Prisma
Legal Center
For Youth Justice

September 24, 2024

Board of State and Community Corrections
Juvenile Regulations Revision Executive Steering Committee
Medical and Mental Health Workgroup

Via email:

Dear Medical and Mental Health Workgroup Members,

Please consider the following comments and suggestions as you deliberate on the appropriate minimum standards juvenile facilities required to keep youth safe, staff and communities safe; provide threshold levels of adequate treatment and rehabilitative services to young people; and ensure basic dignity, care, and humane treatment of securely confined young people.

Discussion Issue– Use of Force:

It is time, indeed long past time, for California to end the use of chemical agents in juvenile facilities. The practice is cruel, poorly tracked, ineffectively overseen and investigated, counterproductive, dangerous and possibly lethal, and out of step with modern systems of juvenile justice and rehabilitation.

The chemical agents used in California's juvenile facilities are, for all intents and purposes, weapons. There are several forms of chemical agent used by law enforcement, and all are currently allowed under the BSCC's existing regulation. ***To date, the BCSS has not prohibited the use of any chemical agent against children in California facilities.*** The agents are designed to irritate the mucous membranes in the eyes, nose, mouth, and

lungs.[1] *They are used to incapacitate a person by causing a variety of reactions including a burning sensation, temporary blindness, body spasms, and difficulty breathing.*[2]

The agent generally used is oleoresin capsicum (also known as OC spray, agent OC, or pepper spray). OC spray, which acts on an individual's TRPV1 pain receptors and stimulates the nerve to cause a burning sensation, was developed in the United States as a deterrent against wild animals.[3] Calling it pepper spray is really a misnomer. The heat of law enforcement issued OC spray is over a thousand times more powerful than the heat from a jalapeno pepper, and it is stronger than commercially available defense sprays. When an individual is assault by OC spray their eyes will immediately close, due to a "bubbling or boiling sensation," and this will be quickly followed by temporary blindness and intense eye pain. The short-term effects can last from 30 to 45 minutes, and include burning in the throat, wheezing, gagging, gasping, inability to breathe, and blistering of the skin.[4]

There is, quite simply, no place for the use of chemical agents in juvenile facilities. In addition to working a direct physical and emotional harm on youth, research suggests these weapons spray can actually increase violence, and are prone to the sort of improper use, such as that described in the OIG.[5] For somewhat obvious reasons, there are not studies cataloguing the effects of chemical agents being used against children, but harm can be fairly extrapolated to youth based on the short and long term effects in the adult population, which include the following:

- *Intense pain, swelling, and blistering of the skin;*
- *Wheezing and an inability to breathe or speak;*
- *Acute hypertension, which may lead to an increased risk of stroke or heart attack;*
- *The deterioration of nerve tissue and permanent corneal damage;*
- *Potential asphyxiation when used in conjunction with physical or mechanical restraint, or when used on individuals with respiratory conditions such as asthma;*
- *Respiratory failure possibly resulting in death;*
- *Immediate death from severe chemical burns to the throat and lungs; and*

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[1] *CENTERS FOR DISEASE CONTROL AND PREVENTION, FACTS ABOUT RIOT CONTROL AGENTS (2003) 1 available at https://emergency.cdc.gov/agent/riotcontrol/factsheet.asp; Eugene J. Olajos & Harry Salem, Riot Control Agents: Pharmacology, Toxicology, Biochemistry and Chemistry, 21 J. APPLIED TOXICOLOGY 355 (2001).*

[2] *Chemical Agents in Juvenile Facilities. Center for Children's Law and Policy. (July 2019)*

[3] Lethal in Disguise 2: How Crowd Control Weapons Impact Health and Human Rights, p. 3 available at: https://lethalindisguise.org/wp-content/uploads/2023/03/LID2-Chemical-Irritants.pdf

[4] *Report Back on Ensuring Safety and Humane Treatment in the County's Juvenile Justice Facilities. County of Los Angeles Office of the Inspector General.*

[5] *Id.*

- *Blindness and glaucoma.*

To make matters worse, children with disabilities, mental illness, and risk of self-injury are disproportionately impacted by chemical agents in juvenile facilities. According to an investigation of Kern County by Disability Rights California, for instance, seven of the nine incidents they reviewed using pepper spray involved youth with documented disabilities. As DRC has stated, "*[y]outh with ADHD and bipolar disorder appear to have been pepper-sprayed for behavior related to their disabilities, over which they have little control.*"[6] That the BSCC, and therefore the State of California, cannot with any degree of certainty say how many times chemical agents were used against young people in juvenile facilities in the course of a week, a month, or a year, to say nothing of how many of those incidents involved youth with documented disabilities, is shameful and should horrify the public at large.

As of 2011, California is one of only 5 of states that allowed juvenile facility personnel to carry these brutal chemical weapons for use against children and only 15 allowed their use at all.[7] Since then more states have prohibited their use in juvenile institutions, leaving California in an ever-shrinking minority of jurisdictions that still allow the use of chemical agents against children.[8]

It is critical that the BSCC finally, albeit very late, arrive at the conclusion that so many other jurisdictions, legislatures, and administrative bodies did long ago: ***the use of chemical agents against children and youth is abusive and cannot be tolerated as a legitimate state act.***

Discussion Issue– Use of Physical Restraints:

The BSCC must make significant efforts to bring the State's minimum standards into line with those across the country and with modern international standards on the treatment of children. These steps must include:

1) prohibiting the use of prone restraints,
2) banning use of "the WRAP,"
3) specifying which mechanical restraints may be utilized in juvenile facilities, and
4) prohibiting the use of any restraint (physical or mechanical) except in situations when a youth's behavior presents an imminent danger of serious harm to self or others.

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[6] https://www.disabilityrightsca.org/post/drc-letter-supporting-phasing-out-pepper-spray-in-juvenile-facilities
[7] *Council of Juvenile Correctional Administrators, Issue Brief: Pepper Spray in Youth Facilities (May 2011).*
[8] *Chemical Agents in Juvenile Facilities. Center for Children's Law and Policy. (July 2019)*

Prone Restraints:

A prone restraint is defined as the application of a restraint on a person in a face down position. It may sound innocuous when compared with chemical agents or mechanical restraints, but prone restraints represent a serious and unjustifiable risk to youths' safety. They are associated with positional and restraint related asphyxia, and under certain conditions, which may go undetected, can lead to death. According to a report by Disability Rights California, the resulting cause of death from positional asphyxia "is a sudden fatal cardiac arrhythmia or respiratory arrest due to a combination of factors causing decreased oxygen delivery at a time of increased oxygen demand."[9]

Despite the known danger the restraints pose, they became commonplace in juvenile facilities for decades, and children paid an extraordinary cost. In one study that reviewed 79 confirmed restraint deaths over 26 years, the leading cause was asphyxia followed by heart arrythmia, suffocation, and exertion— and in 14 of the incidents reviewed, researchers confirmed reports of children saying "I can't breathe" or "I give [up]" just prior to losing consciousness.[10]

Just a few weeks before the death of George Floyd, Cornelius Frederick, age 16, was killed when multiple staff members placed him in a prolonged restraint for throwing a sandwich in the cafeteria of a Michigan residential treatment facility.[11] In response, Michigan officials announced they would be "immediately prohibiting the use of prone restraints, or pinning a child face-down, as well as any other restraint that restricts a child's breathing."[12] New York State followed suit and banned the use of prone restraints in residential group homes and its remaining juvenile detention facilities— New York banned prone restraint in most juvenile justice facilities years earlier in the wake of a lawsuit.[13] Facing the threat of litigation, California, which had youth placed at facilities all over the country, including the one where Cornelius was killed, brought all youth back to California

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[9] The Lethal Hazard of Prone Restraint: Positional Asphyxiation, Disability Rights California (2002)
[10] *Nunno, M.A., McCabe, L.A., Izzo, C.V. et al. A 26-Year Study of Restraint Fatalities Among Children and Adolescents in the United States: A Failure of Organizational Structures and Processes. Child Youth Care Forum (2021). https://doi.org/10.1007/s10566-021-09646-w*
[11] https://www.nbcnews.com/news/us-news/video-shows-fatal-restraint-cornelius-fredericks-16-michigan-foster-facility-n1233122
[12] *https://www.freep.com/story/news/local/michigan/2020/07/16/ban-dangerous-restraints-youth-centers-corneliusfredericks/5450551002/*
[13] *https://www.thecity.nyc/2020/11/30/21754333/new-york-state-ban-face-down-restraining-hold-foster-care*

and ended the use of out-of-state placement.[14] Unfortunately, the state took no steps to prevent the same harm from occurring at its in-state facilities.

