each building in which residents sleep or participate in programs.

B. There shall be a means for communicating between the control center and ~~living~~ housing units.

C. The facility shall be able to provide communications in an emergency.

**6VAC35-71-500. Emergency telephone numbers.**

~~An~~ A. There shall be an emergency telephone number where a staff person may be contacted 24 hours per day and seven days per week.

B. The emergency telephone number shall be provided to residents and the adults responsible for their care when a resident is away from the facility and not under the supervision of direct care ~~staff~~employees, security ~~staff~~employees, or law-enforcement officials.

**6VAC35-71-510. Weapons.**

No firearms or other weapons shall be permitted on the JCC's premises ~~and~~ or during JCC-related activities ~~except~~ unless: 1) the weapon belongs to a law enforcement officer and is either: a) secured in a locked cabinet b) secured in the trunk of the officer's vehicle; or c) present on the premises in response to a request for law enforcement intervention in an emergency; or 2) the director or the director's designee authorizes the weapon to be brought on the premises. ~~as provided~~ authorized ~~in written procedures or authorized by the director or the director's designee. Written procedures shall govern any possession, use, and storage of authorized firearms and other weapons on the JCC's premises and during JCC-related activities.~~

**6VAC35-71-520. Equipment Inventory.**

~~The facility~~Facility staff shall follow written procedures governing the inventory and control of all security, maintenance, recreational, and medical equipment of the facility to which residents reasonably may be expected to have access.

**6VAC35-71-530. Power Equipment.**

The ~~facility~~ JCC administration shall ~~implement~~ have written safety rules in place for use and maintenance of power equipment.

**6VAC35-71-540. Transportation.**

A. ~~Each~~ The JCC administration shall have transportation available or make the necessary arrangements for routine and emergency transportation of residents.

~~B. There shall be A JCC shall follow written safety rules for and security procedures governing transportation of residents and for the use and maintenance of vehicles.~~

~~C~~B. Written ~~procedure~~ procedures shall ~~provide for~~ require ~~the verification of appropriate licensure for staff whose duties involve transporting residents. At a minimum, the procedures shall direct this staff to (i) maintain a valid driver's license and (ii) report to the superintendent or the superintendent's designee any change in their driver's license statuses, including any suspensions, restrictions, or revocations.~~that staff in the facility whose duties involve transporting residents offsite do the following:

1. Maintain a valid driver's license and report to the superintendent or the superintendent's designee any change in the individual's driver's license status, including any suspensions, restrictions, or revocations; and

2. Complete all related training;

C. If a person or entity other than personnel in the juvenile correctional center assumes custody of the resident for purposes of transportation, staff shall:

1. Provide the person or entity with a written document that identifies any pertinent information known to the facility concerning the resident's immediate medical needs or mental health condition that reasonably could be considered necessary for the resident's safe transportation and supervision, including the resident's recent suicidal ideations or suicide attempts. Any such information shall be provided in a manner that protects the confidentiality of the information in accordance with § 16.1-300 of the Code of Virginia and applicable rules and regulations regarding confidentiality of juvenile records.

2. Provide the individual transporting the resident with any medication the resident may be required to take during transport or while absent from the facility.

D. Residents shall be supervised by security ~~staff employees~~ or direct care ~~staff employees~~ during routine and emergency vehicle transportation.

**6VAC35-71-545. Lockdowns.**

A JCC may impose a lockdown only in accordance with the following requirements ~~within a facility in accordance with written procedures that require the following~~:

1. With the exception of a lockdown to respond to an emergency, as defined in 6VAC35-71-10, a lockdown may not be imposed until the superintendent or the superintendent's designee provides approval;

2. ~~In the event of~~If an emergency ~~necessitating~~ necessitates a lockdown, the superintendent shall be notified as soon as practicable;

3. The facility shall have written procedures in place for notifying administrators above the level of superintendent ~~superintendent's supervisor and the administrator at the next level in the department's reporting chain-of-command shall be notified~~ of all lockdowns except lockdowns for routine ~~facility~~ contraband searches;

4. ~~In the event that~~If the lockdown extends beyond 72 hours, the lockdown and the steps being planned or taken to resolve the situation shall be reported immediately to the administrator who is two levels above the superintendent in the department's reporting chain-of-command;

5. Whenever residents are confined to a locked room as a result of a lockdown, the staff shall:

a. Check each locked–down resident visually at least every 15 minutes, and more frequently if necessitated by the circumstances;

b. Ensure that each resident has a means of immediate communication with staff, either verbally or electronically, throughout the duration of the confinement period;

c. Ensure that each resident is afforded the opportunity for at least one hour of large muscle exercise outside of the locked room every calendar day unless the resident displays behavior that is threatening or presents an imminent danger to himself or others, or unless the circumstances that required the lockdown justify an exception.

d. Ensure that the superintendent or the superintendent's designee makes personal contact with each resident who is confined every calendar day; and

e. In response to a resident who exhibits self-injurious behavior after being in room confinement, (i) take appropriate action in response to the behavior, (ii) consult with a ~~qualified~~ mental health clinician ~~professional~~ immediately thereafter and document the consultation, and (iii) monitor the resident in accordance with established protocols, including constant supervision, if appropriate.

Part V
Residents' Rights

**6VAC35-71-550. Prohibited actions.**

A. Residents shall not be subjected to the following actions:

1. Discrimination in violation of the Constitution of the United States, the Constitution of the Commonwealth of Virginia, ~~executive orders,~~ and state and federal statutes and regulations;

2. Deprivation of drinking water or food necessary to meet a resident's daily nutritional needs, except as ordered by a licensed physician or ~~health trained personnel~~licensed medical provider for a legitimate medical or dental purpose and documented in the resident's medical record;

3. Denial of contacts and visits with the resident's attorney, a probation or parole officer, the JCC staff assigned to conduct the resident's due process hearings or resolve the resident's grievance or complaint, the regulatory authority, a supervising agency representative, or representatives of other agencies or groups as required by applicable statutes or regulations;

4. Any action that is humiliating, degrading, abusive, or unreasonably impinges upon the ~~residents'~~ resident's rights, including ~~but not limited to any form of~~ physical abuse, sexual abuse, or sexual harassment, nor shall the resident~~s~~ be subject to retaliation for reporting these actions;

5. Corporal punishment, which is administered through the intentional ~~inflicting~~ infliction of pain or discomfort to the body through actions such as~~, but not limited to~~ (i) striking or hitting with any part of the body or with an implement; (ii) pinching, pulling, or shaking; or (iii) ~~any~~ similar ~~action~~ actions that normally ~~inflicts~~ inflict pain or discomfort;

6. Subjection to unsanitary living conditions;

7. Deprivation of opportunities for bathing or access to toilet facilities, except as ordered by a licensed ~~physician~~ health care professional for a legitimate medical purpose and documented in the resident's medical record;

8. Denial of health care;

9. Denial of appropriate services, programs, activities, and treatment;

10. Application of aversive stimuli, except as ~~provided in this chapter or~~ permitted pursuant to other applicable state regulations~~. Aversive stimuli means any physical forces (e.g.,~~

~~sound, electricity, heat, cold, light, water, or noise) or substances (e.g., hot pepper, pepper sauce, or pepper spray) measurable in duration and intensity that when applied to a resident are noxious or painful to the individual resident~~;

11. Administration of laxatives, enemas, or emetics, except as ordered by a licensed physician or ~~physician~~ ~~health care professional~~ licensed medical provider or poison control center for a legitimate medical purpose and documented in the resident's ~~medical~~ health care record;

12. Deprivation of opportunities for sleep or rest, except as ordered by a licensed ~~physician~~ health care professional for a legitimate medical or dental purpose and documented in the resident's medical record;

13. Use of pharmacological restraints; and

14. Other constitutionally prohibited actions.

B. Employees shall be trained on the prohibited actions as provided in 6VAC35-71-160 and 6VAC35-71-170, as applicable.

**6VAC35-71-555. Vulnerable population.**

A. The facility administration shall implement a procedure for assessing whether a resident is a member of a vulnerable population. Factors including the resident's height and size, English proficiency, sexual orientation, history of being bullied, or history of self-injurious behavior may be considered in determining whether a resident is a member of a vulnerable population. The resident's views with respect to his safety shall be given serious consideration.

B. If the assessment determines a resident is a vulnerable population, the facility administration shall implement any identified additional precautions such as heightened need for supervision, additional safety precautions, or separation from certain other residents. The facility administration shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety and whether the placement would present management or security problems.

~~C. For the purposes of this section, vulnerable population means a resident or group of residents who have been assessed to be reasonably likely to be exposed to the possibility of being attacked or harmed, either physically or emotionally (e.g., very young residents; residents who are small in stature; residents who have limited English proficiency; residents who are gay, lesbian, bi-sexual, transgender, or intersex; residents with a history of being bullied or of self-injurious behavior).~~

C. Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of this identification or status, nor shall any facility consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of a likelihood of being sexually abusive.

**6VAC35-71-560. ~~Residents'~~ Resident mail.**

A. A resident's incoming or outgoing mail may be delayed or withheld only in accordance with this section, as permitted by other applicable regulations, or by order of a court.

B. Staff may open and inspect residents' incoming and outgoing nonlegal mail for contraband. When based on legitimate ~~facility~~ interests of facility order and security, nonlegal mail may be ~~read,~~ censored, or rejected ~~in accordance with written procedures and subject to the restrictions in subsection D of this action~~. The resident shall be notified when incoming or outgoing letters are withheld ~~in part or in full~~ or redacted, as appropriate.

C. In the presence of the resident recipient ~~and in accordance with written procedures~~, staff may open to inspect for contraband~~,~~ but shall not read~~,~~ incoming legal mail, except as authorized in subsection D. ~~For the purpose of this section, legal mail means a communication sent to or received from a designated class of correspondents, as defined in written procedures, including but not limited to the court, an attorney, and the grievance system or department administrators.~~

D. Staff ~~shall~~ may not read incoming or outgoing ~~,~~ mail ~~addressed to parents, immediate family members, legal guardian, guardian ad litem, counsel, courts, officials of the committing authority, public officials, or grievance administrators~~ unless (i) permission has been obtained from a court or (ii) the ~~director~~ superintendent or ~~his~~ the ~~director's~~ superintendent's designee has determined that there is a reasonable belief that the security of a facility is threatened. ~~When so authorized staff may read such~~ this mail, ~~in accordance with written procedures.~~

E. Except as otherwise provided, incoming and outgoing letters shall be held for no more than 24 hours and packages shall be held for no more than 48 hours, excluding weekends and holidays.

F. Upon request, each resident shall be given postage and writing materials for all legal ~~correspondence~~ mail and for at least two other letters per week.

G. Residents shall be permitted to correspond at their own expense with any person or organization provided ~~such~~ this correspondence does not pose a threat to facility order and security and is not being used to violate or to conspire to violate the law.

H. First class letters and packages received for residents who have been transferred or released shall be forwarded to the resident's last known address.

I. Written procedure governing correspondence of residents shall be made available to all employees and residents and updated as needed.

**6VAC35-71-570. Telephone calls.**

~~Telephone~~ Residents shall be permitted to make telephone calls shall be permitted in accordance with written procedures that take into account the need for facility security and order, the resident's behavior, and program objectives.A. Residents shall be permitted to call family members or natural supports. Facility staff shall have flexibility in scheduling these calls based on facility security needs and scheduled activities.

