PREA AUDIT REPORT Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: November 9, 2017

Auditor Information			
Auditor name: Peter Plant			
Address: 6302 Benjamin Rd. #400, Tampa, FL 33634			
Email: pplant@prodigy.net			
Telephone number: 813.784.4478			
Date of facility visit: July 13-14, 2017			
Facility Information			
Facility name: Lebanon Pines			
Facility physical address: 37 Camp Mooween Road, Lebanon, CT 06249			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 860-889-1717			
The facility is:	Federal	State	☐ County
	Military	Municipal	Private for profit
	☒ Private not for profit		
Facility type:	Community treatment center Halfway house ☒ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐Other-Phase Two Residential	
Name of facility's Chief Executive Officer: Rosann Rafala			
Number of staff assigned to the facility in the last 12 months: 60			
Designed facility capacity: 20			
Current population of facility: 17			
Facility security levels/inmate custody levels: N/A			
Age range of the population: 18+			
Name of PREA Compliance Manager: N/A		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of agency: Southeastern Council on Alcoholism & Drug Dependence, Inc.			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 37 Camp Mooween Road, Lebannon, CT 06249			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 860-886-2495			
Agency Chief Executive Officer			
Name: John F. Malone		**Title:** Executive Director	
Email address: jackmalone@scadd.org		**Telephone number:** 860-886-2495 x203	
Agency-Wide PREA Coordinator			
Name: Debbie Larew		**Title:** CSSD Coordinator	
Email address: debbielarew@scadd.org		**Telephone number:** 860-889-1717 x212	

AUDIT FINDINGS

NARRATIVE

The Southeastern Council on Alcoholism and Drug Dependence, Inc. (SCADD) is a private, non-profit agency incorporated in 1966 by a group of recovered professionals who realized the need for an alcoholism service structure. Today SCADD has been in operation for over 43 years and serves more than 3,500 individuals annually. The agency mission is to provide a treatment environment rich in cultural diversity where individuals and families are empowered to overcome substance abuse issues, thereby improving their quality of life. Located on 56 acres in the southeastern region of Connecticut, Lebanon Pines is a 110 bed long term facility for men with alcohol and drug addiction. The minimum length of stay is 90 days. Discharge planning is based on each individual's recovery goals.

The goal of this program is to provide a structured recovery environment with a focus on the psychosocial aspects of treatment. The program is a work therapy program, enhanced by behavioral health, vocational and educational components. Developing recovery skills, along with personal responsibility, managing signs and symptoms of relapse and lifestyle changes are the primary aspects of treatment in this program. Residents develop a knowledge base with which to accept their disease, prevent relapse and to provide motivation for re-integration into the community.

The Prison Rape Elimination Act (PREA) audit of the Lebanon Pines facility was initiated on June 1, 2017, by Peter Plant, a U.S. Department of Justice Certified PREA Auditor for Adult and Juvenile facilities. The Auditor sent the agency/facility the PREA Audit Notices (in English and Spanish) to be posted in the facility in areas where detainees, staff, contractors, volunteers, interns, and visitors may be found. Additionally, the Auditor provided the PREA Coordinator with the Checklist of Documentation and the Pre-Audit Questionnaire, as well as instructions as to how to format the flash drive for the uploading of documents.

The flash drive containing the required documentation and the Pre-Audit Questionnaire was received by June 15, 2017. The Auditor conducted a thorough review of the documentation and data, which included agency policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials that were provided to demonstrate compliance with the PREA standards. The flash drive also included multiple pictures of the audit noticed posted throughout the campus, most being taped to entry/exit doors at eye-level. Questions and issues, relating to compliance with the Standards, raised during this review were documented on the applicable Compliance Tool. A telephone conference call to discuss these items and the audit process was held. The Auditor also requested the PREA Coordinator to provide a written list of facility administrative personnel, specialized staff, medical and mental health staff, and security staff.