Laws applicable to state hospitals operated by the State Department of State Hospitals, significantly limit the use of prone restraints and in some cases prohibit the practice. Health & Safety. Code § 1180.4. (A copy of the statute is included as ATTACHMENT A.) This includes Patton State Hospital whose population includes felony defendants found incompetent to stand trial, parolees who committed certain offenses who are committed for the term of their parole, persons civilly committed pursuant to California Penal Code § 2972 as a danger to themselves or others, persons found not guilty by reason of insanity, and individuals convicted of specified sexual offenses who are civilly committed as sexually violent predators at the conclusion of their sentence. Certainly, the population of Patton can be understood as presenting more challenges and safety concerns than any of the juvenile facilities regulated under Title 15. It should be, at the very least, possible for juvenile facilities to afford the same basic protections to children that the law affords to one of the most challenging populations of adult offenders. The average person might expect that youth receive even greater protections and treatment, but anything less should be considered outrageous.

"The WRAP"

The wrap is yet another disturbing law enforcement tool to emerge from California. Developed by a Walnut Creek police officer and tested by the Walnut Creek Police Department, the wrap is and marketed as a safer and less traumatic restraint, but it has no research or evidence to support its claims.[15] Despite this dearth of evidence, law enforcement agencies have been quick to believe the hype[16] and adopt policies for use of the wrap. This includes county probation departments, several of which allow the use of the device in their juvenile facilities. Indeed, the device has been discussed at BSCC meetings as a safer alternative adopted by some counties.

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[14] *https://imprintnews.org/child-welfare-2/foster-youth-cornelius-fredericks-death-change-nationwide/53986*

[15] https://www.kalw.org/show/crosscurrents/2016-11-21/why-one-popular-body-restraint-used-by-police-cant-always-guarantee-safety

[16] The wrap is heavily marketed including through conferences and professional associations. The Sebastian County Juvenile Detention Center in Arkansas initially tried out the device after winning it as a door prize at a statewide conference. https://www.arkansasonline.com/news/2014/oct/11/3-youth-lockups-urged-to-end-use-of-wra/

Contrary to the unsupported statements of the manufacturer and adopters of the device, the wrap poses serious risks to the health, safety, and well-being of children. And it should be immediately banned in California's juvenile facilities.

In a March 2020 decision from the United States District Court for the Southern District of Iowa, the Court found that use of the wrap in a juvenile facility to be "unconscionable deeply concerning" and in that case held it to violate youths' Fourteenth Amendment substantive due process rights. In issuing the decision, the Court found:

> "**The Court begins with the harms caused by the wrap. It is detrimental to a youth's mental health. It triggers feelings of panic, duress, and claustrophobia. It can traumatize youth in the first instance, and retraumatize youth that have previously suffered trauma. It exacerbates a youth's sense of powerlessness, fear, and paranoia. For students who have been physically or sexually abused, the loss of control they feel in the wrap replicates the feelings they suffered when abused. It is not rehabilitative and creates an increased risk of mental deterioration while students are in the device. Students weep in the wrap. It "crushes both body and spirit."**
>
> **For students with serious health conditions, the wrap can create substantial risks of physical harm as well."**[17]

In 2014, the Arkansas juvenile ombudsman investigated the wrap and, in a letter to the Arkansas Division of Youth Services, referred to it as torture- noting "The WRAP system has no known therapeutic use." Two weeks later the Division exercised its administrative authority and banned the wrap in all its facilities.

In 2017, advocacy organizations including the American Civil Liberties Union and Disability Law Colorado released "Bound & Broken" (ATTACHMENT B) detailing a serious of restraint abuses in Colorado's juvenile justice system, including use of the wrap. According to the report, accounts "from young people about their experiences while in the WRAP were remarkably consistent: they universally found that being in the WRAP was frightening, anxiety provoking and painful. Multiple youth noted that the WRAP caused them to feel like they could not breathe or were being "asphyxiated."59 Those feelings are amplified when staff choose to place a "spit mask" on the youth, which obscures vision and further impedes breathing."[18]Juvenile facilities in California also allow the use of spit

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[17] *C.P.X. through his next friend S.P.X.*, 450 F.Supp.3d 854, 911-912 (S.D. Iowa 2020)

[18] Bound & Broken" available at: https://www.aclu-co.org/sites/default/files/field_documents/bound-and-broken.pdf

hoods or masks. In the wake of the report, Colorado banned the use of the wrap in juvenile facilities.

Adding to the growing list of bans, following accounts from youth (ATTACHMENT C),[19] Manitoba, Canada recently banned the use of the device in its juvenile facilities and adult detention centers.[20] The ACLU report also noted that very few jurisdictions allow use of the wrap in juvenile institutions,[21] once again leaving California within the unimpressive minority with respect to setting juvenile facility standards. California needs to take responsibility for the devices employed against children in juvenile facilities, and it must ban the use of the wrap immediately.

Mechanical Restraints:

Along with banning the use of the wrap, the BSCC must meaningfully review the mechanical restraints used in facilities across the state determine which may continue and which will be prohibited. Counties, on their own, determined the wrap was an appropriate and effective device for use in juvenile facilities, and in doing so evidenced their inability to make such unilateral determinations. It is the BSCC's responsibility, as the agency charged with setting minimum standards, to determine what devices are permissible for use in juvenile facilities and under what circumstances. For instance, many counties authorize use of spit hoods (sometimes called spit socks or spit masks), and the BSCC provides little to no guidance regarding the allowability or allowable use of such devices. Examples of county policies regarding mechanical restraints and the wrap are included as ATTACHMENT D.

Circumstances Permitting Restraint:

The BSCC must raise the standard of care and treatment for youth in facilities by removing any allowance for the use of restraints to protect property and only allowing restraints to be used when there is an "imminent danger of serious harm to self or others."[22]

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[19] https://www.cbc.ca/news/canada/the-wrap-restraint-youth-use-1.6885941

[20] https://www.winnipegfreepress.com/breakingnews/2023/12/22/manitoba-bans-use-of-controversial-restraint-in-jails#:~:text=The%20Manitoba%20government%20has%20phased,said%20Justice%20Minister%20Matt%20Wiebe.

[21] Id.

[22] This is the standard for allowable use of restraint in state hospitals. Health & Safety Code § 1180.4.

Currently, BSCC regulations allow the use of physical restraints for "youth who present an immediate danger to themselves or others, who exhibit behavior which results in the destruction of property or reveals the intent to cause self-inflicted physical harm." Title 15 CRR § 1358.

Even under the most careful applications, physical restraints cause harm, and present significant risks to youth and staff. This hard cannot be justified for the mere protection of property. The standard utilized in Health & Safety Code § 1180.4, which applies to state hospitals, should be the minimum used to apply restraints to youth. That standard makes no mention of property protection. Under that provision, restraints are only allowed when an individual's "behavior presents an imminent danger of serious harm to self or others."

Additionally, Health & Safety Code § 1180.4 provides for individual assessments and the development of individual case plans related to the use of restraint or seclusion. The BSCC should adopt a similar, if not more protective, individualized standard for youth. This should, like the standard applicable to state hospitals, prohibit the use of certain restraints to individuals depending on specific criteria and vulnerabilities. Such a practice will not only reduce the trauma and harm associated with physical restraints, but it will also serve to ensure that youth are not placed in restraints for which they are at high risk of serious injury or death.

It is incumbent upon this workgroup, as it evaluates the minimum standards related to medical and mental health treatment, to bring forward its expertise and develop meaningful standards in line with our evolving standards of treatment and care for young people.

Thank you in advance for your consideration.

Sincerely,

Erin Palacios
Prisma Legal Center for Youth Justice, Executive Director

Attachment A

HEALTH AND SAFETY CODE - HSC

DIVISION 1.5. USE OF SECLUSION AND BEHAVIORAL RESTRAINTS IN FACILITIES [1180 - 1180.6] *(Division 1.5 added by Stats. 2003, Ch. 750, Sec. 2.)*

1180.4. (a) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall conduct an initial assessment of each person prior to a placement decision or upon admission to the facility, or as soon thereafter as possible. This assessment shall include input from the person and from someone whom the person desires to be present, such as a family member, significant other, or authorized representative designated by the person, and if the desired third party can be present at the time of admission. This assessment shall also include, based on the information available at the time of initial assessment, all of the following:

(1) A person's advance directive regarding deescalation or the use of seclusion or behavioral restraints.

(2) Identification of early warning signs, triggers, and precipitants that cause a person to escalate, and identification of the earliest precipitant of aggression for persons with a known or suspected history of aggressiveness, or persons who are currently aggressive.