B. Resident telephone calls with their legal representatives shall comply with 6VAC35-71-590.

**6VAC35-71-580. Resident Contacts and Visitation.**

A. In order to ensure that residents maintain strong family and community relationships, a A resident's contacts and visits with immediate family members ~~or legal guardians shall~~ and natural supports may not be restricted solely for punitive purposes~~, nor may they be subject to unreasonable limitations, and any~~. Any limitation shall be documented and based on ~~implemented only as permitted by written procedures, other applicable regulations, or by order of a court, or written visitation procedures that balance~~ (i) the need for facility security and order and~~,~~ (ii) the behavior of individual residents and the visitors~~, and (iii) the importance of helping the resident maintain strong family and community relationships~~.

~~B. Residents shall be permitted to have visitors, consistent with written procedures that take into account (i) the need for facility security and order, (ii) the behavior of individual residents and the visitors, and (iii) the importance of helping the resident maintain strong family and community relationships. Written procedures shall provide for the accommodation of special circumstances.~~

~~B. A JCC shall provide visitors with occasional opportunities to view the resident's housing unit or room and to interact with staff members unless this access is impracticable or would~~

~~threaten the safety or security of residents, staff, or other visitors. Written visitation procedures shall outline the parameters governing this access and provide for the accommodation of special circumstances.~~

C. Copies of the visitation procedures shall be mailed, either electronically or via first class mail, to the ~~residents'~~ resident's parents or legal guardians, as applicable and appropriate, ~~and other applicable persons~~ no later than the close of the next business day after ~~arrival~~ the resident arrives at the JCC, unless a copy has already been provided to the individual.

D. Resident visitation at ~~an employee's~~ the home ~~is~~ of an employee, volunteer, intern, or contractor shall be prohibited.

**6VAC35-71-610. Showers.**

Residents shall have the opportunity to shower daily except ~~as~~ (i) ~~provided in written procedures~~ for the purpose of maintaining facility security or for the special management of maladaptive behavior if approved by the superintendent or designee or a mental health ~~professional~~ clinician or (ii) ~~approved by the regulatory authority~~ when there is a documented emergency.

**6VAC35-71-630. Nutrition.**

A. Each resident, except as provided in subsection B of this section, shall be provided a daily diet that (i) consists of at least three nutritionally balanced meals, of which two are hot meals (except in emergency situations), and an evening snack; (ii) includes an adequate variety and quantity of food for the age of the resident; and (iii) meets the nutritional requirements of all applicable federal dietary requirements, such as U.S. Department of Agriculture (USDA).

B. Special diets or alternative dietary schedules~~, as applicable,~~ shall be provided in the following circumstances: (i) when prescribed by a ~~physician~~ licensed health care professional; (ii) when necessary to observe the established religious dietary practices of the resident; or (iii) when ~~necessary for the special management of maladaptive behavior or to maintain facility security if~~ food or culinary equipment has been used inappropriately, resulting in a threat to facility security and the special diet or alternative dietary schedule is approved by the superintendent ~~or~~, the superintendent's designee, or a mental health ~~professional~~clinician. ~~In such circumstances~~ If a facility provides special diets or alternative dietary schedules, the meals shall meet the minimum nutritional requirements of all applicable federal dietary requirements, such as USDA, and any required approval shall be documented.

C. Menus of actual meals served shall be kept on file ~~for at least six months~~ in accordance with all applicable federal requirements.

D. Staff who eat in the presence of the residents shall be served the same meals as the residents unless a licensed health care professional has prescribed a special diet ~~has been prescribed by a physician~~ for the staff or residents or unless the staff or residents are observing established religious dietary practices.

E. ~~There~~ ~~A~~ The JCC administration shall not ~~be~~ allow more than ~~15~~ 14 hours to pass between the evening meal and breakfast the following day~~, except when the superintendent approves an extension of time between meals on weekends and holidays. When an extension is granted on a weekend or holiday, there shall never be more than 17 hours between the evening meal and breakfast~~.

F. ~~Each~~ ~~A~~ The JCC administration shall ~~assure~~ ensure that food is available to residents who for documented medical or religious reasons need to eat breakfast before the ~~15~~ 14 hours have expired.

**6VAC35-71-660. Recreation.**

A. ~~Each~~ The JCC administration shall implement a recreational program plan ~~that includes~~ developed and supervised by a person trained in recreation or a related field. The plan shall include:

1. Opportunities for individual and group activities;

2. Opportunity for large muscle exercise daily;

3. Scheduling so that activities do not conflict with meals, religious services, or educational programs~~, or other regular events~~; and

4. Regularly scheduled indoor and outdoor recreational activities that are structured to develop skills. Outdoor recreation ~~will~~ shall be available whenever practicable in accordance with the facility's recreation plan. Staff shall document any adverse weather conditions, threat to facility security, or other circumstances preventing outdoor recreation.

B. Each recreational program plan shall (i) address the means by which residents will be medically assessed for any physical limitations or necessary restrictions on physical activities and (ii) provide for the supervision of and safeguards for residents, including when participating in water~~-~~related and swimming activities.

**6VAC35-71-670. ~~Residents'~~ Resident funds.**

A. ~~Residents'~~ A resident's personal funds, including any per diem or earnings, shall be used only for the following: (i) ~~for their activities, services, or goods for~~ the resident's benefit; (ii) ~~for~~ payment of ~~any~~ fines, restitution, costs, or support ordered by a court or administrative judge; or (iii) ~~to pay~~ payment of ~~any~~ restitution for damaged property or personal injury resulting from an institutional incident, as determined ~~by~~ in accordance with the process established in ~~disciplinary procedures~~6VAC35-71-1110.

Part VI
Program Operation

**6VAC35-71-680. Admission and orientation.**

A. Written procedure governing the admission and orientation of residents to the JCC shall provide for:

1. Verification of legal authority for placement;

2. Search of the resident and the resident's possessions, including inventory and storage or disposition of property, as appropriate and ~~provided for in~~ required by 6VAC35-71-690 ~~(residents' personal possessions)~~;

3. Health screening of the resident as ~~provided for in~~ required by 6VAC35-71-940 ~~(health screening at admission)~~;

4. ~~Notification of~~ Notice to the parent or legal guardian of the resident's admission;

5. Provision to the parent or legal guardian of information on (i) visitation, (ii) how to request information, and (iii) how to register concerns and complaints with the facility;

6. Interview with the resident to answer questions and obtain information;

7. Explanation to the resident of program services and schedules; and

8. Assignment of the resident to a ~~living~~ housing unit~~,~~ and sleeping area~~,~~ or room.

B. The resident shall receive an orientation to the following:

1. The behavior management program as required by 6VAC35-71-745 ~~(behavior management)~~. ~~a.~~ During the orientation, residents shall be given written information

describing rules of conduct, the sanctions for rule violations, and the disciplinary process. ~~These~~ Staff shall have the discretion to provide residents who are noncompliant or are displaying maladaptive behavior ~~one or more~~at least one ~~opportunities~~ opportunity to view the written information instead of providing the resident with a copy. The written information shall be explained to the resident and documented by the dated signature of the resident and staff. ~~In the event that~~If staff ~~exercises~~ exercise the discretion not to provide the resident with a written copy, staff must provide the resident with a copy of the written information once the resident demonstrates the ability to comply with the rules of the facility.

~~b. Where a language or literacy problem exists that can lead to a resident misunderstanding the rules of conduct and related regulations, staff or a qualified person under the supervision of staff shall assist the resident.~~

2. The grievance procedure as required by 6VAC35-71-80 ~~(grievance procedure)~~.

3. The disciplinary process as required by 6VAC35-71-1110 ~~(disciplinary process)~~.

4. The resident's responsibilities in implementing the emergency procedures as required by 6VAC35-71-460 ~~(emergency and evacuation procedures)~~.

5. The resident's rights, including ~~but not limited to~~ the prohibited actions provided for in 6VAC35-71-550 ~~(prohibited actions)~~.

6. The resident's rights relating to religious participation as required by 6VAC35-71-650 ~~(religion)~~.

C. The facility administration shall ensure that all ~~the~~ information provided to the resident pursuant to this section is explained in an age-appropriate or developmentally-appropriate manner and is available in a format that is accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, or who have limited reading skills.

D. The facility administration shall maintain documentation that the requirements of this section have been satisfied.

**6VAC35-71-690. ~~Residents'~~ Resident personal possessions.**

A. ~~Each~~ ~~A~~ JCC administration shall inventory ~~residents'~~ each resident's personal possessions upon admission and document the information in ~~residents'~~ the resident's case records.

B. The department shall have written procedures for the disposition or storage of ~~When a resident arrives at a JCC with~~ items that the resident is not permitted to possess in the facility~~, staff shall:~~. At a minimum, the procedures shall require that if the items are nonperishable property that the resident may otherwise legally possess, staff shall: (i) securely store the property and return it to the resident upon release or (ii) make reasonable, documented efforts to return the property to the resident, or resident's parent or legal guardian.

~~1. Dispose of contraband items in accordance with written procedures;~~

~~2. If the items are nonperishable property that the resident may otherwise legally possess, (i) securely store the property and return it to the resident upon release; or 3. Make (ii) make reasonable, documented efforts to return the property to the resident, or resident's parent or legal guardian.~~

B. Personal property that remains unclaimed six months following a resident's discharge from DJJ and after a documented attempt to return the property may be disposed of in accordance with § 66-17 of the Code of Virginia. ~~and written procedures governing unclaimed personal property~~.

**6VAC35-71-700. Classification plan.**

A. ~~A~~ The JCC administration shall utilize an objective classification system for determining ~~appropriate security levels the~~ a resident's level of risk, needs, and ~~the~~ most appropriate services ~~of the residents~~ and for assigning ~~them~~ the resident to ~~living units according to their~~ a housing unit based on the resident's needs and existing resources.

B. Residents shall be placed according to their classification levels. ~~Such classification~~ These classifications shall be reviewed as necessary in light of (i) the facility's safety and security and (ii) the resident's needs and progress.

**6VAC35-71-710. Resident transfer and reassignment between and within JCCs.**

A. When a resident is transferred between JCCs, the following shall occur:

1. The resident's case records~~, including medical~~ and health care records~~, and behavioral health records,~~ shall accompany the resident to the receiving facility; and

2. The resident's parents or legal guardian, if applicable and appropriate, and the court service unit or supervising agency shall be notified within 24 hours of the transfer.

B. ~~When~~ If a resident is ~~transferred~~ reassigned to a more restrictive unit~~,~~ or program~~, or facility~~ within a JCC or transferred between JCCs, the JCC administration shall provide due process safeguards for ~~residents~~ the resident prior to ~~their~~ transfer. The due process safeguards shall be documented in writing and provided to the resident, both during orientation and when facility staff determine that a transfer is necessary.

C. In the case of emergency transfers, ~~such~~ the safeguards and notifications shall be instituted as soon as practicable after transfer.