During the course of the pre-audit period it was determined that there are currently two contracts for services, one being for 20 treatment beds for the Court Support Services Division (CSSD) of the Connecticut Judicial Branch. It was this population that is the subject of this audit. The CSSD requires each of its contractors to have a PREA audit every three years, even if the facility does not meet the threshold for requiring an audit, e.g., under CSSD contracts even a facility that has only one or two clients is required to have an audit. The remaining beds at this facility are not correctional and do not fall with PREA requirements.

The Auditor arrived at the facility on July 13, 2017 at 8 a.m. and met with the PREA Coordinator and Executive Director. An overview of the audit process was provided and was followed by a tour of the facility.

During the course of the audit interviews were conducted with the agency Executive Director, the PREA Coordinator, the Program Director, administrative human relations staff, two staff who conduct admissions and risk screening assessments, respectively, APRN and two nursing staff, ten counselors and supervision staff, and ten of CSSD contracted residents of fifteen residents on-site.

DESCRIPTION OF FACILITY CHARACTERISTICS

As mentioned above, the facility is located on 56 acres of wooded land in the southeastern region of Connecticut. At first impression it appears to be a retreat or resort-like setting. There are five resident buildings dining hall, administration building, nurse station, library, recreation spaces, and spaces for a green house, woodshop, garage, pavilion, and storage. Admissions are all conducted at the nurse's station.

The residence buildings are configured in dormitory style. Residents are assigned to various buildings, based on their contract referral source, but this is not rigid. For example, if a resident were threatened in their "base" residence, he or she could be moved to another building for their protection. The CSSD clients are currently housed in Building 1.

SUMMARY OF AUDIT FINDINGS

The Interim Report reflected that 0 Standards were exceeded, 25 Standards were met, 7 Standards were not met, and 7 Standards were not applicable. It is important to note that of the 7 Standards not met, four were for not having an MOU in place with Safe Futures for the services the latter was making available to residents. The remaining three Standards involved the posting of certain items on the agency website. All seven Standards were fully corrected and are now in compliance.

Number of standards exceeded: 0

Number of standards met: 32

Number of standards not met: 0

Number of standards not applicable: 7

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has a comprehensive written policy, stating it has a "zero tolerance toward all forms of sexual abuse and sexual harassment, particularly in its residential facilities. All SCADD employees are responsible for helping keep SCADD's facilities free of sexual abuse and sexual harassment. All incidents of sexual abuse and sexual harassment will be reported and investigated thoroughly. Any SCADD employee who engages in the sexual abuse or sexual harassment of an individual in one of SCADD's facilities or who is found to be negligent in pursuing these responsibilities will be subject to disciplinary and/or corrective action. Arrest and prosecution may also be pursued when conduct requires such response." In addition, "Any SCADD volunteer or intern who engages in the sexual abuse or sexual harassment of an individual in a SCADD program will be terminated," and, "Any contractor who engages in the sexual abuse or sexual harassment of an individual in a SCADD program may be subject to contract cancellation."

These and supplemental policies are detailed, outlining the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment. It includes specific definitions of prohibited behaviors and possible sanctions for both staff and residents. The agency has designated its CSSD Liaison as the PREA Coordinator. She reports that she has sufficient time and authority to develop, implement, and oversee the agency's and facility's efforts to comply with PREA standards. This was clearly evident throughout the audit and in interviews with facility staff and residents.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Southeastern Council on Alcoholism and Drug Dependency is not a public agency, nor does it contract with other entities for the confinement of residents; therefore, this standard is N/A.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