(3) Techniques, methods, or tools that would help the person control the person's behavior.

(4) Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion.

(5) Any trauma history, including any history of sexual or physical abuse that the affected person feels is relevant.

(b) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 may use seclusion or behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others.

(c) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall not use either of the following:

(1) A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places the staff member's body weight against the person's torso or back.

(2) A pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint or containment process.

(d) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall not use physical or mechanical restraint or containment on a person who has a known medical or physical condition and there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition.

(e) (1) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall not use prone mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors that are known to the provider:

(A) Obesity.

(B) Pregnancy.

(C) Agitated delirium or excited delirium syndromes.

(D) Cocaine, methamphetamine, or alcohol intoxication.

(E) Exposure to pepper spray.

(F) Preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders.

(G) Respiratory conditions, including emphysema, bronchitis, or asthma.

(2) Paragraph (1) shall not apply when written authorization has been provided by a physician, made to accommodate a person's stated preference for the prone position or because the physician judges other clinical risks to take precedence. The written authorization may not be a standing order, and shall be evaluated on a case-by-case basis by the physician.

(f) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall avoid the deliberate use of prone containment techniques whenever possible, utilizing the best practices in early intervention techniques, such as deescalation. If prone containment techniques are used in an emergency situation, a staff member shall observe the person for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the person shall not be involved in restraining the person.

(g) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall not place a person in a facedown position with the person's hands held or restrained behind the person's back.

(h) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall not use physical restraint or containment as an extended procedure. A facility described in subdivision (a) of Section 4684.80 or paragraph (1) of subdivision (a) of Section 4698 of the Welfare and Institutions Code that is licensed by the State Department of Social Services shall not use physical restraint or containment for more than 15 consecutive minutes. The department may, by regulation, authorize an exception to the 15-minute maximum duration if necessary to protect the immediate health and safety of residents or others from risk of imminent serious physical harm and the use of physical restraint or containment conforms to the facility program plan approved by the State Department of Developmental Services pursuant to subdivision (i) of Section 4684.81 or subdivision (d) of Section 4698, as applicable, of the Welfare and Institutions Code.

(i) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall keep under constant, face-to-face human observation a person who is in seclusion and in any type of behavioral restraint at the same time. Observation by means of video camera may be utilized only in facilities that are already permitted to use video monitoring under federal regulations specific to that facility.

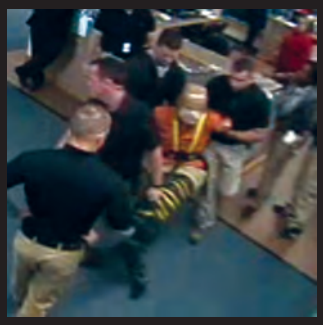
(j) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall afford to persons who are restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the person and others, and shall use the least number of restraint points.

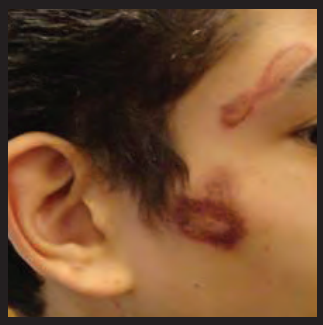
(k) A person in a facility described in subdivision (a) of Section 1180.2 and subdivision (a) of Section 1180.3 has the right to be free from the use of seclusion and behavioral restraints of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes, but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the person's freedom of movement, if that drug is not a standard treatment for the person's medical or psychiatric condition.

(Amended by Stats. 2019, Ch. 28, Sec. 1. (SB 81) Effective June 27, 2019.)

Attachment B

BOUND &BROKEN





HOW DYC'S CULTURE OF VIOLENCE IS HURTING COLORADO KIDS AND WHAT TO DO ABOUT IT

A REPORT BY THE COLORADO CHILD SAFETY COALITION • FEBRUARY 2017

BOUND&BROKEN

PRESENTED BY THE COLORADO CHILD SAFETY COALITION

Young people incarcerated in Colorado are in crisis. Violence in Colorado's Division of Youth Corrections (DYC) facilities has risen dramatically in recent years, leaving youth and staff feeling unsafe and afraid. Colorado's youth correctional facilities have higher rates of fights and assaults than other states, and youth and staff are commonly injured during these incidents. In this chaotic and violent environment, children cannot thrive.

42%
increase in fights and assaults in DYC facilities, 2013-2016

108%
increase in critical incidents in DYC facilities, 2013-2016

3611
times DYC staff physically restrained kids, Jan 2016-2017

2240
times DYC staff placed youth in solitary confinement, Jan 2016-17

ACLU AMERICAN CIVIL LIBERTIES UNION of COLORADO

DISABILITY LAW COLORADO™ Protecting the rights of Coloradans of all ages since 1976

COLORADO STATE PUBLIC DEFENDER

CJDC COLORADO JUVENILE DEFENDER CENTER WE BELIEVE IN YOUTH

FRONT COVER (FROM LEFT TO RIGHT): 1) Child in WRAP restraint in DYC's Lookout Mountain Youth Services Center.
2) Isolation cell at DYC's Lookout Mountain Youth Services Center, photo credit to © Richard Ross, www.juvenile-in-justice.com.
3) Child injured by staff during physical restraint at DYC's Lookout Mountain Youth Services Center.

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Executive Summary

Despite a mission of rehabilitation rather than punishment, the culture of the Colorado Division of Youth Corrections (DYC) is plagued by punitive practices that cause physical and emotional harm to the young people in its care. DYC's culture of violence makes facilities unsafe for both children and staff and deters rehabilitation. This report draws on interviews with 21 young people who are or have been incarcerated in eleven of DYC's thirteen state-owned facilities, as well as a review of over 1,000 pages of internal DYC documents, videos and medical reports regarding incidents that occurred between 2013 and 2016. The report concludes that DYC staff used physical pain, isolation and verbal degradation against vulnerable young people, most of whom suffer from past abuse and mental illness. Knee strikes, painful pressure points and the WRAP – a full body straitjacket – are common currency in DYC's culture.

There is a better way. In Missouri, juvenile facilities focus on true internalized change for kids by building strong relationships between youth and their peers and between youth and staff. Staff never use isolation, restraints like the WRAP, or pain compliance, because these punitive measures hurt children and prohibit development of trusting relationships with staff. Statistics show that Missouri kids and staff are safer. The "Missouri Approach" has become the gold standard for the care of juveniles and has been exported to other states with success. A pilot program in Colorado could change the culture of violence at DYC to keep kids and staff safe while promoting rehabilitation.

Key Facts and Findings

1. Violence has been escalating in DYC facilities. External and internal measures confirm a dramatic increase in the number of documented fights and assaults, and complaints about violence from youth and staff to outside agencies have skyrocketed.

2. Young people and staff consistently report feeling unsafe in DYC facilities.

3. Most young people in DYC have experienced trauma. When youth with a history of trauma feel unsafe, they are less likely to be rehabilitated.

4. DYC staff routinely use physical force and pain to control young people.

    - DYC staff physically restrained youth at least 3,611 times between January 2016 and January 2017. Of those restraints, over sixty percent resulted in the use of mechanical restraints, such as handcuffs, shackles, or the WRAP.

    - **The WRAP:** DYC sanctions use of the WRAP, a full-body restraint banned in Arkansas after it was described as "torture" by the Juvenile Ombudsman. DYC placed children in the WRAP 253 times between January 2016 and January 2017.

    - **Pain Compliance:** DYC staff commonly use pain compliance techniques, whereby staff strike or put pressure on sensitive parts of the child's body to purposely cause pain and gain compliance with staff directives. The U.S. Department of justice found pain

compliance techniques violate children's constitutional rights.

- DYC staff use force against youth who refuse to follow staff directives, even when those youth pose no immediate threat to safety.
- These punitive techniques injure both youth and staff. According to DYC's own records, rates of injury to both young people and DYC staff are consistently higher than the national average and DYC's internal goals.

5. **Solitary Confinement:** DYC placed young people in solitary confinement 2,240 times between January 2016 and January 2017.
6. DYC's own data shows that increased staffing alone, without changing DYC's punitive culture, will not ensure reduction of violence.
7. The Missouri Youth Services Institute, a non-profit dedicated to exporting the Missouri Approach, can bring a pilot program to Colorado and provide a template for broad cultural change within DYC, for a fraction of the cost of the funding requested this year by DYC.

Policy Recommendations

To start transforming the culture of violence at DYC into a culture of caring and rehabilitation, and to make young people and staff safer, the Colorado Child Safety Coalition makes the following recommendations.