**6VAC35-71-720. ~~Release~~ Discharge from direct care.**

~~A. Residents shall be released discharged from a JCC in accordance with written procedure.~~

~~B~~A. The case record of each resident ~~serving~~committed to the department and discharged from direct care ~~an indeterminate commitment, who is not released discharged pursuant to a court order,~~ shall contain the following:

~~1. A discharge plan developed in accordance with written procedures;~~

~~2~~1. Documentation that the ~~release~~ discharge was discussed with the parent or legal guardian, if applicable and appropriate, the court ~~services~~ service unit, and the resident; and

~~3~~2. As soon as possible, but no later than 30 days after ~~release~~ discharge, a comprehensive ~~release~~ discharge summary ~~placed in the resident's record and~~, which also shall be sent to the persons or agency that made the placement. The ~~release~~ discharge summary shall review:

a. Services provided to the resident;

b. The resident's progress toward meeting individual service plan objectives;

c. The resident's continuing needs and recommendations, if any, for further services and care;

d. The names of persons to whom the resident was ~~released~~ discharged;

e. Dates of admission and ~~release~~ discharge; and

f. Date the ~~release~~ discharge summary was prepared and the identification of the person preparing it.

~~C~~B. In addition to the requirements in subsection A of this section, t~~T~~he case record of each resident serving a determinate commitment or ~~released~~ discharged pursuant to an order of a court also shall contain a copy of the court order.

D. As appropriate and applicable, information concerning current medications, need for continuing therapeutic interventions, educational status, and other items important to the resident's continuing care shall be provided to the legal guardian or legally authorized representative~~, as appropriate and applicable~~.

E. Upon discharge, the (i) date of discharge and (ii) the name of the person to whom the resident was discharged, if applicable, shall be documented in the case record.

**6VAC35-71-735. Therapeutic communities in housing units.**

A. ~~A~~ The JCC administration shall ensure that each housing unit functions as a therapeutic community that, at a minimum, includes the following components:

1. Designated staff assigned to one housing unit and, to the extent practicable, continued assignment to that unit for the therapeutic benefit of residents;

2. Continued resident assignment to the same housing unit throughout the duration of commitment, unless the continued assignment would threaten facility safety or security or the resident's needs or progress;

3. Daily, structured therapeutic activities provided in accordance with 6VAC35-71-740; and

4. Direction, guidance, and monitoring provided by an interdisciplinary team consisting of designated JCC staff and representatives from the department's mental health, education, and medical units.

B. The department shall establish written procedures governing therapeutic communities in housing units that include these components.

**6VAC35-71-740. Structured programming.**

A. ~~Each facility~~The facility administration shall implement a comprehensive, planned, and structured daily routine~~, including appropriate supervision,~~ designed to:

1. Meet the residents' physical and emotional needs;
2. Provide protection, guidance, and supervision;
3. Ensure the delivery of program services; and
4. Meet the objectives of ~~any~~ the resident's individual service plan.

B. Residents shall be provided the opportunity to participate in programming, as applicable, upon admission to the facility.

**6VAC35-71-745. Behavior management program.**

A. ~~Each~~ ~~A~~ The JCC administration shall implement a behavior management program approved by the director or the director's designee ~~Behavior management shall mean those principles and methods employed to help a resident achieve positive behavior and to address and correct a resident's inappropriate behavior in a constructive and safe manner in accordance with written procedures governing program expectations, treatment goals, resident and staff safety and security, and the resident's individual service plan. and shall adhere to written procedures governing the behavior management program~~.

B. Written procedures governing this program shall ~~provide the following~~:

1. List the behavioral expectations for the resident;

2. ~~Define and list~~ List and explain techniques that are available or used ~~and available for use~~ to manage behavior, including incidents of noncompliance;

~~3. Specify the staff members who may authorize the use of each technique;~~

~~4.~~ 3. Specify the processes for implementing the program; and

~~5. Means~~ 4. Identify the means of documenting and monitoring ~~of~~ the program's implementation.

C. ~~When~~ If substantive revisions are made to the behavior management program, ~~written information concerning the revisions shall be provided to the residents and direct care staff~~ residents and direct care ~~staff~~ employees shall be notified of these revisions in writing prior to implementation.

**6VAC35-71-747. Behavior support contract.**

A. ~~When~~ If a resident exhibits a pattern of behavior indicating a need for behavioral support ~~in addition to that~~ beyond the support provided in the ~~facility's~~ department's behavior management program, a written behavior support contract shall be developed~~, in accordance with written procedures, with the intent of assisting~~ to assist the resident ~~to self-manage~~ in self-managing these behaviors. ~~The support contract shall be developed in accordance with written procedures, which Procedures governing behavior support contracts shall address (i) the circumstances under which such the contracts will be utilized and (ii) the means of documenting and monitoring the contract's implementation.~~

~~B.~~ The facility shall have written procedures in place that address the circumstances under which such contracts will be utilized and the means of documenting and monitoring the contract's implementation.

~~B~~C. ~~Prior to working alone with an~~ Staff regularly assigned to work with a resident~~, each staff member~~ in a housing unit shall review and be prepared to implement the resident's behavior support contract.

**6VAC35-71-765. Family engagement.**

To the extent practicable ~~and in accordance with written procedures, a~~ the JCC administration shall adhere to the following in order to ensure the inclusion and involvement of immediate family members and natural supports during a resident's commitment to the department:

1. Permit the resident ~~a specified number of weekly~~ calls in accordance with Section 570, ~~as identified in written procedures,~~ to immediate family members or natural supports;

2. Ensure ~~the periodic arrangement of~~ events and activities~~, as specified in written procedures,~~ in which family members will be invited to participate;

3. Ensure that a designated visiting area is available that is conducive to family visits in accordance with 6VAC35-71-410; and

4. Maximize involvement of immediate family members and natural supports in the resident treatment process~~, as prescribed in written procedures~~.

**6VAC35-71-770. Case management services.**

A. The facility administration shall implement written procedures governing case management services~~, which~~ that shall address:

1. The resident's adjustment to the facility, group living, and separation from the resident's family;

2. Supportive counseling, as needed;

3. Transition and community ~~reintegration~~ reentry planning and preparation; and

4. ~~Communicating~~ Communication with (i) staff at the facility; (ii) the parents or legal guardians, as appropriate and applicable; (iii) the court service unit; and (iv) community resources, as needed.

B. The provision of case management services shall be documented in the case record.

**6VAC35-71-805. Suicide prevention.**

Written procedure shall ~~provide~~ require that (i) there is a suicide prevention and intervention program developed in consultation with a qualified medical professional or mental health ~~professional~~ clinician and (ii) all direct care ~~staff~~ employees, direct supervision employees, security employees, and employees providing medical services are trained and retrained in the implementation of the program, in accordance with 6VAC35-71-160 and 6VAC35-71-170, as applicable.

**6VAC35-71-815. Daily housing unit log.**

A. A daily housing unit log shall be maintained in each housing unit~~, in accordance with written procedures~~, to inform staff of significant ~~happenings~~ incidents or problems experienced by residents, including ~~but not limited to~~ health and dental complaints and injuries.

B. Each entry in the daily housing unit log shall contain (i) the date of the entry, (ii) the name of the individual making the entry, and (iii) the time each entry is made.

C. If the daily housing unit log is electronic, all entries shall be made in accordance with subsection B of this section. The computer program shall possess the functionality to prevent previous entries from being overwritten.

**6VAC35-71-820. Staff supervision of residents.**

A. ~~Staff~~ Direct care employees shall provide 24-hour awake supervision seven days a week.

B. No ~~member of the~~ direct care ~~staff~~ employee shall be on duty more than six consecutive days without a rest day, except in an emergency. ~~For the purpose of this section, a rest day means a period of not less than 24 consecutive hours during which the direct care staff person has no responsibility to perform duties related to the operation of a JCC.~~

C. Direct care ~~staff~~ employees shall be scheduled with an average of at least two rest days per week in any four-week period.

D. Direct care ~~staff~~ employees shall not be on duty more than 16 consecutive hours, except in an emergency.

E. There shall be at least one trained direct care ~~staff~~ employee on duty and actively supervising residents at all times ~~that~~ in areas of the premises in which one or more residents are present.

F. Notwithstanding the requirement in subsection E of this section, an employee ~~staff member~~ who meets the definition of a direct supervision employee and who satisfies the following additional requirements shall be authorized to be alone with a resident outside the active supervision of a direct care ~~staff~~employee:

1. The direct supervision employee completes the training required by 6VAC35-71-160 C and satisfies any additional retraining requirements provided for in 6VAC35-71-170;

2. The staff completes agency-approved training for direct supervision employees on safety and security including training on the supervision of residents, verbal de-escalation techniques, personal protection techniques, and emergency intervention ~~prior to~~before being alone with residents outside of the active supervision of ~~security series staff~~ direct care employees;

3. The direct supervision ~~staff~~ employee passes an assessment demonstrating the ability to perform all physical requirements related to personal protection;

4. During any period in which the resident is not actively supervised by direct care employees, the direct supervision employee has the ability to communicate immediately with a direct care employee through a two-way radio or by other means provided in written procedures; and

5. The direct supervision employee notifies the direct care employee immediately ~~prior to~~before and immediately ~~following~~ after meeting with the resident.

~~F.~~ G. The facility administration shall ~~implement~~ have written procedures in place that address staff supervision of residents, including contingency plans for resident illnesses, emergencies, and off-campus activities. These procedures shall be based on the:

1. Needs of the population served;

2. Types of services offered;

3. Qualifications of staff on duty; and

4. Number of residents served.

~~G. H. Staff shall regulate the movement of residents within the facility in accordance with written procedures.~~

~~H.~~ IH. ~~No~~ The JCC administration ~~shall~~ may not permit an individual resident or group of residents to exercise control or authority over other residents except when practicing leadership skills as part of an approved program under the direct and immediate supervision of staff.

**6VAC35-71-830. Staffing pattern.**

A. During the hours that residents are scheduled to be awake, there shall be at least one direct care ~~staff member~~employee awake, on duty, and responsible for supervision of every ~~10~~ eight residents, or portion thereof, ~~on the premises or participating in~~ wherever there are youth present in the facility, as well as wherever residents are attending off-campus, facility-sponsored activities. However, pursuant to 6VAC35-71-540, security ~~staff~~ employees shall be authorized to transport residents for routine or emergency purposes, such as for work release programs or in response to an injury, without the presence of direct care ~~staff~~employees, provided the same staffing ratios are maintained as required in this subsection.

B. During the hours that residents are scheduled to sleep, there shall be ~~no less than~~ at least one direct care ~~staff member~~employee awake, on duty, and responsible for supervision of every 16 residents, or portion thereof, ~~on the premises~~ wherever there are youth present in the facility.

C. There shall be at least one direct care ~~staff member~~employee on duty and responsible for the supervision of residents in each building or ~~living~~ housing unit where residents are sleeping.

D. Notwithstanding the requirements in this section, residents may be supervised by security employees or direct care employees while assigned to or receiving health care services in the infirmary or nurse's station.

**6VAC35-71-880. ~~Local health~~ Health authority.**

~~A.~~ The JCC administration shall ensure that a physician, health administrator, government authority, health care contractor, supervising registered nurse or head nurse, or health agency ~~shall be~~ is designated to serve as the ~~local~~ health authority responsible for organizing, planning, and monitoring the timely provision of appropriate health care services in that facility, including ~~arrangements~~ arranging for all levels of health care and ~~the~~ ensuring ~~of~~ the quality and accessibility of all ~~health services, including~~ medical, nursing, dental, and mental health care services, consistent with applicable statutes, prevailing community standards, and medical ethics. All medical, psychiatric, dental, and nursing matters are the province of the physician, psychiatrist, dentist, and nurse, respectively.