A staffing plan dated November 3, 2016, was provided during the Pre-Audit stage. It complies with the Standard and also with the facility's policy, which mirrors the requirements of the Standard and requires an annual review. There were no noted deviations from the plan. The facility has in place an on-call staffing procedure, or if that is not effective, overtime is approved until the staff can be relieved. The facility's 2016 Annual Report reflects that were no PREA-related incidents during the year, evidencing that the current staffing plan is adequate.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Agency policy prohibits a resident physical search solely for the purpose of determining a resident's genitalia status. Residents may, at any time, be subject to random personal searches. This search will include emptying all pockets, removing shoes, removing belt and jacket or coat for a visual inspection. This inspection will not, under any circumstances, involve physical touching. This was confirmed by all residents and staff interviewed. Facility policy also states that all residents have the right to privacy while in a state of undress, including but not limited to the shower facilities, bathroom facilities, and bedroom. Non-medical staff of the opposite gender are not permitted to enter any private living areas (bedroom or bathroom) without being properly announced. Again, all residents interviewed confirmed that this policy is consistently enforced. Not one had a complaint in this regard.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Agency policy states that when a resident limited in English proficiency is referred to a SCADD program, the receiving program will make a reasonable effort to accommodate the language needs of the individual. These efforts may include engaging the assistance of bi-lingual staff, and paid or unpaid interpreters and/or translators. These efforts may also include the use of telephone interpreters, when appropriate. PREA education and information materials are provided in both English and Spanish. The use of peer translators will be engaged only where an extended delay in obtaining an effective interpreter could compromise the client's safety or the performance of first responder duties.

The facility has not admitted any residents with either physical or intellectual disabilities during the previous twelve months; however, facility administrators stated that their agency has the resources necessary to assist in communicating with such residents, whenever necessary.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Agency policy states that the agency will not hire or promote anyone, or enlist the services of any contractor, who may have contact with residents, consistent with all the criteria in the standard. The agency conducts a criminal history background check, as well as a review of state Department of Motor Vehicles records. References are also checked. If the candidate has been employed within a prison institution, the supervisor will make his or her best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The agency does consider any incidents of sexual harassment, as well as any other concerning behavior, with regards to promotion or hiring decisions. Agency policy requires all background checks to be run every five years. The agency complies with state law, regarding providing prospective employers with allegations of sexual abuse or sexual harassment.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The facility did not make any upgrades, so this Standard is N/A.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency does not conduct sexual abuse allegations. The agency states that it would take a victim to a local hospital to provide medical exams and advocacy for victims of sexual assault, forensic exams follow SANE protocols, and that such exams are provided at no cost to the resident; however, there is no documentation of this resource.

CORRECTIVE ACTION REQUIRED: The agency and facility should attempt to enter into an MOU with a local hospital that provides no-cost to resident forensic exams that follow SANE protocols and with the Safe Futures agency or similar resource for victim advocacy services. The availability of this resource should be made known to CSSD residents through a brochure and posting in the living dorm where the CSSD residents reside.

CORRECTIVE ACTION COMPLETED: On October 16, 2017, the agency entered into an MOU with Safe Futures, which meets the requirements of the Standard. Although CSSD residents were aware of the services available from Safe Futures prior to the implementation of the MOU, they have been informed of the MOU.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Agency policy requires that all incidents of sexual abuse and sexual harassment will be reported and investigated thoroughly. All staff interviewed confirmed they understood the policy and their reporting duties. All incidents or complaints of alleged sexual abuse, sexual harassment, or retaliation involving LP CSSD residents or LP residents will be immediately reported to the highest level supervisor on duty. The Supervisor will contact the Lebanon Pines PREA Coordinator for any incidents involving an LP CSSD resident. The Lebanon Pines PREA Coordinator will contact the Program Director and initiate an investigation into the complaint or reported incident in accordance with all appropriate policies and procedures.

If an employee learns that a CSSD resident was sexually abused while confined at another facility, the employee must contact their PREA Coordinator, as soon as practical, but no later than 48 hours from the time of the report. The PREA coordinator must notify the head of the facility where the alleged sexual abuse occurred, as soon as practical, but no later than 72 hours from the time of the report and contact the Judicial Branch PREA Coordinator. The allegation and report to the facility where the alleged sexual abuse occurred will be documented on the PREA Incident Report Form.