1. Bring a Missouri Approach pilot program to DYC, under the guidance of Missouri Youth Services Institute, to begin within six months. Colorado's children cannot wait.
2. Prohibit physical management methods that harm and re-traumatize children.
   - Prohibit the WRAP.
   - Prohibit pain compliance techniques.
   - Prohibit the use of leg irons and wrist-to-waist restraints.
   - Prohibit staff from physical contact with disobedient youth who pose no immediate threat of harm to self or others.
3. End the practice of isolating children who act out.
4. Provide intensive training and retraining to all staff in the provision of trauma-informed care and build a positive culture based on relationships, not punishment or control.
5. Provide staff the tools they need to de-escalate and, when necessary, physically manage escalated youth in a manner that does not harm youth or staff, such as the methods taught in Safe Crisis Management.
6. Increase transparency at DYC. The public has a right to know the circumstances under which DYC uses force on the youth in its care. The legislature should amend Colorado Revised Statutes § 19-1-304(8) to require DYC to provide such information.

Introduction

Young people incarcerated in Colorado are in crisis. Violence in Colorado's Division of Youth Corrections (DYC) facilities has risen dramatically in recent years, leaving youth and staff feeling unsafe and afraid. Colorado's correctional facilities have higher rates of fights and assaults than other states, and youth and staff are commonly injured during these incidents. In this chaotic and violent environment, children cannot thrive.

DYC is charged with rehabilitating the troubled young people in its care, to fulfill Colorado's promise that the juvenile justice system will "provid[e] appropriate treatment..." and help each young person become "a productive member of society."[1] The young people in DYC's care, most of whom have experienced trauma or violence in their childhood and struggle with mental illness, need treatment and tools that prepare them to safely rejoin our communities, not exposure to violence that traumatizes them and inhibits rehabilitation.

While DYC's leadership publicly promotes rehabilitative care that addresses the trauma suffered by at-risk youth, in practice DYC facilities are plagued by a punitive and damaging culture that makes it extremely difficult to build the positive relationships necessary for effective treatment. This culture is characterized by practices that physically and emotionally harm the children in DYC's care.

Specifically, DYC authorizes staff to:

- **Place young people in the "WRAP," a full body restraint akin to a straitjacket that causes numbing, pain, and psychological damage;**
- **Place young people in solitary confinement, sometimes in barren isolation cells with only a metal toilet and bed frame;**
- **Use pain compliance techniques by purposely manipulating nerve pressure points to cause pain to youth and knee striking young people in thighs, buttocks, and ribs; and**
- **Respond to disobedient youth who are non-violent, and often seated, with physical force.**

As a result of these practices, many children suffer bruises, scratches, rug burns, separated joints and closed head injuries. These practices also make youth scared, angry, and resentful; feelings that stymie rehabilitation. Several DYC staff members have been charged with crimes for harming young people. In just the past three months, at least two DYC staff members have been charged in court, including a staff member charged with felony assault and child abuse in February of 2017.[2] Staff members have also suffered serious injuries and young people have been charged with crimes for assaulting staff.

There is a better way. The "Missouri Approach" is a relationship-based, wholly therapeutic

group treatment approach toward incarcerated youth devised and implemented over the course of the past three decades by the Missouri Division of Youth Services. Missouri Youth Services wholly rejects punitive practices that harm children, including the WRAP, solitary confinement, pain compliance, and shackles. Even so, Missouri institutions have far *fewer* assaults against both staff and young people, while maintaining low recidivism rates and high education outcomes.[3] In stark contrast to Colorado, children and staff in Missouri report a sense of safety and well-being in Youth Services facilities, as well as extremely strong and caring relationships between young people and staff.

The Missouri Youth Services Institute (MYSI), a non-profit dedicated to implementing the Missouri Approach in other states, can bring a pilot program to Colorado to provide a template for broad cultural change within DYC, for a fraction of the cost of the additional funding requested this year by DYC. The most critical aspect of MYSI's services is the aspect most needed in Colorado: "culture change" that transforms a punitive correctional environment into a safe, rehabilitative treatment program based on positive peer and staff relationships.

Investigation

The Child Safety Coalition, which includes the American Civil Liberties Union of Colorado, Disability Law Colorado, the Office of the Colorado State Public Defender, and the Colorado Juvenile Defender Center, interviewed 21 young people who have been incarcerated in eleven of DYC's thirteen state owned facilities.[4] The attorneys and social workers in our coalition have collectively represented more than 100 young people housed in DYC facilities, and the information collected during this investigation is consistent with dozens of other reports from young people and parents received during past representation. Many incarcerated children spoke to our coalition despite their limited access to telephones. Several children were fearful of retaliation from DYC staff for speaking out. For some young people, sharing their stories meant revisiting past trauma and re-traumatization caused by DYC's punitive practices.

The stories and quotes from the young people presented in this report reflect the accounts of multiple youth spread across different facilities throughout the state. Young people who did not know each other and were held in facilities hundreds of miles apart repeatedly provided extraordinarily similar accounts of the punitive culture within DYC and use of force techniques by DYC staff, including the WRAP, pain compliance, and knee strikes.

The Coalition reviewed over a thousand pages of DYC documents regarding use of force in these facilities, including Incident Reports and medical records, as well as several videos of incidents inside DYC facilities. These materials provided support for the information given by young people and confirmed the use of the punitive techniques described below. The incidents described in this report occurred between 2013-2016.

Finally, the Coalition reviewed voluminous information about the "Missouri Approach" and visited Missouri facilities in February 2017 to speak with youth and staff and observe the Missouri Approach in action.

Obstruction by DYC

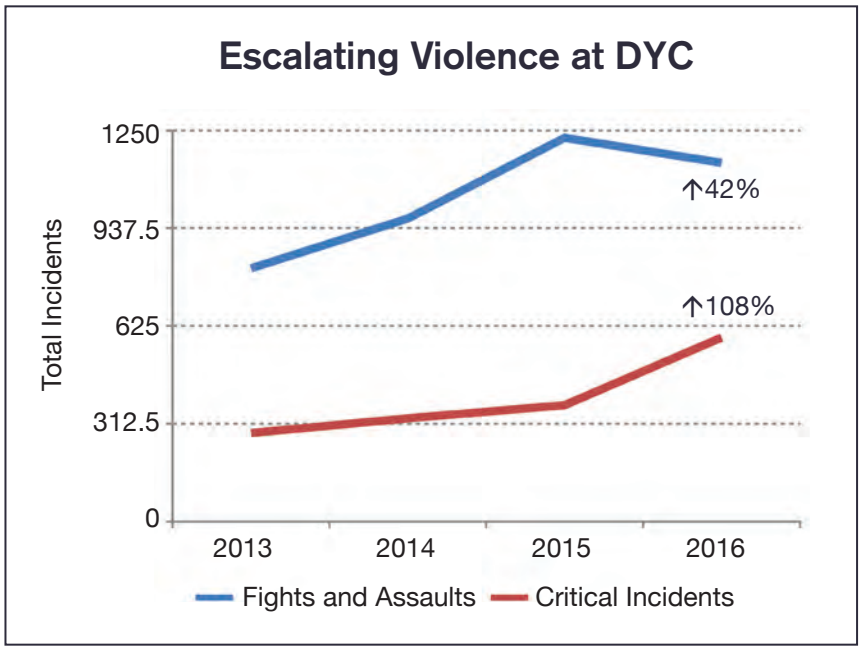
Despite repeated requests for the information from DYC, the Coalition was unable to review certain documents reflecting staff accounts of use of force on young people, called "use of force reports." When provided with appropriate releases, DYC readily agreed to disclose to the Coalition staff accounts of *young people's* actions leading up to restraints and discipline, but refused to provide staff accounts of *staff's* actions during the course of restraints, even when *young people* were injured by *staff*. Similarly, in records requests made by lawmakers pursuant to a recently enacted law that requires DYC to provide information about "critical incidents," DYC stated it would provide only information about the actions of young people during the critical incident, and refused to provide information about the conduct of staff, including staff use of force such as knee strikes, pain compliance, the WRAP, or other mechanical restraints. This lack of transparency shields DYC and its staff at the expense of public knowledge.