**6VAC35-71-890. Provision of health care services.**

~~A. The health care provider shall be guided by recommendations of the American Academy of Family Practice or the American Academy of Pediatrics, as appropriate, in the direct provision of health care services.~~

~~B. Treatment by nursing personnel~~ A. Licensed health care professionals shall ~~be performed~~ provide treatment pursuant to the laws and regulations governing the applicable practice ~~of nursing~~ within the Commonwealth.

B. Other health-trained personnel shall provide care within their level of training and certification and shall not administer health care services for which they are not qualified or specifically trained.

C. The facility administration shall retain documentation of the training received by health trained personnel necessary to perform any designated health care services. Documentation of applicable, current licensure or certification shall constitute compliance with this section.

**6VAC35-71-900. Health care procedures.**

A. The department shall have and implement written procedures for promptly:

1. Providing or arranging for the provision of medical and dental services for health problems identified at admission;

2. Providing or arranging for the provision of routine ongoing and follow-up medical and dental services after admission;

3. Providing emergency services for each resident who has reached 18 years of age and consents to these services or for any other resident, as provided by statute ~~or by the agreement with the resident's legal guardian, if under the age of 18, or the resident, if over the age of 18~~;

4. Providing emergency services and ongoing treatment, as appropriate and applicable, for any resident experiencing or showing signs of suicidal or homicidal thoughts, symptoms of mood or thought disorders, or other mental health problems; and

5. Ensuring that the required information in subsection B of this section is accessible and up to date.

B. The following written information concerning each resident shall be readily accessible to designated staff who may have to respond to a medical or dental emergency:

1. The name, address, and telephone number of the physician or dentist to be contacted;

2. ~~Name,~~ The name, address, and telephone number of ~~a relative or other person~~ the parent, legal guardian, or supervising agency, as applicable, to be notified; and

3. Information concerning:

a. Use of medication;

b. ~~All allergies,~~ Allergies, including medication allergies;

c. Substance abuse and use; and

d. Significant past and present medical problems.

~~C. Other health trained personnel shall provide care as appropriate to their level of training and certification and shall not administer health care services for which they are not qualified or specifically trained.~~

~~D. The facility shall retain documentation of the training received by health trained personnel necessary to perform any designated health care services. Documentation of applicable, current licensure or certification shall constitute compliance with this section.~~

**6VAC35-71-930. Consent to and refusal of health care services.**

A. ~~The~~ An appropriately-trained medical professional shall advise the resident ~~or~~ and parent or legal guardian, as applicable and appropriate, ~~shall be advised by an appropriately trained medical professional~~ of (i) the material facts regarding the nature, consequences, and risks of the proposed treatment, examination, or procedure; and (ii) the alternatives to ~~it~~ the proposed treatment, examination, or procedure.

B. ~~Health~~ Consent to health care services, as defined in 6VAC35-71-10 ~~(definitions)~~, shall be provided in accordance with § 54.1-2969 of the Code of Virginia.

C. Residents may refuse, in writing, ~~medical~~ health care and treatment ~~and care~~. This subsection does not apply to medication refusals that are governed by 6VAC35-71-1070 ~~(medication)~~.

D. When health care is rendered against the resident's will, it shall be in accordance with applicable laws and regulations.

**6VAC35-71-960. Medical examinations.**

A. Within five days of ~~arrival~~ an initial intake at a JCC, all residents ~~who are not directly transferred from another JCC~~ shall be medically examined by a licensed physician or a ~~qualified~~ licensed health care practitioner operating under the supervision of a licensed physician to determine if the resident requires medical attention or poses a threat to the health of staff or other residents. This examination shall include the following:

1. Complete medical, immunization, and psychiatric history;

2. Recording of height, weight, ~~body mass index,~~ temperature, pulse, respiration, and blood pressure;

3. Reports of medical laboratory testing and clinical testing results, as deemed medically appropriate, to determine both clinical status and freedom from communicable disease;

4. ~~Medical~~ Physical examination, including gynecological assessment of females, when appropriate;

5. Documentation of immunizations administered; and

6. A plan of care, including initiation of treatment, as appropriate.

B. ~~For residents~~ Residents transferring ~~from one~~ to the JCC ~~to another, shall be acceptable~~ from a direct care placement may submit the report of a medical examination conducted within the preceding 13 months at the discretion of the health care provider, upon review of the health screening at admission and prior medical examination report.

C. Each resident shall have an annual physical examination by or under the direction of a licensed physician.

**6VAC35-71-990. Health screening for intrasystem transfers.**

A. All residents transferred between JCCs shall receive a medical, dental, and mental health screening by health trained or qualified health care personnel upon arrival at the facility. The screening shall include:

1. A review of the resident's ~~health care medical~~ health care record;

2. Discussion with the resident on his medical status; and

3. Observation of the resident.

B. All findings shall be documented and the resident shall be referred for follow-up care as appropriate.

**6VAC35-71-1000. Infectious or communicable diseases.**

A. A resident with a known communicable disease that can be transmitted person-to-person shall not be housed in the general population unless a licensed ~~physician~~ health care professional certifies that:

1. The facility is capable of providing care to the resident without jeopardizing residents and staff; and

2. The facility is aware of the required treatment for the resident and the procedures to protect residents and staff.

B. The facility administration shall implement written procedures, approved by ~~a medical professional~~the health authority, that:

1. Address staff (i) interactions with residents with infectious, communicable, or contagious medical conditions; and (ii) use of standard precautions;

2. Require staff training in standard precautions, initially and annually thereafter as required in 6VAC35-71-160 and 6VAC35-71-170; and

3. Require staff to follow procedures for dealing with residents who have infectious or communicable diseases.

C. Employees providing medical services shall be trained in tuberculosis control practices as required in 6VAC35-71-160.

**6VAC35-71-1020. ~~Residents' health~~ Resident ~~medical~~ health records.**

A. Each resident's ~~health~~ ~~medical~~ health care record shall include written documentation of (i) the initial physical examination, (ii) an annual physical examination by or under the direction of a licensed physician including any recommendation for follow-up care, and (iii) ~~documentation of~~ the provision of follow-up medical care recommended by the physician or as indicated by the needs of the resident.

B. Each initial physical examination report shall include:

1. Information necessary to determine the health and immunization needs of the resident, including:

a. Immunizations administered at the time of the exam;

b. ~~Vision exam~~ Hearing and vision exams, conducted, at a minimum, on students in grades three, seven, eight, and 10 pursuant to 8VAC20-250-10;

~~c. Hearing exam;~~

~~d. General~~ c. A statement of the resident's general physical condition~~, including~~ and documentation of ~~apparent freedom from~~ communicable disease status, including tuberculosis;

d. Current medical conditions or concerns;

e. Allergies, chronic conditions, and ~~handicaps,~~ disabilities, if any;

f. Nutritional requirements, including special diets, if any;

g. Restrictions on physical activities, if any; and

h. Recommendations for further treatment, immunizations, and other examinations indicated.

2. Date of the physical examination; and

3. Signature of a licensed physician, the physician's designee, or an official of a local health department.

C. ~~Each~~ A resident's ~~health medical~~ health care record shall include written documentation of (i) an annual examination by a licensed dentist and (ii) ~~documentation of~~ follow-up dental care recommended by the dentist based on the needs of the resident.

D. ~~Each~~ A resident's ~~health medical~~ health care record shall include notations of health and dental complaints and injuries and ~~shall summarize~~ a summary of the resident's symptoms and treatment given.

E. ~~Each~~ A resident's ~~health medical~~ health care record shall include, or document the facility's efforts to obtain, treatment summaries of ongoing psychiatric or other mental health treatment and reports, if applicable.

F. Written procedure shall provide that ~~residents'~~ each resident's active ~~health medical~~ health care records shall be:

1. Kept confidential from unauthorized persons and in a file separate from the case record;

2. Readily accessible in case of emergency; and

3. ~~Made available~~ Available to authorized staff consistent with applicable state and federal laws.

G. ~~Residents'~~ A resident's inactive health records shall be retained and disposed of as required by The Library of Virginia.

**6VAC35-71-1030. First aid kits.**

A. ~~Each facility~~ ~~A~~ The JCC administration shall ~~have~~ maintain first aid kits ~~that shall be maintained~~ within the facility, as well as in facility vehicles used to transport residents. The facility shall have ~~in accordance with~~ written procedures in place that shall address the (i) contents; (ii) location; and (iii) method of restocking first aid kits.

B. The first aid kit shall be readily accessible for minor injuries and medical emergencies.

**6VAC35-71-1040. Sick call.**

A. All residents shall have the opportunity daily to request health care services.

B. Resident requests for health care services shall be documented, reviewed for the immediacy of need and the intervention required, and responded to daily by qualified medical staff. Residents shall be referred to a licensed physician consistent with established protocols and written or verbal orders issued by personnel authorized by law to give ~~such~~ these orders.

C. The frequency and duration of sick call shall be sufficient to meet the health needs of the facility population. ~~For the purpose of this section, sick call shall mean the evaluation and~~

~~treatment of a resident in a clinical setting, either on or off site, by a qualified health care professional.~~

**6VAC35-71-1050. Emergency medical services.**

A. ~~Each~~ ~~A~~ The JCC administration shall ~~have~~ ensure that residents have access to 24-hour emergency medical, mental health, and dental services for the care of an acute illness or unexpected health care need that cannot be deferred until the next scheduled sick call.

B. Procedures shall include arrangements for the following:

1. Utilization of 911 emergency services;

2. Emergency transportation of residents from the facility;

3. Security procedures for the immediate transfer of residents when appropriate;

4. Use of one or more designated hospital emergency departments or other appropriate facilities consistent with the operational procedures of local supporting rescue squads;

5. Response by on-call health care providers to include provisions for telephonic consultation, guidance, or direct response as clinically appropriate; and

6. ~~On-site~~ Onsite first aid and crisis intervention.

C. Staff who respond to medical or dental emergencies shall do so ~~in accordance with written procedures.~~within the scope of their training and certifications.

**6VAC35-71-1060. Hospitalization and other outside medical treatment of residents.**

A. ~~When~~ If a resident needs hospital care or other medical treatment outside the facility:

1. The resident shall be transported ~~safely and in accordance with applicable safety and security procedures that are applied consistent with the severity of the medical condition; and~~ in accordance with 6VAC35-71-540.

2. Staff shall escort and supervise residents when outside the facility for hospital care or other medical treatment, until appropriate security arrangements are made. This subdivision shall not apply to the transfer of residents under the Psychiatric Inpatient Treatment of Minors Act (§ 16.1-355 et seq. of the Code of Virginia).

3. Any exceptions to subsections 1 and 2 shall be made in accordance with the resident's medical condition.

B. ~~In accordance with applicable laws and regulations, t~~The parent or legal guardian, as appropriate and applicable, shall be informed that the resident was taken outside the facility for ~~medical attention~~health care ~~as soon as is practicable~~in accordance with 6VAC35-71-60.

**6VAC35-71-1070. Medication.**

A. All medication shall be properly labeled consistent with the requirements of the Virginia Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia). Medication prescribed for individual use shall be so labeled.

B. All medication shall be securely locked, except when otherwise ordered by a licensed physician or licensed health care provider on an individual basis for keep-on-person or equivalent use.