The Connecticut State Police serves as the investigating authority for all allegations of sexual abuse that occur within Lebanon Pines. All allegations of sexual abuse that occur at Lebanon Pines either between LP CSSD residents or between LP CSSD and LP residents or by a SCADD employee must be reported to the Connecticut State Police. The Lebanon Pines Program Director, the Executive Director of SCADD, the Judicial Branch and the Lebanon Pines PREA Coordinator should all be notified within 2 hours of the incident report. Notification of the Connecticut State Police shall be done by the Executive Director or his/her designee immediately following the above notifications. Sexual abuse investigations by the Connecticut State Police may occur concurrently with an administrative investigation by SCADD personnel. SCADD will assist the Connecticut State Police, as needed.

There were no sexual abuse or sexual harassment allegations during the previous twelve months.

The Standard requires that the agency's policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior, is published on its Web site. Currently, this policy is not published on its website.

REQUIRED CORRECTIVE ACTION: The agency must publish its policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior, on its Web site.

CORRECTIVE ACTION COMPLETED: The agency added a PREA Information section to its Residential Programs webpage which meets the requirements of the Standard.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility training mirrors all of the requirements of the standard, including all ten elements of the required curriculum. The curriculum is very detailed and is presented by the agency PREA Coordinator, who is very knowledgeable about the PREA standards and requirements. The training is especially strong in the area of how to communicate effectively with residents and the provision of trauma-informed care. Refresher training is provided, as required at least every two years. Training records are well documented and signed. A review indicated that all staff in the review sample were properly trained. During staff interviews staff demonstrated knowledge of the PREA requirements.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy mirrors the requirements of the standard. Agency policy states that it will not enlist the services of any individual contractor who may have contact with LP CSSD residents or LP residents who has engaged in, or has attempted to engage in, sexual abuse. The agency will consider any incidents of sexual harassment in determining whether to enlist the services of any individual contractor who may have contact with LP CSSD residents or LP residents. Contractors will be required to provide evidence that they perform criminal history checks for all staff who will have contact with Lebanon Pines residents and that crimes related to sexual abuse would exclude the person from providing any services to the agency and facility. Contractors and volunteers are provided a copy of the agency's PREA brochure.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Facility policy states that during the admission process, all LP CSSD residents are provided information about SCADD's zero-tolerance policy along with instructions for reporting a complaint. This information is delivered both verbally and in writing. Brochures written in Spanish are available for people with limited English proficiency. Staff did not report any other languages, or disabilities, that caused problems with communication. Residents sign a receipt document in regard to being informed of the PREA policy which is placed in the resident chart. PREA information flyers are posted throughout the facility in both English and Spanish. All residents interviewed reported they received the admission orientation and understood how they could make a report.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The agency, nor facility, conduct criminal or administrative investigations. Such investigations are conducted by the Connecticut State Police; therefore, this standard is N/A.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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No full-time or part-time mental health care practitioners regularly work in the facility. All mental health needs of residents are met through referrals to community-based practitioners. The nurses interviewed stated that their professional training included the required specialized training. They do not perform forensic exams.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy mirrors all the requirements of the Standards. The facility screening instrument is objective in nature and contains all the elements required by the standard. Screenings are required to be conducted within 72 hours; however, a review of sample resident files indicated that all screenings are actually completed within 24 hours. Residents are informed that they would not receive disciplinary action, if they refused to disclose information. Resident interviews confirmed that residents receive both screenings and that they are not threatened with disciplinary action, if they refuse to disclose any information.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy states that if a new admission scores as high risk for victimization or perpetration adjustments in housing assignment will be made, although to date, this has not occurred. This is an on-going process. All residents' own views with respect to his or her own safety are given serious consideration. This was confirmed during interviews with residents who had high praise for how staff treat them. The decision-making process and individualized determinations are documented. There are sufficient rooms in a number of buildings to ensure that high risk residents can be adequately separated and protected. All residents interviewed stated they have felt safe in their current housing.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Facility policy states that the agency will accept all reports of sexual abuse and sexual harassment seriously, regardless of who made the report or the manner in which the report was made. Reports of sexual abuse, sexual harassment, or retaliation may come from a variety of sources including, but not limited to, employees, individuals in treatment, family members of individuals in treatment, other agencies and facilities, and members of the public. These reports can be made verbally and/or

in writing and/or anonymously. Anyone who wishes to make a report to a public or private office that is not part of the agency may make their report directly to the State of Connecticut Department of Mental Health and Addiction Services Resident Rights Division.