Increased Violence at DYC

In 2014, an investigation revealed that DYC violated Colorado law and national best practices by keeping children in long-term solitary confinement and relying heavily on pain compliance techniques—causing pain by applying pressure and force to specific sensitive areas of a child's body—to discipline and manage children.[5] Since then, DYC leadership has publicly expressed both its willingness to reduce the use of solitary confinement and force, and a desire to provide non-punitive, trauma-informed care to young people. Unfortunately, DYC policy and practice are not consistent with this vision, and the culture at DYC remains punitive and broken.[6]

Over the last two and a half years, complaints of violence at DYC and injury to both young people and staff have skyrocketed. In the three months preceding this report, our coalition received over 28 complaints of abuse. Children, unable to trust DYC, are contacting outside organizations for help. Staff, unable to gain support within DYC, are calling legislators and the media to express fear of violence in the facilities. Some staff are so fearful and undertrained that they are asking for pepper spray and stun guns to use on children in their care.[7]

Both external and internal measures confirm escalating violence at DYC facilities. The Office of the State Auditor completed an audit in September of 2016, finding that the number of fights, assaults, and critical incidents[8] increased dramatically between 2013 and 2016:[9]



DYC's own data confirm increased violence. DYC admits that between fiscal year 2012-13 and fiscal year 2015-16, "the overall trend is that fights and assaults have increased."[10] DYC data also show that rates of injury to both young people and staff consistently exceed the national average and DYC's internal goals.[11]

Violence persists despite increases in staff and funding for DYC.

The increases in violence and injury described above have occurred despite:

1. A decrease in the number of young people committed to DYC's care;[12]
2. Consistency in the age of young people in secure care;[13]
3. Consistency in the percentage of violent young people in secure care;[14]
4. Consistency in the percentage of young people with prior involvement with law enforcement in secure care;[15] and
5. Significant increases in staffing and funding for DYC.[16]

While good staff-to-young people ratios are important, DYC's data demonstrate that unless increased staffing is accompanied by culture change, violence will not abate. For example, between fiscal years 2014-15 and 2015-16, staff to youth ratios improved by 13.2%, 16.4 %, and 17.6% at Platte Valley Youth Services Center, Spring Creek Youth Services Center, and Pueblo Youth Services Center, but those facilities saw an *increase* in fights and assaults by 22.5%, 35.3%, and 3.3 %, respectively.[17]

Kids and Staff Feel Unsafe

"This is not safe to me."[18]

Both young people and staff consistently report feeling unsafe in DYC facilities. One youth commented, "This is a place that is supposed to keep us safe because we can't be in the community. But if I was in the community, I wouldn't be getting bruises every day and be being beat up on by grown people." She explained, "I never know what might happen. I never know if staff is going to grab me up, or I never know if I'm going to be put on seclusion for something."[19] Many young people echoed these sentiments, expressing fear of staff and uncertainty about when staff would engage with them physically.

Staff have also expressed fear. One staff member sought whistle-blower protection to file complaints about what she said was a dangerous environment for staff and young people.[20] She reported that staff "were struggling with these kids and were working long hours at their breaking point," complaining that conditions at one facility had deteriorated to the point of constituting child abuse and neglect.[21]

"This is a place that is supposed to keep us safe because we can't be in the community. But if I was in the community, I wouldn't be getting bruises every day and be being beat up on by grown people."

It is clear to the Coalition that most DYC staff do not want to hurt young people. In interviews, young people reported staff reactions that reflected staff's desire for tools and training to avoid use of force. One youth noted that after staff use of force, staff "will apologize and say 'it's not what we want to do, we don't want to put hands on you guys, but when you put us in a situation like that there's no other options.'"[22] This youth reported a specific time when a staff member who had used his knee to strike the youth "came to my unit the next day and was tearing up and said I'm so sorry, that's not what I wanted to do. I actually really care about all you kids...."[23] Staff feel powerless because the methods they have to manage youth behavior are harmful tools that they do not want to use. DYC staff need a different set of tools to manage behavior without causing harm and injury.

Safety is Required to Rehabilitate Traumatized Children

"A fundamental goal in developing trauma-informed care in juvenile custodial situations is to provide an environment in which youth are safe and perceive themselves to be safe."

—Sue Burrell, Youth Law Center.[24]

Children must feel safe to engage in treatment and rehabilitation. If the environment around them is free of danger, young people are more likely to let down their guard and open themselves up to a positive relationship with staff and with their treatment team. If children feel unsafe, their fear of danger keeps them from building relationships and engaging in treatment.

Creating this sense of safety is difficult in juvenile facilities because most young people detained in those facilities have extensive histories of exposure to psychological trauma.[25] In one study, over 90% of juvenile detainees reported at least one prior traumatic incident.[26] These children may have been beaten by their parents, sexually abused, abandoned, witnessed violence in the home, been exposed to street violence, or forced to grieve for lost family members and friends at a very young age.[27] For these youth, isolation, pain, physical touch, or even the threat of physical touch may trigger memories of prior victimization, betrayal, or abandonment.[28] When these traumas are re-experienced in the juvenile facility, they may reinforce the child's mistrust and hypervigilance, which prevents rehabilitation. It is also likely that such a youth may engage in self-destructive or aggressive behavior to distract, soothe, avoid, or otherwise reduce the feelings triggered through trauma response.[29] Re-traumatizing children makes them more defensive, more aggressive, and less likely to be rehabilitated.

Nationally accepted studies demonstrate that trauma-informed programs are more likely to rehabilitate young people than punitive measures.[30] These programs make facilities safer, reduce threats to staff, reduce physical management and seclusion of young people, and improve mental health.[31] Trauma-informed programs ensure that staff are trained to understand and expect trauma in the young people being served,[32] to resist the re-traumatization of clients and to recognize how organizational practices may trigger painful memories that traumatize youth.[33] "For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery."[34] A sense of physical and psychological safety and trust between clients and staff are key to trauma-informed care.[35]

"Perhaps the most potentially damaging way youth may be re-traumatized is in the use of force or solitary confinement."

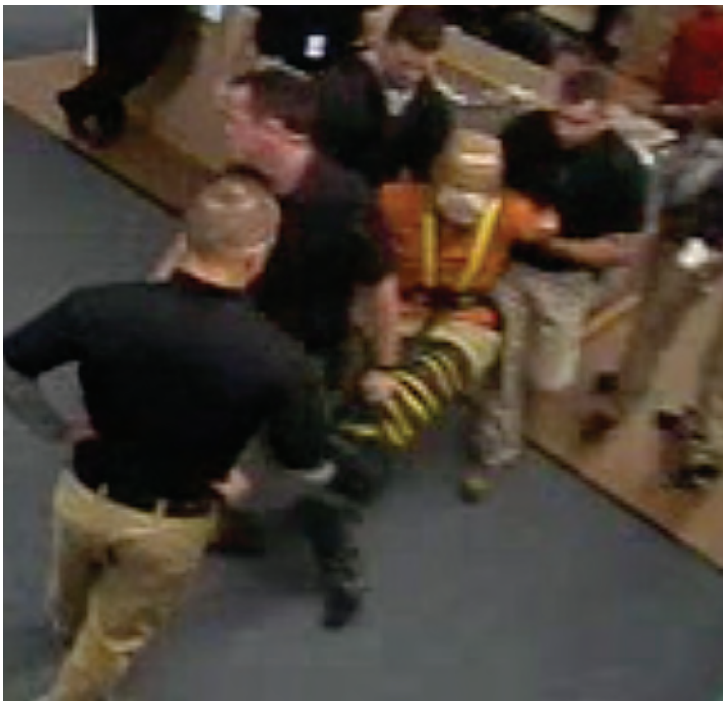
—Sue Burrell, Youth Law Center[36]

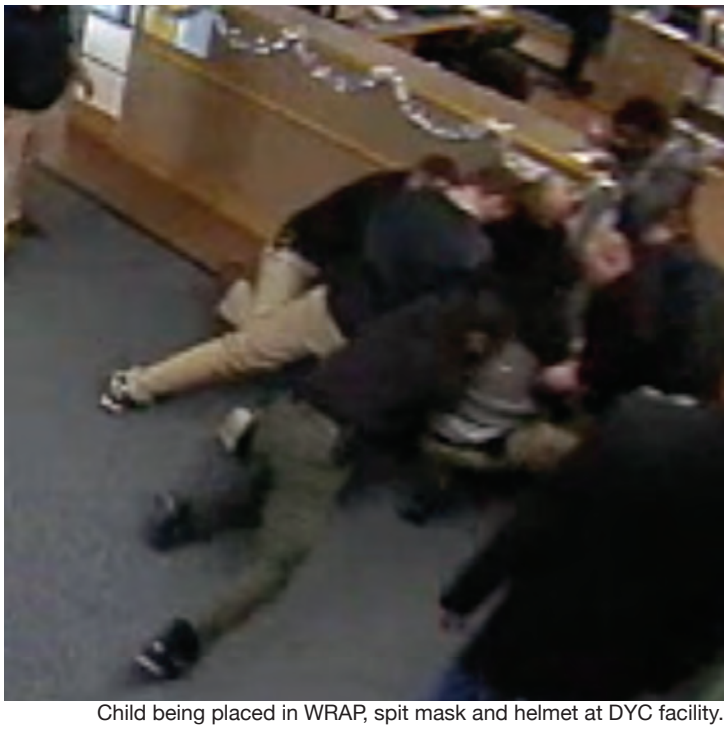
Because pain and fear re-traumatize already traumatized young people and impede the rehabilitation process, DYC's punitive culture must be altered to provide a safe and therapeutic environment where meaningful, trusting relationships can grow between young people and staff.