C. All staff responsible for medication administration who do not hold a license issued by the Virginia Department of Health Professions authorizing the administration of medications shall successfully complete a medication training program approved by the Board of Nursing and receive required annual refresher training ~~as required~~ before they ~~can~~ may administer medication.

D. Staff authorized to administer medication shall be informed of any known side effects of the medication and the symptoms of the effects.

E. A program of medication~~, including procedures regarding the use of over-the-counter medication pursuant to written or verbal orders signed by personnel authorized by law to give such orders,~~ shall be initiated for a resident only when prescribed in writing by a person authorized by law to prescribe medication. This includes over-the-counter medication administered pursuant to a written or verbal order that is issued by personnel authorized by law to give these orders.

F. All medications shall be administered in accordance with the physician's or other prescriber's instructions and consistent with the requirements of ~~§ 54.2-2408~~ § 54.1-3408 of the Code of Virginia and the Virginia Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

G. A medication administration record shall be maintained ~~of~~ that identifies all medicines received by each resident and ~~shall include~~ that includes:

1. Date the medication was prescribed or most recently refilled;
2. Drug name;
3. Schedule for administration, to include notation of each dose administered or refused;
4. Strength;
5. Route;
6. Identity of the individual who administered the medication; and
7. ~~Dates~~ Date the medication was discontinued or changed.

H. ~~In the event of~~If a medication incident or an adverse drug reaction occurs, first aid shall be administered if indicated. As addressed in the physician's standing orders, staff shall promptly contact a poison control center, hospital, pharmacist, nurse, or physician~~, nurse, pharmacist, or poison control center~~ and shall take actions as directed. If the situation is not addressed in standing orders, the attending physician shall be notified as soon as possible and the actions taken by staff shall be documented. ~~A medical incident shall mean an error made in administering a medication to a resident including the following: (i) a resident is given incorrect medication; (ii) medication is administered to the incorrect resident; (iii) an incorrect dosage is administered; (iv) medication is administered at a wrong time or not at all; and (v) the medication is administered through an improper method. A medication incident does not include a resident's refusal of appropriately offered medication.~~

I. Written procedures shall ~~provide for~~ require (i) the documentation of medication incidents, (ii) the review of medication incidents and reactions and ~~making~~ implementation of ~~any~~ necessary improvements, (iii) the storage of controlled substances, and (iv) the distribution of medication off campus. The procedures must be approved by a the department's health ~~administrator~~ services director. Documentation of this approval shall be retained.

J. Medication refusals and actions taken by staff shall be documented ~~including action taken by staff~~. The facility administration shall ~~follow~~ have procedures for managing ~~such~~ these refusals~~, which~~ that shall address:

1. ~~Manner~~ The manner by which medication refusals are documented; and
2. Physician follow-up, as appropriate.

K. Disposal and storage of unused, expired, and discontinued medications and medical implements shall be in accordance with applicable laws and regulations.

L. The telephone number of a regional poison control center and other emergency numbers shall be posted on or next to each nonpay telephone that has access to an outside line in each building in which residents sleep or participate in programs.

M. Syringes and other medical implements used for injecting or cutting skin shall be locked and inventoried ~~in accordance with facility procedures~~.

**6VAC35-71-1080. Release physical.**

Each resident shall be medically examined by a licensed physician or qualified health care practitioner ~~operating under the supervision of a physician~~ within 30 days prior to release, unless exempted by the responsible physician based on a ~~sufficiently recent~~ full medical examination conducted within 90 days prior to release.

## Part VIII – Behavior Interventions

### Article 1, Behavior, Discipline, and Room Confinement *(§1090 through 1170)*

**6VAC35-71-1110. Disciplinary process.**

A. ~~A~~ The JCC administration shall ensure that, to the extent practicable, resident behavioral issues are addressed (i) in the context of a therapeutic community; (ii) in a manner that is consistent with the department's behavior management program; (iii) with consideration of the safety and security of the residents, staff, and others in the facility; and (iv) with the goal of rehabilitating, rather than punishing the resident.

B. ~~Each~~ The JCC administration shall ~~follow written procedures for handling~~address (i) minor resident misbehavior through an informal process and (ii) instances when a resident is charged with a violation of the rules of conduct through the formal process outlined ~~below~~ in subsections C, D, and E of this section. ~~Such The procedures shall provide for (i) graduated sanctions and (ii) staff and resident orientation and training on the procedures~~.

~~B. When~~ C. If staff have reason to believe a resident has committed a rule violation that cannot be resolved through the facility's informal process, staff shall prepare a disciplinary report detailing the alleged rule violation. A written copy of the report shall be maintained by the housing unit staff. The resident shall be given a written copy of the report within 24 hours of the alleged rule violation; however, staff shall have the discretion to provide residents who are noncompliant or are displaying maladaptive behavior at least one ~~or more opportunities~~opportunity to view the written report instead of providing a copy to the resident within 24 hours of the alleged rule violation. ~~In the event that~~If staff ~~exercises~~ exercise this option, a copy of the written report shall be provided to the resident once the resident demonstrates that he is able to comply with the rules of the facility.

~~C.~~ D. After the resident receives notice of an alleged rule violation, the resident shall be provided the opportunity to admit or deny the charge.

1. The resident may admit to the charge in writing to a superintendent or the superintendent's designee who was not involved in the incident, accept the sanction prescribed for the offense, and waive his right to any further review.

2. If the resident denies the charge or there is reason to believe that the resident's admission is coerced or that the resident does not understand the charge or the implication of the admission, the formal process for resolving the matter detailed in subsection ~~D~~ E of this section shall be followed.

~~D.~~ E. The formal process for resolving rule violations shall provide the following:

1. A disciplinary hearing to determine if substantial evidence exists to find the resident guilty of the rule violation shall be scheduled to occur no later than seven days, excluding

weekends and holidays, after the rule violation. The hearing may be postponed with the resident's consent.

2. The resident alleged to have committed the rule ~~violations~~ violation shall be given at least 24 ~~hours~~ hours' notice of the time and place of the hearing~~, but~~; however the hearing may be held within 24 hours with the resident's written consent.

3. The disciplinary hearing on the alleged rule violation shall:

a. Be conducted by an impartial and objective ~~staff~~ employee who shall determine (i) what evidence is admissible, (ii) the guilt or innocence of the resident, and (iii) if the resident is found guilty of the rule violation, what sanctions shall be imposed;

b. Allow the resident to be present throughout the hearing, unless the resident waives the right to attend, his behavior justifies exclusion, or another resident's testimony must be given in confidence. The reason for the resident's absence or exclusion shall be documented;

c. Permit the resident to make a statement ~~and~~, present evidence, and ~~to~~ request relevant witnesses on his behalf. The reasons for denying ~~such~~ these requests shall be documented;

d. Permit the resident to request a staff member to represent him and question the witnesses. A staff member shall be appointed to help the resident when it is apparent that the resident is not capable of effectively collecting and presenting evidence on his own behalf; and

e. Be documented, with a record of the proceedings kept for ~~six months~~three years.

4. A written record shall be made of the hearing disposition and supporting evidence. The hearing record shall be kept on file at the JCC.

5. The resident shall be informed in writing of the disposition and, if found guilty of the rule violation, the reasons supporting the disposition and the right to appeal.

6. If the resident is found guilty of the rule violation, a copy of the disciplinary report shall be placed in the resident's case record.

7. The superintendent or the superintendent's designee shall review all disciplinary hearings and dispositions to ensure conformity with procedures and regulations.

8. The resident shall have the right to appeal the disciplinary hearing decision to the superintendent or the superintendent's designee within 24 hours of receiving the decision. The appeal shall be decided within 24 hours of its receipt, and the resident shall be notified in writing of the results within three days. These ~~time-frames~~ timeframes do not include weekends and holidays.

~~E. When it is necessary to place the resident in confinement to protect the facility's security or the safety of the resident or others, the charged resident may be confined pending the formal hearing for up to 24 hours. Confinement for longer than 24 hours must be reviewed at least once every 24 hours by the superintendent or designee who was not involved in the incident. For any confinement exceeding 72 hours, notice shall be made in accordance with 6VAC35-71-1140 D (room confinement).~~

**6VAC35-71-1120. Timeout.**

A. Facilities that use ~~a systematic behavior management technique program component designed to reduce or eliminate inappropriate or problematic behavior by having a staff require a resident to move to a specific location that is away from a source of reinforcement for a specific period of time or until the problem behavior has subsided (timeout)~~ timeout shall implement written procedures ~~governing~~ that provide the following:

~~1. The conditions, based on the resident's chronological and developmental level, under which a resident may be placed in timeout;~~

~~2. The maximum period of timeout based on the resident's chronological and developmental level; and~~

~~3. The area in which a resident is placed.~~

~~1. A resident may be placed in timeout only after less restrictive alternatives have been applied;~~

~~2~~1. Timeout may be imposed only to address minor ~~behavior infractions~~ inappropriate or problematic behavior, such as talking back or failing to follow instructions~~, and shall not be applied to address any chargeable offenses as designated in written procedures or any aggressive behaviors;~~

~~3~~2. A resident shall be released from the timeout period when the resident demonstrates the ability to rejoin the group activity and comply with ~~the~~ expectations that are in place; and

~~4~~3. Staff shall be authorized to determine the area in which a resident is placed for timeout on a case-by-case basis.

B. A resident in timeout shall ~~be able to communicate~~ have a means of immediate communication with staff, either verbally or electronically.

C. Staff shall ~~check on~~ monitor the resident in the timeout area at least every 15 minutes and more often depending on the nature of the resident's ~~disability,~~ condition~~, and~~ or behavior.

D. Use of timeout and staff checks on the residents shall be documented.

~~**6VAC35-71-1130. Physical restraint.**~~

~~A. Physical restraint shall be used as a last resort only after less restrictive behavior intervention techniques have failed or to control residents whose behavior poses a risk to the safety of the resident, others, or the public.~~

~~1. Staff shall use the least force necessary to eliminate the risk or to maintain security and order and shall never use physical restraint as punishment or with intent to inflict injury.~~

~~2. Trained staff members may physically restrain a resident only after less restrictive behavior interventions have failed or when failure to restrain would result in harm to the resident or others.~~

~~3. Physical restraint may be implemented, monitored, and discontinued only by staff who have been trained in the proper and safe use of restraint.~~

~~4. For the purpose of this section, physical restraint shall mean the application of behavior intervention techniques involving a physical intervention to prevent an individual from moving all or part of that individual's body.~~

~~B. Each JCC shall implement written procedures governing use of physical restraint that shall include:~~

~~1. A requirement for training in crisis prevention and behavior intervention techniques that staff may use to control residents whose behaviors pose a risk;~~

~~2. The staff position who will write the report and time frame;~~

~~3. The staff position who will review the report for continued staff development for performance improvement and the time frame for this review;~~

~~4. Methods to be followed should physical restraint, less intrusive behavior interventions, or measures permitted by other applicable state regulations prove unsuccessful in calming and moderating the resident's behavior; and 5. Identification of control techniques that are appropriate for identified levels of risk.~~

~~C. Each application of physical restraint shall be fully documented in the resident's record including:~~

~~1. Date and time of the incident;~~

~~2. Staff involved;~~

~~3. Justification for the restraint;~~

~~4. Less restrictive behavior interventions that were unsuccessfully attempted prior to using physical restraint;~~

~~5. Duration;~~

~~6. Description of method or methods of physical restraint techniques used;~~

~~7. Signature of the person completing the report and date; and~~

~~8. Reviewer's signature and date.~~

**6VAC35-71-1140. Room confinement.**

A. Written procedures ~~shall govern how and when residents may be confined to a locked~~ governing room confinement shall address the following issues:

1. The actions or behaviors that may result in room confinement;

2. The factors, such as age, developmental level, or disability, that should be considered prior to placing a resident in room confinement;

3. The process for determining whether the resident's behavior threatens the safety and security of the resident, others, or the facility; the protocol for determining whether the threat necessitating room confinement has been abated; and the necessary steps for releasing the resident ~~to a less restrictive setting~~from room confinement after the threat is abated; and

4. The circumstances under which a debriefing with the resident should occur after the resident is released from confinement; the party that should conduct the debriefing; and the topics that should be discussed in the debriefing, including the cause and impact of the room confinement and the appropriate measures post-confinement to support positive resident outcomes.