All staff interviewed stated that they are aware of their duty to report and that they can make reports privately and anonymously, but none reported doing so. Likewise, all residents interviewed knew they could make a report privately, as well as anonymously, if they choose; however, none reported doing so. Most of the residents interviewed stated that they would tell a relative, if they wanted to report outside the facility.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Allegations of sexual abuse or sexual harassment are not allowed to be reported through the resident grievance system, therefore this Standard is N/A.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility states that it would provide these support services through referrals to Safe Futures, a sexual assault crisis center, in New London, CT; however, none of the residents interviewed were aware of this resource. The agency and facility do not have am MOU with this agency.

CORRECTIVE ACTION REQUIRED: The agency and facility should attempt to enter into an MOU with the Safe Futures agency or similar resource. The availability of this resource should be made known to CSSD residents through a brochure and posting in the living dorm where the CSSD residents reside.

CORRECTIVE ACTION COMPLETED: On October 16, 2017, the agency entered into an MOU with Safe Futures, which meets the requirements of the Standard. Although CSSD residents were aware of the services available from Safe Futures prior to the implementation of the MOU, they have been informed of the MOU.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Facility policy states, and visitors are informed through provision of a brochure, that anyone who wishes to make a report to a public or private office that is not part of the agency may make their report directly to the State of Connecticut Department of Mental Health and Addiction Services Resident Rights Division.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy mirrors all the requirements of the standard. All agency employees, regardless of title, are under a duty to report any knowledge, suspicion, or information regarding incidents and complaints of sexual abuse, sexual harassment. All agency employees are also under a duty to report any act of retaliation against any individual for reporting an incident of sexual abuse or sexual harassment or for participating in an investigation of an allegation of sexual abuse or sexual harassment. All agency employees, regardless of title, are also under a duty to report any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff should not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Staff interviews indicated that all staff are very aware of their PREA-related reporting duties. They also are aware of the requirements not to reveal any information, except as necessary to make appropriate decisions. All of the staff stated that they would report any allegations to their supervisor and not reveal such information to anyone, other than upper management and any state or local investigators. The nursing staff interviewed stated that they inform residents of their duty to report any form of abuse. This was confirmed by most of the residents; however, three residents just could not recall if they were informed.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

Facility policy states that if there is concern that the resident is at risk of imminent sexual abuse, the resident will immediately be brought to a safe place with staff present, and supervisory staff will determine a plan to establish the resident's safety. The first choice in this regard is to move the resident to a room in another building. During the tour it was evident that the facility has sufficient vacant rooms in several buildings that could accommodate a move. During interviews with management it was clear that any resident who threatened any one would not be allowed to remain in the program. Interviews with agency and facility management, as well as with staff, confirm that all have a strong sense of their duty to protect residents. Importantly, interviews with residents confirmed that they believe that staff will protect them, if needed. Several residents expressed that this facility was the safest they have ever been in.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility

Facility policy mirrors all the requirements of the standard. If an employee learns that a CSSD resident was sexually abused while confined at another facility, the employee must contact their PREA Coordinator as soon as practical but no later than 48 hours from the time of the report. The PREA coordinator must notify the head of the facility where the alleged sexual abuse occurred as soon as practical, but no later than 72 hours from the time of the report and contact the Judicial Branch PREA Coordinator. The allegation and report to the facility where the alleged sexual abuse occurred will be documented on the PREA Incident Report Form. There were no allegations of this nature received during the previous twelve months.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy mirrors the requirements of the standard. All staff are considered first responders, and staff interviews confirmed that all staff understand their duties as a first responder in a PREA-related incident. In the event of an allegation of recent sexual abuse, security and nursing staff (if available) should be notified immediately. The first security staff to respond should ensure the alleged victim and perpetrator have been separated. Simultaneously, another staff member shall call Emergency Medical Services and the State Police who shall be in charge of the crime scene and investigation. Once resident safety is established, security staff will restrict access to the scene. Medical staff will attend to any urgent needs of the alleged victim while requesting efforts to preserve the physical evidence if the alleged abuse was recent. This includes not: washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating. Security staff will attempt to ensure the alleged abuser does not do the above actions that may destroy evidence as well. Any staff present before security arrives should attempt to preserve the evidence until the authorities arrive. There were no PREA-related incidents during the