DYC's Punitive Practices

"It's... it's like rival gangs, that's how bad it is, between staff and youth."[37]

The punitive practices used by DYC produce and reflect a violent culture, and are obstacles to rehabilitation.[38] DYC staff use the WRAP restraint, solitary confinement, and force against children, including purposeful manipulation of nerve pressure points to cause pain, striking young people with staff's knees, and using physical force against disobedient but non-violent young people who do not pose a threat. While youth reports and DYC documents strongly suggest that staff commonly use pain compliance as part of physical management, there is currently no publicly available information regarding how frequently DYC uses this technique. However, recently released DYC data provide some information regarding the frequency with which staff use force on youth. During a thirteen month period between January 2016 and January 2017, DYC staff physically restrained young people at least 3,611 times, which is an average of 277 incidents per month.[39] Of those physical restraints, over sixty percent resulted in the use of handcuffs, shackles, and/or the WRAP.[40] This data almost certainly underreports the number of incidents of use of force, because it likely excludes or undercounts data from DYC's three state owned, privately operated facilities.[41] Based on our Coalition's past knowledge, interviews of youth, and review of documents regarding use of force at two of these facilities, Ridge View Youth Services Center and Betty Marler Youth Services Center, we believe there is a strong inference that staff frequently physically restrain youth in these facilities, often by using pain compliance.





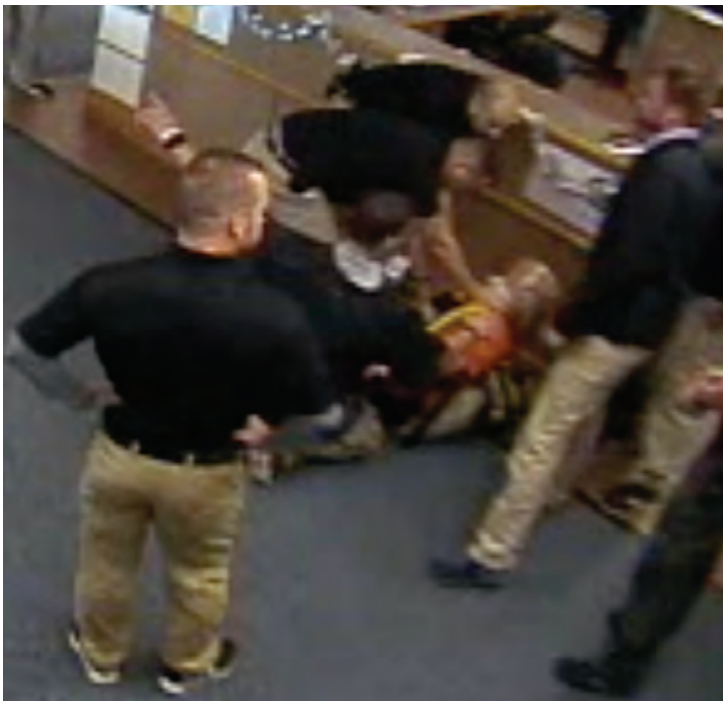
Child being placed in WRAP, spit mask and helmet at DYC facility.

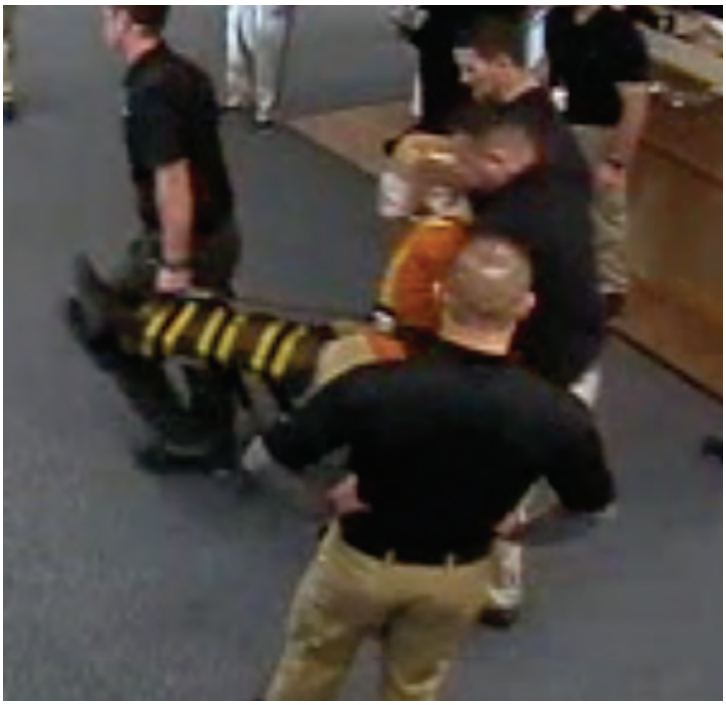
The WRAP

"I can't breathe, I can't breathe."[42]

The WRAP physical restraint device is used in at least nine of the twelve secure DYC facilities.[43] The device is a full body restraint akin to a straitjacket.[44] To place a young person in the WRAP, DYC staff put the youth in handcuffs, bind the youth's legs together, and then wrap the youth in the full body restraint. A strap placed between the chest and legs forces the youth into a seated position. DYC facilities sometimes apply a "spit mask," a cloth that covers the child's head and face, and a helmet while the child is in the WRAP restraint. DYC reports that during the thirteen month period from January 2016 through January 2017, DYC staff have placed a young person in the WRAP at least 253 times. [45]

Colorado is one of the few juvenile justice systems in the country that uses the WRAP restraint. Colorado's nine DYC facilities that utilize the WRAP account for almost a quarter of all the juvenile justice facilities in the country which have contracted to use this restraint.[46] Other jurisdictions have recognized the harm that the WRAP causes to children: in 2014, the Arkansas Juvenile Ombudsman investigated the use of the WRAP in the Yell County Juvenile Detention Center, and called the device "torture."[47] During his investigation, the Ombudsman subjected himself to the device and helmet, finding it was difficult to breath and that it increased anxiety.[48] Less than two weeks after receiving the Ombudsman's letter, the Arkansas Division of Youth Services banned the use of the WRAP, commenting that the WRAP has "no known therapeutic uses," exposes youth to ridicule and humiliation, and presents a serious risk of harm to youth.[49]





DYC staff use the WRAP in at least nine of its twelve secure facilities.[50] More than half of the young people we interviewed reported being placed in the WRAP, most of them more than once.[51] DYC records document that one youth was placed in the WRAP at least 17 times while in DYC custody, and two young people reported being placed in the WRAP in excess of ten times.[52] One young person explained that, at her facility, "They go straight to the WRAP. That's what they do."[53]

Young people reported being in the WRAP for anywhere from minutes to hours; multiple youth described being kept in the WRAP for 1-3 hours. DYC refused to provide "use of force" reports that would document the amount of time youth remained in the WRAP restraint. However, the Coalition was able to locate DYC records that document five instances where young people remained in the WRAP for 30 minutes,[54] 47 minutes,[55] over an hour,[56] over an hour and a half,[57] and over two hours.[58]

Reports from young people about their experiences while in the WRAP were remarkably consistent: they universally found that being in the WRAP was frightening, anxiety provoking and painful. Multiple youth noted that the WRAP caused them to feel like they could not breathe or were being "asphyxiated."[59] Those feelings are amplified when staff choose to place a "spit mask" on the youth, which obscures vision and further impedes breathing.

Multiple young people also described how the WRAP caused their extremities to go numb, reporting that their entire legs were numb within 10 minutes.[60] One youth reported that when he was released from the WRAP he was so numb that he could not walk.[61]

The WRAP also causes pain.[62] Once a youth is placed in the WRAP, a strap that connects the chest to the legs is tightened, locking the youth in a seated position. When that strap is not adjusted correctly the youth is forced to lean in a "v" or "c curve" position, which several young people reported to be extremely painful.[63]

DYC staff have held deeply sad and even suicidal children in the WRAP. Records from one child shows he was placed in the WRAP twice in one day, the second time "for his own safety" after staff found him with a shirt wrapped around his neck and his head bowed.[64] The same youth was placed in the WRAP again after a later suicide attempt.[65] Another DYC record documents that a young person who had been placed in the WRAP was "sitting quietly while tears streaming down face." Instead of releasing this youth, staff kept him in the WRAP for 40 additional minutes.[66]

The WRAP is traumatizing and painful, has no therapeutic purpose, and should never be used on children. DYC's commitment to using the WRAP in nine of its twelve secure facilities is evidence of the Division's punitive culture at its clearest.