~~B. Whenever a resident is confined to a locked room, including but not limited to being placed in isolation, staff shall check the resident visually at least every 30 minutes and more frequently if indicated by the circumstances.~~

~~C. Residents who are confined to a locked room, including but not limited to being placed in isolation, shall be afforded the opportunity for at least one hour of physical exercise, outside of the locked room, every calendar day unless the resident's behavior or other circumstances justify an exception. The reasons for any such exception shall be approved in accordance with written procedures and documented~~

B. If a resident is placed in room confinement, regardless of the duration of the confinement period or the rationale for the confinement, staff shall take measures to ensure the continued health and safety of the confined resident. At a minimum, the following measures shall be applied:

1. Staff shall monitor the resident visually at least every 15 minutes and more frequently if indicated by the circumstances. If a resident is placed on suicide precautions, staff shall make additional visual checks as determined by the ~~qualified mental health professional~~mental health clinician.

2. A qualified medical health professional or ~~mental health professional~~mental health clinician shall, at least once daily, visit with the resident to assess the resident's medical and mental health status.

3. The resident shall have a means of immediate communication with staff, either verbally or electronically, throughout the duration of the confinement period.

4. The resident shall be afforded the opportunity for at least one hour of large muscle activity outside of the locked room every calendar day unless the resident displays behavior that is threatening, presents an imminent danger to himself or others, or ~~otherwise justifies an exception or unless~~ other circumstances, ~~such as lockdown or power failure,~~ prevent the activity. The reasons for the exception shall be approved by the superintendent or his designee and documented ~~in accordance with written procedures~~.

5. If the resident, while placed in room confinement, exhibits self-injurious behavior, staff shall (i) take appropriate action in response to the behavior to prevent further injury and to notify supervisory staff; (ii) consult with a ~~qualified mental health professional~~mental health clinician immediately after the threat is abated and document the consultation; and (iii) ~~monitor the resident in accordance with established protocols~~adjust the frequency of face-to-face checks, as needed, never allowing more than 15 minutes to pass between checks~~, including constant supervision, if appropriate~~.

C. A resident shall never be placed in room confinement as a sanction for noncompliance or as a means of punishment. Room confinement may be imposed only in response to the following situations:

1. If a resident's actions threaten facility security or the safety and security of residents, staff, or others in the facility; or

2. In order to prevent damage to real or personal property ~~when the damage is committed with the intent of fashioning an object or device~~ that may threaten facility security or the safety and security of residents, staff, or others in the facility.

D. Room confinement may be imposed only after less restrictive measures have been exhausted or cannot be employed successfully. Once the threat necessitating the confinement is abated, staff shall initiate the process for releasing the resident from confinement ~~and returning him to a lesser restrictive setting~~.

E. ~~In the event that~~If a resident is placed in room confinement, the resident shall be provided medical and mental health treatment, as applicable, education, daily nutrition in accordance with 6VAC35-71-630, and daily opportunities for bathing in accordance with 6VAC35-71-550 ~~afforded the same opportunities as other residents in the housing unit, including treatment, education, and as much time out of the resident's room as security considerations allow~~.

F. Within the first three hours of a resident's placement in room confinement, a designated staff member shall communicate with the resident to explain (i) the reasons for which the resident has been placed in confinement; (ii) the expectations governing behavior while placed in room confinement; and (iii) the steps necessary in order for a resident to be released from room confinement.

G. A resident confined for six or fewer waking hours shall be afforded the opportunity at least once during the confinement period to communicate ~~with a staff member~~, wholly apart from the communications required in subsection F of this section, with a staff member regarding his status or the impact of the room confinement. A resident confined for a period that exceeds six waking hours shall be afforded an opportunity twice daily during waking hours for these communications.

H. The superintendent or the superintendent's designee shall make personal contact with every resident who is placed in room confinement each day of confinement.

~~D.~~ I. If a resident is ~~confined to a locked~~ placed in room confinement for ~~more than~~ 24 hours, the superintendent or the superintendent's designee shall be notified and shall provide written approval for any continued room confinement beyond the 24-hour period.

~~E. If the confinement extends to more than 72 hours, the (i) confinement and (ii) the steps being taken or planned to resolve the situation shall be immediately reported to the department staff, in a position above the level of superintendent, as designated in written procedures. If this report is made verbally, it shall be followed immediately with a written, faxed, or secure email report in accordance with written procedures.~~

~~F. The superintendent or designee shall make personal contact with each resident who is confined to a locked room each day of confinement.~~

~~G. When confined to a room, the resident shall have a means of communication with staff, either verbally or electronically.~~

~~H. If the resident, after being confined to a locked room, exhibits self-injurious behavior (i) staff shall immediately consult with, and document that they have consulted with, a mental health professional; and (ii) the resident shall be monitored in accordance with established protocols, including constant supervision, if appropriate.~~

J. The facility superintendent's supervisor shall provide written approval before any room confinement may be extended beyond 48 hours.

K. The administrator who is two levels above the superintendent in the department's reporting chain-of-command shall provide written approval before any room confinement may be extended beyond 72 hours. The administrator's approval shall be contingent upon receipt of a written report outlining the steps being taken or planned to resolve the situation. The facility administration ~~shall~~ convene a treatment team consisting of stakeholders involved in the resident's treatment to develop this plan. The department shall establish written procedures governing the development of this plan.

L. Room confinement periods that exceed five days shall be subject to a case management review ~~process in accordance with written procedures~~ that ~~provide the following~~adheres to the following requirements:

1. A facility-level review committee shall conduct a case-management review at the committee's next scheduled meeting immediately following expiration of the five-day period.

2. If the facility-level case management review determines a need for the resident's continued confinement, the case shall be referred for a case management review at the division-level committee meeting, which shall occur no later than seven business days ~~following the referral's next scheduled meeting immediately following the meeting for the facility-level review~~.

3. Upon completion of the initial reviews in subdivisions L 1 and L 2 of this section, any additional time that the resident remains in room confinement shall be subject to a recurring review by the facility-level review committee and the division-level review committee, as applicable, until either committee recommends the resident's release from room confinement. ~~However, u~~Upon written request of the division-level review committee, the administrator who is two levels above the superintendent in the department's reporting chain-of-command shall be authorized to reduce the frequency of or waive the division-level reviews ~~in accordance with written procedures~~. The rationale for the waiver shall be documented and placed in the resident's record.

~~M. The provisions of this section shall become effective (insert effective date of this regulation).~~

## Article 2 – Physical Restraints

### 6VAC35-71-1175. Physical Restraints

A. Physical restraint shall be used as a last resort only after less restrictive behavior intervention techniques have failed or to control residents whose behavior poses a risk to the safety of the resident, staff, or others.

1. Staff shall use the least force deemed reasonably necessary to eliminate the risk or to maintain security and order and shall never use physical restraint as punishment or with intent to inflict injury.

2. Physical restraint may be implemented monitored, and discontinued only by staff trained in the proper and safe use of restraint in accordance with the requirements in 6VAC35-71-160 and 6VAC35-71-170.

B. The JCC administration shall implement written procedures governing use of physical restraint that shall:

1. Require training in crisis prevention and behavior intervention techniques that staff may use to control residents whose behaviors pose a risk;

2. Identify the staff position that will write the report and time frame for completing the report;

3. Identify the staff position that will review the report for continued staff development for performance improvement and the time frame for this review; and

4. Identify the methods to be followed should physical restraint, less intrusive behavior interventions, or measures permitted by other applicable state regulations prove unsuccessful in calming and moderating the resident's behavior.

C. Each application of physical restraint shall be fully documented in the resident's record. The documentation shall include:

1. Date and time of the incident;

2. Staff involved in the incident;

3. Justification for the restraint;

4. Less restrictive behavior interventions that were unsuccessfully attempted prior to using physical restraint;

5. Duration of the restraint;

6. Description of the method of physical restraint techniques used;

7. Signature of the person completing the report and date; and

8. Reviewer's signature and date.

## Article 3 – Mechanical Restraints and Protective Devices

### 6VAC35-71-1180. Mechanical restraints and protective devices.

~~A. Written procedure shall govern the use of mechanical restraints and shall specify:~~

~~1. The conditions under which handcuffs, waist chains, leg irons, disposable plastic cuffs, leather restraints, and mobile restraint chair may be used;~~

~~2. That the superintendent or designee shall be notified immediately upon using restraints in an emergency situation;~~

~~3. 2. That mechanical restraints shall never be applied as punishment;~~

~~3. That mechanical restraints shall not be applied for routine on-campus transportation unless (i) there is a heightened need for additional security as identified in written procedures or (ii) the resident is noncompliant and needs to be moved for the resident's own safety or security;~~

~~4. That residents a resident shall not be restrained to a fixed object or restrained in an unnatural position;~~

~~5. That each use of mechanical restraints, except when used to transport a resident off campus, shall be recorded in the resident's case file or record and in a central log book; and~~

~~6. That the facility maintains a written record of routine and emergency distribution of restraint equipment.~~

~~B. If a JCC uses mechanical restraints, written procedure shall provide that (i) all staff who are authorized to use restraints shall receive department-approved training in their use, including which training shall address procedures for checking the resident's resident for signs of circulation and checking for injuries; and (ii) only properly trained staff shall use restraints.~~

~~C. For the purpose of this section, mechanical restraint shall mean the use of an approved mechanical device that involuntarily restricts the freedom of movement or voluntary functioning of a limb or portion of an individual's body as a means to control his physical activities when the individual being restricted does not have the ability to remove the device. A JCC shall be authorized to use a mobile restraint chair for the sole purpose of controlled movement of a resident from one area of the facility to another and shall observe the following when utilizing the chair:~~

~~1. Staff shall be authorized to utilize the mobile restraint chair only after less restrictive interventions have been unsuccessful in moving a resident from one area of the facility to another or when use of the restraint chair is the least restrictive intervention available to move the resident.~~

~~2. Staff shall remove the resident from the restraint chair immediately upon reaching the intended destination. In no event shall a resident who is not being moved from one area of the facility to another be confined to a restraint chair for any period of time.~~

A. Mechanical restraints and protective devices may be used for the following purposes subject to the restrictions enumerated in this section: (i) to control residents whose behavior poses an imminent risk to the safety of the resident, staff, or others; (ii) for purposes of controlled movement, either from one area of the facility to another or to a destination outside the facility; and (iii) to address emergencies.