previous twelve months.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility has a facility-specific coordinated response plan that details the actions to be taken by first responders and facility administrators. Staff interviews confirmed that staff are aware of their responsibilities in being a first responder.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility does not have any collective bargaining agreements; therefore, this standard is N/A.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy mirrors all the requirements of the standard. Any employee, contractor, intern, volunteer, or individual under the supervision of CSSD who reports an incident of sexual abuse or sexual harassment or cooperates in a sexual abuse or sexual harassment investigation must not be retaliated against. Any complaint of retaliation by an employee, contractor, intern, volunteer, or individual under the supervision of CSSD will be reported and investigated in accordance with the procedures and instruction provided in this policy. Any individual who is found to have been in violation of this policy will be subject to appropriate disciplinary action or referred to the State Police for criminal investigation. The Clients Rights Officer or her or his designee will monitor the resident for the duration of treatment to ensure there will be no retaliation. Any

employee who believes that an incident involving sexual abuse, sexual harassment, or retaliation has occurred, or who received a complaint about such activity shall immediately contact any of the following: the SCADD PREA Coordinator, the Program Director, the Deputy Director, the Executive Director, the nursing staff, counseling staff, security staff or any other program staff. Employees must notify the appropriate personnel.

There were no incidents or allegations during the previous twelve months that required protective measures of any kind. As mentioned earlier, all agency and facility staff are keenly aware of their duties to protect residents under any circumstances. None of the residents interviewed stated that they had been the subject of retaliation.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency, nor facility, conduct criminal or administrative investigations. Such investigations are conducted by the Connecticut State Police; therefore, this standard is N/A.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency, nor facility, conducts criminal or administrative investigations. Such investigations are conducted by the Connecticut State police; therefore, this standard is N/A.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

The agency, nor facility, conduct criminal or administrative investigations. Such investigations are conducted by the Connecticut State Police. There were no such investigations during the previous twelve months; however, facility policy addresses all requirements of this Standard.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy mirrors all requirements of the standard. Should any investigation conclude there was employee sexual abuse, sexual harassment, or staff misconduct or neglect which contributed to the incident, the findings will be referred to the staff member's supervisor and Human Resources for disciplinary action up to and including employment termination. The disciplinary actions should take into account the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies. There were no PREA-related violations during the previous twelve months.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy reflects the requirements of the standard. Should any investigation determine that there was sexual abuse or sexual harassment perpetrated by a contractor or volunteer, the agency will terminate the relationship with the individual and notify the contracting agency, if applicable. There were no PREA-related incidents involving contractors or volunteers in the previous twelve months that required corrective action.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy mirrors all the requirements of the standard. Should the findings of the Administrative or Criminal investigation find a resident perpetrated sexual abuse of another resident, if the perpetrator is still a client at the time of the investigation's findings, they will be discharged from Lebanon Pines with a referral to a more appropriate provider. If the perpetrator is a CSSD client, they will be referred back to court within one business day by the CSSD Coordinator. The client's mental disabilities and behavioral health issues will be taken into account when making the referral. There were no PREA-related incidents in the previous twelve months that required disciplinary sanctions for residents.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility states that it would provide these emergency medical and mental health services through referrals to Safe Futures, a sexual assault crisis center, in New London, CT; however, none of the residents interviewed were aware of this resource. The agency and facility do not have am MOU with this agency.