Placing injured youth in the WRAP

Several youth reported being placed in the WRAP while injured, including a youth with facial injuries, a youth with a bleeding hand, and a youth who had an active bloody nose and reported spitting blood onto the floor. This youth recalled: "I was trying to breathe to talk to them and say 'stop, stop, stop.' They wouldn't listen so they put the spit mask on me. I was trying to breathe and blood was filling up in my mouth and coming up in my nose. And I was trying to spit it out but I couldn't. And I was crying."[67]

Solitary Confinement

Isolation is "like being treated like an animal. You're doing bad, go to your cage." [68]

Young people in DYC facilities spend a great of deal of time locked alone in a small, barren room. Sometimes staff isolate youth for disciplinary reasons; other times for administrative convenience. Either way, the time in isolation has no therapeutic purpose and is often experienced by young people, especially those who have past trauma, as punishment, abuse, or neglect.[69]

DYC staff commonly use solitary confinement to address misbehavior by young people, even in the wake of irrefutable evidence that isolation hurts children. Between January 2016 and Junuary 2017, DYC staff placed a young people in isolation 2,240 times.[70] While in isolation, children are locked in a tiny, completely barren cell with only a metal toilet, a metal bedframe, a sleeping mat, a blanket, and a roll of toilet paper. Data from March to August 2016 reflects that average stays in isolation ranged from .8–5.7 hours,[71] with some children spending days in isolation. Most of the children placed in isolation were 15–17 years old, but DYC also isolated one 11-year-old, two 12-year-olds, and nine 13-year-olds.[72] These isolation statistics do not account for the many times that staff sent young people into a locked room for a "time out," used special management plans to isolate youth from their peers, or locked youth alone in their rooms for "administrative" convenience, as discussed below.

Solitary confinement fosters stress and anxiety. Young people have even fewer psychological resources than adults to manage this stress.[73] In the DYC population, this developmental immaturity is often compounded by mental disabilities and histories of trauma, abuse, and neglect. These factors can dramatically exacerbate the negative mental health effects of solitary confinement, and they at least partially explain why "the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement."[74] In recognition of the vulnerabilities of youth, psychiatrists support international standards for the care of incarcerated youth that prohibit the isolation of children.[75]

"The majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement."

Isolation cell at Lookout Mountain Youth Services Center. Photo credit © Richard Ross, www.juvenile-in-justice.com

All of the young people interviewed, who were subjected to punitive isolation, reported suffering while in isolation. For example, a DYC Incident Report reflects staff's account of one young person who was crying, angry, frustrated, and screaming after over 45 minutes in isolation. Staff continued to keep the youth in isolation, and discovered him an hour later in the isolation cell with his shirt around his neck. The youth had to be placed on suicide watch.[76] Another youth explained that he hated isolation because it reminded him of abuse from home: "My dad had put a lock on the outside of my door. He purposely got a doorknob with a lock on the outside so he could lock me in there. He would lock me up for a couple hours."[77]

In 2016, the Colorado Legislature passed a law to curb the use of isolation by DYC after it came to light that DYC had an official policy and persistent practice of illegally holding children in long-term solitary confinement.[78] Even with this law in place, recent trends in DYC's use of isolation are alarming: both the number of isolation incidents and average lengths of isolation are on the rise.[79]

"Time Outs": Isolation by another name

Staff commonly ask or order youth to take a "time out," which requires a youth to be locked alone in either their own room or an isolation cell. Failure to follow a staff directive to take a time out can lead to physical management, restraint, and further isolation, as discussed below. The Office of the State Auditor recently raised concerns with the use of these "time outs" in DYC facilities, noting that a "time out" was just as restrictive as seclusion, because children were locked alone in a room at the direction of staff.[80] The Auditor pointed out that DYC did not track the use of "time outs" and therefore was unable to quantify or monitor their use.

Youth room at Lookout Mountain Youth Services Center.
Photo credit © Richard Ross, www.juvenile-in-justice.com

Special Management Plans that Isolate Youth

DYC also imposes isolation from programming and peers through "special management plans," raising concerns that DYC has replaced its past pattern of illegally holding children in long-term in-room solitary confinement with similarly isolating practices in empty pods. Two youth reported being on such a plan. DYC records document these isolating special management plans. One Incident Report confirmed that a youth was being "programmed" in the control area and was required to "sit at his desk facing the wall" and not communicate with any peers.[81] A written DYC special management plan required the youth to sleep in an isolation cell, complete morning hygiene alone in his isolation cell, complete schoolwork and lunch alone in an empty classroom, eat meals on the unit alone with one staff member present, have no contact with peers, and take recreation "one on one with staff on the pod."[82]

Administrative Isolation

Young people held by DYC spend significant periods of time locked alone in their rooms for "administrative reasons," such as cleaning the pod, staff meetings, and shower time. Additionally, children are locked in their room for at least 10 hours each weeknight and 12 hours on weekends for what DYC calls "sleeping hours."[83] DYC records indicate that, at some DYC facilities, sleeping hours begin at 8:30 pm. DYC does not track its use of administrative seclusion, so it is impossible to quantify the amount of time children are isolated for administrative convenience. Several youth, however, reported being locked in their rooms for several hours during each day.[84]

Young people reported that during these lengthy periods of administrative isolation and "sleeping hours", staff often refused to let them out of their locked rooms to use the restroom. (Unlike isolation cells, youth rooms do not have toilets.) As a result, these young people had no choice but to urinate in their cups, on their clothing, or on the floor of their rooms.[85] A DYC grievance also documents a complaint that a youth was not permitted to leave his locked room for a drink of water; another confirms that staff placed a youth in a locked room and refused to provide him with his evening medication.[86]

Pain Compliance and Pressure Points

"It hurts, it's like they're pushing too hard,
I don't know what's right there but it just hurts."[87]

DYC sanctions the use of pain compliance techniques, including placing pressure on nerve points to purposefully cause pain and thereby force children to comply with staff directives.[88] For example, staff may put pressure behind the ear, on the neck, or may bend a child's wrist backwards to induce pain, forcing them to the ground in submission. **The Department of Justice has found that pressure point control tactics are "neither designed, nor developmentally appropriate, for use with children and adolescents," and that "use of pressure point control tactics violates children's constitutional rights."**[89]

DYC staff commonly use pressure points and pain compliance on young people. DYC records document the use of the "tibia pressure point," "straight arm bar take down,"[90] "Tibial Nerve Motor Point to right nerve,"[91] "pressure to the mandibular angle,"[92] "arm bar takedown,"[93] "mandibular angle touch pressure," and "knee on right calf."[94] Over half of the young people interviewed by the Coalition experienced pressure points and pain compliance in DYC facilities.[95] These young people reflexively reached toward their necks when pressure points were mentioned during interviews. They described how staff used fingers, fists, and knees to cause pain to the ear, behind the ear, the neck, the nose, the chin, the calf, the shoulder blades, and the arm.[96] Multiple youth reported that pressure points would cause bruising, and that sometimes staff would dig their fingernails into the skin when applying the pressure point.[97]

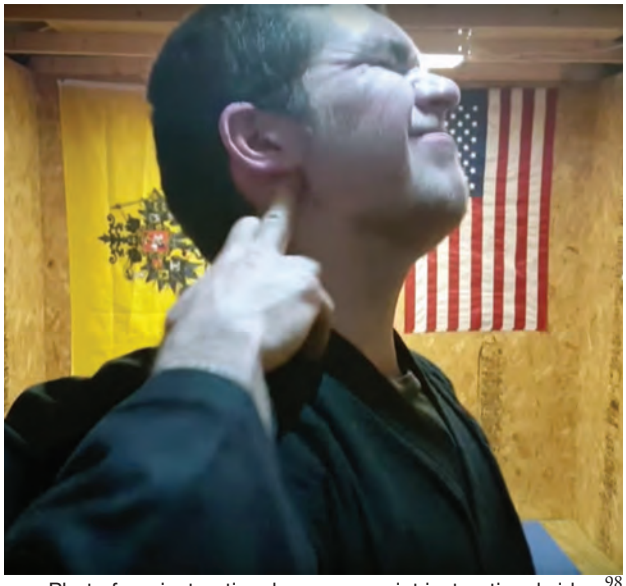


Photo from instructional pressure point instructional video.[98]

Staff use pain compliance techniques during restraints to try to force the youth to stop moving or resisting. This is often ineffective, however, because the sharp pain causes young people to move reflexively, making

it impossible for the child to follow staff instructions to remain still. One youth stated, "When it hurts, it's hard not to move. Then once you move, they hit you more."[99] Another reported that, while he was on the ground in handcuffs and shackles, he moved away from staff who were putting pressure on his neck because he could not breathe. In response, "they picked me up and slammed me down and started pressure pointing my neck again."[100]

Things may become dangerous when staff place hands on passive youth in part because young people with prior trauma react instinctually when touched.