B. When JCC staff use mechanical restraints or protective devices, they shall observe the following general requirements:

1. Mechanical restraints and protective devices shall be used only for as long as necessary to address the purposes established in subsection A. Once the imminent risk to safety has been abated, the resident has reached the intended destination within the facility or has returned to the facility from a destination offsite, or the emergency has been resolved, the mechanical restraint or protective device shall be removed.

2. The superintendent or the superintendent's designee shall be notified immediately upon using mechanical restraints or protective devices in an emergency.

3. The facility administration may not use mechanical restraints or protective devices as a punishment or a sanction.

4. Residents shall not be restrained to a fixed object or restrained in an unnatural position.

5. A mental health clinician, or other qualifying licensed medical professional may order termination of a mechanical restraint or protective device at any time upon determining that the item poses a health risk.

6. Each use of a mechanical restraint or protective device, except when used to transport a resident or during video court hearing proceedings, shall be recorded in the resident's case record and in the daily housing unit log;

7. A written system of accountability shall be in place to document routine distribution of mechanical restraints and protective devices;

8. All staff who are authorized to use mechanical restraints or protective devices shall receive training in such use in accordance with 6VAC35-71-160 and 6VAC35-71-170, as applicable; and only trained staff shall use restraint or protective devices.

C. If staff in a JCC use a mechanical restraint to control a resident whose behavior poses a safety risk in accordance with subdivision (A)(i) of this section, they shall notify a qualified health care professional and a mental health clinician before continuing to use the restraint and, if applicable, the accompanying protective device, if the imminent risk has been abated, but staff determine 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. This may include instances in which the resident verbally expresses the intent to continue the actions that required the restraint.

D. Staff in a juvenile correctional center may not use a protective device unless the use is in connection with a restraint and shall remove the device when the resident is released from the restraint.

E. In addition to the requirements in subsections A through D of this section, if staff in a juvenile correctional center use a spit guard to control resident behavior, they shall observe the following requirements:

1. Staff may not use a spit guard unless it possesses the following characteristics:

a. The spit guard's design may not inhibit the resident's ability to breathe;

b. The spit guard must be constructed to allow for visibility;

c. The spit guard must be manufactured and sold specifically for the prevention of biting or spitting.

2. The spit guard may be used only on a resident who: (i) previously has bitten or spat on a person at the facility, or (ii) in the course of a current restraint, threatens or attempts to spit on or bite or actually spits on or bites a staff member.

3. The spit guard must be applied in a manner that will not inhibit the resident's ability to breathe.

4. While the spit guard remains in place, staff shall provide for the resident's reasonable comfort and ensure the resident's access to water and meals, as applicable;

5. Staff must employ constant supervision of the resident while the spit guard remains in place to observe whether the resident exhibits signs of respiratory distress. If any sign of respiratory distress is observed, staff shall take immediate action to prevent injury and to notify supervisory staff.

6. Staff may not use a spit guard on a resident who is unconscious, vomiting, or in obvious need of medical attention.

**6VAC35-71-1190. Monitoring residents placed in mechanical restraints.**

A. Written procedure shall provide that ~~when~~ if a resident is placed in mechanical restraints, except when being transported offsite, staff shall:

1. Provide for the resident's reasonable comfort and ensure the resident's access to water, meals, and toilet; and

2. ~~Make~~ Conduct a ~~direct personal~~ ~~visual~~ face-to-face check on the resident at least every 15 minutes and more often if the resident's behavior warrants. During each check, a staff member shall monitor the resident for signs of circulation and for injuries.

3. Attempt to engage verbally with the resident during each periodic check. These efforts may include explaining the reasons for which the resident is being restrained or the steps necessary to be released from the restraint or otherwise attempting to deescalate the resident.

B. If a resident remains in a mechanical restraint for a period of two hours or more, except during transportation of residents offsite:

1. The resident shall be permitted to exercise his limbs for a minimum of 10 minutes every two hours in order to prevent blood clots.

2. A medical staff member shall conduct a check on the resident at least once every two hours.

~~B~~C. When a resident is placed in mechanical restraints for more than ~~two hours cumulatively~~ one ~~consecutive~~ continuous hour in a 24-hour period, with the exception of use in routine off-campus transportation of residents, staff shall ~~immediately~~ consult with a ~~qualified mental health professional~~mental health clinician. This consultation shall be documented.

~~C~~D. If the resident, after being placed in mechanical restraints, exhibits self-injurious behavior, ~~(i)~~ staff shall (i) take appropriate action in response to the behavior to prevent further injury and to notify supervisory staff; (ii) consult with a ~~qualified mental health professional~~mental health clinician and medical staff immediately ~~consult with,~~ thereafter and document ~~that they have consulted with, a mental health professional~~ the consultation; and (iii) adjust the frequency of face-to-face checks as needed~~monitor the resident shall be monitored in accordance with established protocols, including constant supervision, if appropriate~~. ~~Any such~~ ~~The protocols shall be in compliance comply with the written procedures required by 6VAC35-71-1200 (restraints for medical and mental health purposes)~~.

**6VAC35-71-1195. Written procedures regarding mechanical restraints and protective devices.**

The department shall develop written procedures approved by the director that reflect the requirements established in this article.

**6VAC35-71-1200. ~~Restraints for medical and mental health purposes~~(Repealed).**

~~Written procedure shall govern the use of restraints for medical and mental health purposes. Written procedure should shall identify (i) the authorization needed; (ii) when, where, and how restraints may be used; (iii) for how long restraints may be applied; and (iv) what type of restraint may be used.~~

## Article 4 – Mechanical Restraint Chair

**6VAC35-71-1203. Mechanical restraint chair; general provisions.**

If staff in a JCC utilize a mechanical restraint chair, they shall observe the following requirements, regardless of whether the chair is used for purposes of controlled movement in accordance with 6VAC35-71-1204 or for other purposes in accordance with 6VAC35-71-1205.

1. The restraint chair shall never be applied as punishment or as a sanction.

2. All staff authorized to use the restraint chair shall receive training in such use in accordance with 6VAC35-71-160 and 6VAC35-71-170.

3. Prior to placement in the chair, the health authority or his designee shall ensure that the resident's medical and mental health condition are assessed to determine whether the restraint is contraindicated based on the resident's physical condition or behavior and whether other accommodations are necessary.

4. The superintendent or the superintendent's designee shall provide approval before a resident may be placed in the restraint chair.

5. Staff shall notify the health authority or designee immediately upon placing the resident in the restraint chair. The health authority or designee also shall ensure that a mental health clinician conducts an assessment to determine whether, on the basis of serious danger to self or others, the resident should be in a medical or mental health unit for emergency involuntary treatment. The requirements of this subdivision shall not apply when the restraint chair is requested by a resident for whom such voluntary use is part of an approved plan of care by a mental health clinician in accordance with subsection C of 6VAC35-71-1205.

5. If the resident, after being placed in the mechanical restraint chair, exhibits self-injurious behavior, staff shall: (i) take appropriate action in response to the behavior to prevent further injury and to notify supervisory staff (ii) consult a mental health clinician immediately thereafter and obtain approval for continued use of the restraint chair;

6. The health authority or his designee, a mental health clinician, or other qualifying licensed medical professional may order termination of restraint chair use at any time upon determining that use of the chair poses a health risk;

7. Each use of the restraint chair shall constitute a serious incident, to which the provisions of 6VAC35-71-60 shall apply;

8. Each use of the restraint chair shall be documented in the resident's case record and in the daily housing unit log. The documentation shall include:

a. Date and time of the incident;

b. Staff involved in the incident;

c. Justification for the restraint;

d. Less restrictive interventions that were attempted or an explanation of why the restraint chair is the least restrictive intervention available to ensure the resident's safe movement;

e. Duration of the restraint;

f. Signature of the person documenting the incident and date;

g. Indication that all applicable approvals required in this article have been obtained; and

h. Reviewer's signature and date.

9. Staff involved in the use of the chair, together with supervisory staff, shall conduct a debriefing after each use of the restraint chair.

**6VAC35-71-1204. Mechanical restraint chair use for controlled movement; conditions.**

A. JCC staff shall be authorized to use a mechanical restraint chair for purposes of controlled movement of a resident from one area of the facility to another, provided the following conditions are satisfied:

1. The resident's refusal to move from one area of the facility to another poses a direct and immediate threat to the resident or others or interferes with required facility operations; and

2. Use of the restraint chair is the least restrictive intervention available to ensure the resident's safe movement.

B. When facility staff utilize the restraint chair in accordance with this section, staff shall remove the resident from the chair immediately upon reaching the intended destination. If staff, upon reaching the intended destination, determine that continued restraint is necessary, staff shall consult with a mental health clinician for approval of the continued restraint.

**6VAC35-71-1205. Mechanical restraint chair use for purposes other than controlled movement; conditions for use.**

A. JCC staff shall be authorized to use a mechanical restraint chair for purposes other than controlled movement provided the following conditions are satisfied:

1. The resident's behavior or actions present a direct and immediate threat to the resident or others;

2. Less restrictive alternatives were attempted but were unsuccessful in bringing the resident under control or abating the threat;

3. The resident remains in the restraint chair only for as long as necessary to abate the threat or help the resident gain self-control.

B. Once the direct threat is abated, if staff determines that continued restraint is necessary to maintain security due to the resident's ongoing credible threat to injure himself or others, staff shall consult a mental health clinician for approval of the continued restraint. The ongoing threat may include instances in which the resident verbally expresses the intent to continue the actions that required the restraint.

C. JCC staff 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 mental health clinician.

D. Whenever a resident is placed in a restraint chair for purposes other than controlled movement, staff shall observe the following monitoring requirements:

1. Employ constant, one-on-one supervision until the resident is released from the chair;

2. Attempt to engage verbally with the resident during the one-on-one supervision. These efforts may include explaining the reasons for which the resident is being restrained or the steps necessary to be released from the restraint or otherwise attempting to deescalate the resident;

3. Ensure that a licensed medical provider monitors the resident for signs of circulation and for injuries at least once every 15 minutes; and

4. Ensure that the resident is reasonably comfortable and has access to water, meals, and toilet.

**6VAC35-71-1206. Monitoring residents placed in a mechanical restraint chair.**

A. If a resident remains in the restraint chair for a period that exceeds one hour, the resident shall be permitted to exercise each of his limbs for a minimum of 10 minutes every two hours to prevent blood clots.

B. The JCC administration shall ensure that a video record of the following is captured and retained for a minimum of three years in accordance with 6VAC35-71-30:

1. The placement of a resident in a restraint chair when a resident is restrained for purposes of controlled movement;

2. The entire restraint from the time the resident is placed in the restraint chair until his release when a resident is restrained in the chair for purposes other than controlled movement. The JCC may satisfy this requirement by positioning the restraint chair within direct view of an existing security camera.

**6VAC35-71-1207. Department monitoring visits; annual reporting; board review**

A. If staff in a JCC use a mechanical restraint chair to restrain a resident, regardless of the purpose or duration of the use, the JCC shall be subject to a monitoring visit conducted by the department pursuant to the authority provided in 6VAC35-20-60. The purpose of the monitoring visit shall be to assess staff' compliance with the provisions of this article.

B. Upon completion of the monitoring visit, the department shall provide the JCC administration with a written report of its findings in accordance with 6VAC35-20-90.