CORRECTIVE ACTION REQUIRED: The agency and facility should attempt to enter into an MOU with the Safe Futures agency or similar resource to ensure that the emergency medical and mental health services required by this Standard are available to residents at no financial charge. The availability of this resource should be made known to CSSD residents through a brochure and posting in the living dorm where the CSSD residents reside.

CORRECTIVE ACTION COMPLETED: On October 16, 2017, the agency entered into an MOU with Safe Futures, which meets the requirements of the Standard. Although CSSD residents were aware of the services available from Safe Futures prior to the implementation of the MOU, they have been informed of the MOU.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility states that it would provide these ongoing medical and mental health services for sexual abuse victims and abusers through referrals to Safe Futures, a sexual assault crisis center, in New London, CT; however, none of the residents

interviewed were aware of this resource. The agency and facility do not have am MOU with this agency.

CORRECTIVE ACTION REQUIRED: The agency and facility should attempt to enter into an MOU with the Safe Futures agency or similar resource to ensure that the ongoing medical and mental health services required by this Standard are available to residents at no financial charge. The availability of this resource should be made known to CSSD residents through a brochure and posting in the living dorm where the CSSD residents reside.

CORRECTIVE ACTION COMPLETED: On October 16, 2017, the agency entered into an MOU with Safe Futures, which meets the requirements of the Standard. Although CSSD residents were aware of the services available from Safe Futures prior to the implementation of the MOU, they have been informed of the MOU.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy states that following every investigation in which there is a substantiated or unsubstantiated finding that sexual abuse occurred the Quality Assurance Committee of SCADD will initiate a review of the incident within 30 days of the conclusion of the investigation. Upon the conclusion of the review, the facility will implement the recommendations for improvement or document its reasons for not doing so. There were no PREA-related incidents during the previous twelve months.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy states that data will be compiled annually into a report in order to assess the agency's prevention, detection and response policies, practices and trainings. The report should include identifying problem areas, taking corrective actions, and comparing current data to the prior year's data in order to determine progress in preventing sexual harassment and abuse. The report should be approved by the Executive Director and kept in printed form available for public request; however, during the course of the audit facility management indicated it would be adding this report to their website. The report will maintain confidentiality in accordance with all state and federal regulations. There were no PREA-related incidents during the previous twelve months.

REQUIRED CORRECTIVE ACTION: The report required by this Standard must be posted on the agency's website.

CORRECTIVE ACTION COMPLETED: The Report has been added to the agency website.

Standard 115.288 Data review for corrective action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility policy states that data will be compiled annually into a report in order to assess the agency's prevention, detection and response policies, practices and trainings. The report should include identifying problem areas, taking corrective actions, and comparing current data to the prior year's data in order to determine progress in preventing sexual harassment and abuse. The report should be approved by the Executive Director and kept in printed form available for public request; however, during the course of the audit facility management indicated it would be adding this report to their website. The report will maintain confidentiality in accordance with all state and federal regulations. There were no PREA-related incidents during the previous twelve months.

REQUIRED CORRECTIVE ACTION: The data report required by this Standard must be posted on the agency's website.

CORRECTIVE ACTION COMPLETED: The Report has been added to the agency website.

Standard 115.289 Data storage, publication, and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

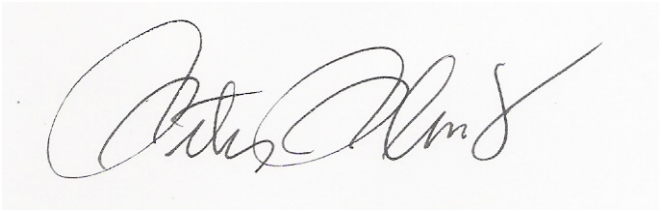
Facility policy requires that all PREA-related data be securely maintained for 10 years. During the course of the audit facility management indicated it would be adding this report to their website.

AUDITOR CERTIFICATION
I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.



November 9, 2017

Auditor Signature Date