

*Investigation of the Lansing Residential Center, Louis Gossett, Jr. Residential Center,  
Tryon Residential Center, and the Tryon Girls Center*  
U.S. Department of Justice, Civil Rights Division  
Letter to Honorable David A. Paterson  
August, 2009

Report Summary

Accounts of youth injured with broken bones, concussions, lacerations, bruises, and broken teeth from various incidents of unnecessary use of restraints and excessive force permeate this devastating report on the conditions in New York's juvenile justice facilities. At one center with a capacity of 50, 698 restraints were used in one year resulting in 123 injuries. Prone restraints, banned in many facilities nationwide, are particularly dangerous but remain in practice in New York State. In 2006, the use of a prone restraint resulted in a 15 year-old's death.

Life in juvenile justice facilities is particularly difficult for youth with mental illness. The report documents the appalling lack of appropriate mental health treatment in the facilities and the increased use of restraints on youth with mental illness. At one facility, boys with mental illness comprised 50% of the population but 82% of the restraint episodes. At another, girls represented 48% of the population and 60% of the restraints. Some of the incidents mentioned in the report reveal many circumstances where youth were put under restraint for demonstrating behaviors symptomatic of their mental illness, including head banging and self-mutilation.

The investigation of four upstate New York State juvenile justice facilities was conducted by the U.S. Department of Justice to assess whether or not youth were adequately protected from harm; specifically, were there incidents of sexual misconduct or unreasonable use of restraints. Two site visits were made to each facility in 2008. The investigation included a review of documents including policies, incident reports, medical records, unit logs and training materials; interviews with youth, staff, professionals, and administrators; and observations. The report found that corrective actions are required to protect youth from harm and to bring mental health care up to professional standards. Investigators did not find any systemic issues leading to sexual misconduct requiring improvement.

The report details numerous incidents where excessive force and inappropriate restraints were used in violation of OCFS policy. Investigators found that staff uses the same approach to discipline youth for small infractions such as taking a cookie at snack time without asking permission, slamming a door, or refusing to get dressed; they routinely used "pin pushing", calling a response team for support by pushing a button on their radio. Several staff members then arrive on the scene to aid the worker, often resulting in escalating the situation to one where restraint was used. Staff reported they knew of no other option to manage behavior in response to such incidents than this "one-size-fits-all" approach and that OCFS' recent policies to reduce the use of

restraints put their own safety at greater risk. The report went on to state that investigations of these incidents by administrators or staff were inadequate and in some cases were conducted by the staff involved in the incident. Corrective or disciplinary steps were lacking or inappropriate to the seriousness of the violation.

The report further documents inadequate diagnoses of mental health issues, inadequate administration of medication, and poor treatment planning. Psychiatric evaluations fell well short of professional standards and often conflicted with assessments and treatment plans by other providers. Treatment was often based on poor information and was ineffective. Little rationale was found in the records that indicated the use of a specific medication to treat targeted symptoms and little follow-up was provided to determine effectiveness and potential side-effects of that medication. Treatment team staff were more focused on behavior control instead of trauma-informed treatment planning. Often the outcome of poor treatment was the escalation of minor incidents into ones which triggered the aggressive reactions of traumatized youth. Unexpectedly, investigators found few youth identified with substance abuse problems and, in many instances, those identified as having a problem were not receiving treatment. In addition, youth with mental illness and substance abuse were treated for one but not both problems.

The report also details remedial measures that must be taken by OCFS. They include:

- a review of the use of physical restraint in OCFS facilities and changes to policies;
- increased training and supervision of staff;
- improved investigations of incidents and staff misconduct in order to protect youth from harm; and
- changes to policies and procedures to raise the level of mental health services provided for youth in placement - the diagnosis, use of psychotropic medications, treatment planning, and monitoring of mental illness - to professional standards.

The conditions found at these four facilities violated the constitutional rights of youth in placement and were so serious the Department of Justice may sue the state to take over the system if corrective actions are not taken. New York State does not plan to contest the findings in the report and has entered into negotiations with the U.S.

Department of Justice to remedy the system. The report is available at

[http://www.justice.gov/crt/split/documents/NY\\_juvenile\\_facilities\\_findlet\\_08-14-2009.pdf](http://www.justice.gov/crt/split/documents/NY_juvenile_facilities_findlet_08-14-2009.pdf)