C. The department shall document each monitoring visit conducted pursuant to subsection A of this section and provide a written report to the board annually that details, at a minimum, the following information regarding each separate incident in which the restraint chair is used:

1. The facility in which the chair is used;

2. The date and time of the use;

3. A brief description of the restraint, including the purpose for which the restraint was applied, the duration of the restraint, and the circumstances surrounding the resident's release from the restraint;

4. The extent to which the JCC complied with the regulatory requirements related to mechanical restraint chair use, as set forth in Sections 1203 through 1208 of this chapter; and

5. The plans identified to address findings of noncompliance, if applicable.

D. The annual report shall be placed on the agenda for the next regularly scheduled board meeting for the board's consideration and review.

**6VAC35-71-1208. Written procedures regarding mechanical restraint chairs.**

Department staff shall develop written procedures approved by the director that reflect the requirements established in this article.

## Part IX
## Privately operated JCCs

**6VAC35-71-1210. Private contracts for JCCs.**

A. ~~Each~~ A ~~The administration for~~ privately operated ~~JCC~~ JCCs shall abide by the ~~requirement~~ requirements of (i) the Juvenile Corrections Private Management Act (§ 66-25.3 et seq. of the Code of Virginia), (ii) ~~its~~ the governing contract with the department, and (iii) this chapter~~, and (iv) applicable department procedures, including but not limited to procedures relating to case management, the use of physical restraint and mechanical restraints, confidentiality, visitation, community relationships, and media access~~.

B. ~~Each~~ A ~~The administration for~~ privately operated ~~JCC~~ JCCs shall develop procedures, approved by the ~~department~~ director or the director's designee, to facilitate the transfer of the operations of the facility to the department in the event of the termination of the contract.

## Part X
## Boot Camps

### 6VAC35-71-1230. Definition of boot camp. (Repealed.)

For the purpose of this chapter, a boot camp shall mean a short-term secure or nonsecure juvenile residential program that includes aspects of basic military training, such as drill and ceremony. Such programs utilize a form of military style discipline whereby employees are authorized to respond to minor institutional offenses, at the moment they notice the institutional offenses being committed, by imposing immediate sanctions that may require the performance of some physical activity, such as pushups or some other sanction, as provided for in the program's written procedures.

### 6VAC35-73-1240. Staff Physical and Psychological Qualifications (Repealed.).

The boot camp shall include in the qualifications for staff positions a statement of:

1. The physical fitness level requirements for each staff position; and

2. Any psychological assessment or evaluation required prior to employment.

### 6VAC35-71-1250. Residents' Resident physical qualifications. (Repealed.)

The boot camp shall have written procedures that govern:

1. Admission, including a required which shall require a written statement from (i) a physician that the resident meets the American Pediatric Society's guidelines is cleared to participate in contact sports; and (ii) from a licensed qualified mental health professional that the resident is an appropriate candidate for a boot camp program; and

2. Discharge, should a resident be physically unable to keep up with continue the program.

### 6VAC35-71-1260. Residents' Resident nonparticipation. (Repealed.)

The boot camp shall have written procedures approved by the department director for dealing with addressing residents who are do not complying comply with boot camp program requirements.

### 6VAC35-71-1270. Program description. (Repealed.)

The boot camp shall have a written program description that states specifies:

1. How residents' physical training, work assignment assignments, education and vocational career readiness training, and treatment program participation will be interrelated;

2. The length duration of the boot camp program and the kind and duration of treatment and supervision that will be provided upon the resident's release from the residential program;

3. That any juvenile boot camp program established by or as a result of a contract with the department shall require at least six months of intensive after care following a resident's release from the boot camp program and the type of treatment and supervision that will be provided upon the resident's release from the program;

4. Whether residents will be cycled through the program individually or in platoons; and

4. 5. The program's incentives and sanctions, including whether military or correctional discipline will be used. If military style discipline is used, written procedures shall specify what summary punishments are permitted.

~~DOCUMENTS INCORPORATED BY REFERENCE (6VAC35-71)~~

~~Compliance Manual - Juvenile Correctional Centers, effective January 1, 2014, Virginia Department of Juvenile Justice~~

## CHAPTER 73 (6VAC35-73)

## Boot Camps

### 6VAC35-73-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Boot camp" means a short-term secure or nonsecure juvenile residential program that includes aspects of basic military training and that utilizes a form of military-style discipline whereby employees are authorized to respond to minor institutional offenses, by imposing immediate sanctions that may require the performance of some physical activity based on the program's written procedures.

"Department" means the "Department of Juvenile Justice."

"Director" means the director of the department.

"Resident" means an individual, regardless of age, who resides in a juvenile boot camp.

### 6VAC35-73-20. Staff Physical and Psychological Qualifications.

The boot camp shall include in the qualifications for staff positions a statement of:

1. The physical fitness level requirements for each staff position; and

2. Any psychological assessment or evaluation required prior to employment.

### 6VAC35-73-30. Resident physical qualifications.

The boot camp shall have written procedures that govern:

1. Admission, which shall require a written statement from (i) a physician or licensed medical provider that the resident is cleared to participate in contact sports; and (ii) a mental health clinician that the resident is an appropriate candidate for a boot camp program; and

2. Discharge, should a resident be physically unable to continue the program.

### 6VAC35-73-40. Resident nonparticipation.

The boot camp shall have written procedures approved by the director or the director's designee for addressing residents who do not comply with boot camp program requirements.

### 6VAC35-73-50. Program description.

The boot camp shall have a written program description that specifies:

1. How residents' physical training, work assignments, education and career-readiness training, and treatment program participation will be interrelated;

2. The duration of the boot camp program;

3. That any juvenile boot camp program established by or as a result of a contract with the department shall require at least six months of intensive after care following a resident's release from the boot camp program and the type of treatment and supervision that will be provided upon the resident's release from the program;

4. That the programming for such boot camp shall consider the therapeutic needs of each participant;

5. Whether residents will be cycled through the program individually or in platoons; and

6. The program's incentives and sanctions, including whether military or correctional discipline will be used and what summary punishments are permitted.

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1512 Willow Lawn Drive, Suite 100, Richmond, VA 23230
www.dLCV.org

T: 800-552-3962
F: 804-662-7431

November 27, 2019

Kristen Peterson, Regulatory Coordinator
Department of Juvenile Justice
PO Box 1110
Richmond, VA 23218-1110

RE: Regulations Governing Juvenile Correctional Centers

Dear Ms. Peterson,

The disAbility Law Center of Virginia (dLCV), the Commonwealth's federally mandated protection and advocacy system, respectfully submits the following public comment in relation to the Department of Juvenile Justice's (DJJ's) periodic review of its *Regulations Governing Juvenile Correctional Centers* (Regulations). For clarity, "Draft" means the September 20, 2019 draft regulations for this section.

dLCV would like to start by commending the Department of Juvenile Justice (Department), its Board, and participating stakeholders for all the dedicated work put into this process. It is clear that a strong focus was placed on ensuring proper care and treatment of youth committed to the Department.

In part, the proposed regulations give youth a stronger voice regarding their care (see the expanded role of the student government association, in Draft 6VAC35-71-90) and provide opportunities to maintain and strengthen family relations (see Draft 6VAC35-71-580 and Draft 6VAC35-71-765). At the center of these various initiatives is a commitment to work towards providing youth with a therapeutic environment. (Draft 6VAC35-71-735).

Regarding youth health and safety, the Department has made drastic changes to their regulations regarding room confinement. (Draft 6VAC35-71-1140). Room confinement is a traumatic experience that research has shown often exacerbates the behaviors that led to room confinement. The new proposed regulations ensure that staff do not subject youth to room confinement merely as punishment and that this practice is only used when necessary to maintain safety and security. When room confinement is used, the proposed regulations provide additional due process and health protections for youth. dLCV supports the Department's effort to reduce the use of room confinement and to increase the protections for youth when room confinement is used.

In addition, the proposed regulations also place additional restrictions on the use of the mobile restraint chair, a device which dLCV has seen lead to trauma, injury and even death. While dLCV advocates for the complete ban of the mobile restraint chair as it is unnecessary (evidenced by the fact that several juvenile detention centers do not use this device) and dangerous, the additional restrictions are an improvement from the regulations currently in effect. (Draft 6VAC35-71-1180)

dLCV has several recommendations regarding the most recent draft of the Regulations:

1. Due to the detrimental physical and mental health effects of room confinement, dLCV urges that the effective date of the revised 6VAC35-71-1140 be as early as possible.
2. The current proposed language allows the Department to manage and contract with "Boot Camps." (Draft Part X "Boot Camps") dLCV recommends that Boot Camps have the same requirements to maintain a therapeutic community environment as juvenile correctional centers.
3. The current proposed language allows for a facility to be put on "Lockdown" for the purpose of "relieving temporary tensions within the facility." The use of a "Lockdown" can result in confinement of youth to their housing unit or cells and thus should only be used when necessary for safety and security. The current phrase "relieving temporary tension within the facility" is vague and open to broad interpretation. dLCV recommends that this phrase be removed, or in the alternative, narrowed or defined in order to ensure that a facility is not placed on "Lockdown" unless necessary for safety and security. (Draft 6VAC35-71-10 and Draft 6VAC35-71-545)
4. dLCV recommends that the language prohibiting the use of spit guards and similar devices that the Board incorporated into the proposed juvenile detention center (JDC) regulations at the May 2019 DJJ Board meeting also be included in these Regulations. (See May 2019 board packet and corresponding board minutes) The additional protections for youth subjected to the mobile restraint chair incorporated into the JDC regulations at this meeting should also be included in the juvenile correctional center regulations. (*Id.*) However, the juvenile correctional center regulations should *not* expand the scope of use for this device beyond the current draft language due to the dangers in using this device, which are discussed briefly above. The limitation that staff only use this device in very specific circumstances for controlled movement of a resident should be retained in the proposed juvenile correctional center regulations.
5. dLCV recommends that there be a requirement that the facility-level review committee and the division-level review committee complete all case management reviews for youth confined to their rooms for more than five days within two business days. The current proposed language for this section bases the review time on the "next scheduled meeting" for these committees which fails to ensure that the committees complete the reviews within a certain time frame. Due to the detrimental effects of room confinement, these reviews should be completed as soon as possible and as frequent as possible to protect youth from

being confined to their rooms for longer than necessary. (6VAC35-71-1140(L) Draft).

6. For room confinement reports made to an administrator under Draft 6VAC35-71-1140(K), dLCV recommends that the report be required to contain a summary of the facts leading to the room confinement in addition to the current draft requirement for the report to outline "the steps being taken or planned to resolve the situation."
7. dLCV recommends a response time for all grievances, to ensure that violations of resident's rights are resolved in a timely manner. (Draft 6VAC35-71-80)
8. The "due process safeguards" afforded to residents when the facility transfers them to a more restrictive setting in accordance with Draft 6VAC35-71-710(B), should be required to be documented in writing and provided to the resident both at orientation and when the facility decides that it will make such a transfer.
9. Written procedures governing required housing unit visits of the assistant superintendent and the community manager should also specify the required frequency of such visits. (6VAC35-71-110(B) & (D) Draft).

DJJ should adopt the above recommendations and incorporate them into the *Regulations Governing Juvenile Correctional Centers*. dLCV is in strong support of all the current revisions that protect the rights and safety of youth in the care of the Department. Thank you for your thoughtful consideration of dLCV's public comment.

Sincerely,

Colleen Miller
Executive Director