A 2015 incident illustrates how responding physically to young people engaged in passive disobedience can be dangerous to both staff and young people. When youth Roger became disrespectful during community group, he was asked to take a "timeout," which would require him to go into an isolation cell. Roger refused to go to the isolation cell. Video of the incident shows that, as Roger and the staff member argue verbally, Roger walks away from the staff member to the other side of the room. Staff and Roger continue to exchange words across the room, and the staff member again moves toward Roger and lays hands on him. When the staff member grabs Roger's arm, Roger swings at the staff member and the two become physically engaged. The staff member was hit multiple times in the face.

Knee Strikes

DYC staff also use their knees to strike young people. Youth accounts and DYC records indicate that young people have been struck this way by staff in the legs, ribcage, and head. Though staff are instructed not to hit children in the head, the practice of using the knee to strike children on other parts of the body is sanctioned by DYC. Staff document the use of knee strikes in Incident Reports, including strikes to the "femoral nerve point" and the "common peroneal."[101]

"When it hurts, it's hard not to move. Then once you move, they hit you more."

Over half of the young people interviewed reported experiencing or observing staff strike young people with their knees.[102] Five young people reported being struck in the head or the face by a staff member's knee.[103] Youth also reported being struck in the side, leg, and stomach.[104] One youth reported that staff accidentally knee struck her in "her private part."[105] Another reported that staff continued to knee strike him in the thighs and ribs after he was in handcuffs,[106] causing him to limp the next day. Multiple DYC medical records also contain reports from young people of being struck by staff with a knee.[107]

Use of force on disobedient but passive youth

"All the times I get restrained, I don't want to go to my room. Then they call a code and they have people come and then they throw you to the ground."[108]

Even when a youth is not following a staff directive—for example, an order to go into isolation—but is not posing a threat to self or others, DYC staff often escalate the situation by putting hands on youth. When staff transform such non-physical situations into physical ones, young people often escalate, and both staff and youth can be injured. Young people reported that staff placed hands on them when they refused to move from a chair, refused to give staff a drawing pencil, refused to hand staff a book, and reached over the staff counter for juice and milk.[109]

Multiple DYC records from different facilities document incidents in which a young person was seated at the time that staff put hands on the youth; multiple youth similarly described staff putting hands on them while they were seated. One youth who refused to go to an isolation cell said, "I went and sat in the chair. My intention of sitting in the chair was I thought that maybe they wouldn't restrain me in the chair. If I was sitting down not looking violent just sitting in a chair I thought 'they can't really restrain me like this.'" The youth reported that when he continued to refuse to go to isolation, staff threw him to the ground, and multiple staff used pressure points and knee strikes before he was picked up and taken to an isolation room.[111] **The available staff account in a DYC Incident Report confirms that staff were first to lay hands on this youth, noting that when "verbal processing" became "repetitive," "physical response was initiated."**[112] DYC refused to provide the use of force report that would document the type of physical force used in this incident.

"If you leave the classroom without permission there are like 5-6 [staff] out there...They will throw you to the ground, smash your face in the ground, and knee strike...I've seen it happen to kids that walk out of class."[110]

Our investigation revealed many instances of young people being physically managed by staff when youth passively refuse to go into isolation.[113] Multiple DYC records document incidents in which youth refused to go into a locked room alone, and staff responded physically[114]—one staff member used a "straight arm bar" to bring a youth to the ground, others began a "physical management" when youth struggled after staff put hands on the youth to force the youth into isolation.[115] These "physical managements" can include anything from physically forcing a child into an isolation cell to taking a child to the ground and using knee strikes to force compliance. The child is at risk of injury, and if the child responds by fighting back, staff are at risk as well.

Things may become dangerous when staff place hands on passive youth in part because young people with prior trauma react instinctually when touched.[116] Young people with prior trauma may enter "fight or flight" mode when touched by staff, flinch away, attempt to move away from staff, or react with violence. One youth explained that unwanted touching from "someone I don't know or don't like...I can get really triggered. The reason why I get triggered is my stepdad used to abuse

me, so when people are rough with me I get really triggered and I'll get pissed off or really sad."[117] Another youth explained that because of prior abuse, "I just don't like people putting their hands on me ...I start having a panic attack...every time I get restrained I get a panic attack. Sometimes before I get restrained, and that's what leads up to the restraint." Youth reported that as a result, they often instinctively pull away when staff touch them, which can lead staff to use more aggressive force to control the child, which can result to injury of both staff and youth.[118] Videos of incidents in DYC facilities, showing staff attempting to grab young people, young people pulling away, and a resulting physical restraint, corroborate these youth accounts.[119]

David's Story: Why Children Refuse to Go into Isolation

It is not hard to understand why a child would want to avoid being locked in a barren cell. But for some children currently in DYC custody, placement in a locked room is especially traumatic because DYC has previously held them in solitary confinement for long periods of time.

Some young people currently held in DYC facilities were previously subjected to illegal DYC "Special Management Plans" that allowed children to be held in isolation for up to 23 hours a day, for weeks or even months at a time. These plans were in place at DYC facilities as recently as 2015. Youth subjected to these plans are likely to refuse further attempts to place them alone in a locked room. When staff then lay hands on the youth to force him or her into an isolation cell, a physical altercation can result, putting young people and staff in danger.

For example, David was previously placed on a DYC plan that required isolation for 23 hours per day, allowing David out of his locked cell only for "one hour out" and to shower. In his isolation cell, David had only his bed mat, a blanket, one book, one roll of toilet paper, one crayon, and a single sheet of paper. He was not permitted to attend school, and only received an occasional packet of school work. If he completed the packet, and it was actually collected, he would not get it back, so he did not know if he had done the work correctly. At times, David "progressed" on his special management plan and was allowed to leave his cell in wrist to waist restraints—hands in handcuffs, connected to a belt around his middle. When he had not earned these "extra hours out" through good behavior, David was returned to "23 and 1" status. **David was in isolation for 23 hours a day for weeks and sometimes months at a time, on and off, for over two years.** David reports that he would become frustrated in isolation, but when he yelled at staff that he wanted to be let out, staff would simply cover the window of his cell.

David was in isolation for 23 hours a day for weeks and sometimes months at a time, on and off, for over two years.

After an investigation revealed that DYC was illegally placing youth like David in isolation, DYC finally removed David from the plan. David remembers that he then learned for the first time that he was being held in was on a campus with a school and dining hall.

***David's isolation is documented in special management plans from three different DYC facilities. The terms of his plan were documented in writing, and David described his experience during his interview.*

Use of Force at Lookout Mountain Youth Services Center

"They say they don't have to show us respect cause we're inmates. I don't think we're inmates, were just juveniles."[120]

Lookout Mountain Youth Services Center is a boys-only facility for young people who have been found guilty and sentenced, or "committed," to DYC's care. Four different young people from this facility separately described a practice called "DEF" or "ALE," occurring between 2013 and 2016. Their descriptions of DEF are similar to descriptions provided by other youth to members of the Coalition over the last several years. During DEF, security staff bring a group of children into the auditorium rather than sending them to school for the day. One youth explained, "They call you 'uninvested youth.'...Anyone who is not doing good can go into DEF."[121] Youth explained that they are required to sit in the auditorium,[122] are provided with an assignment packet, and are told to sit facing forward in silence.[123] Three young people reported that if youth break these rules in any way, for example, by speaking to a peer, staff will "throw you on your face,"[124] "pick you up and start slamming and knee striking you,"[125] or "dump kids on their face and start 'free wheeling' on them, as if they are like street fighting or something."[126] Another stated that staff took a peer into the hallway and "you could just hear him screaming."[127] This youth articulated exactly how these practices can pose a risk to staff as well as youth, stating, "I don't want to go to DEF 'cause I'll catch cases in DEF. If you restrain me for sneezing I'll fight you back."[128]

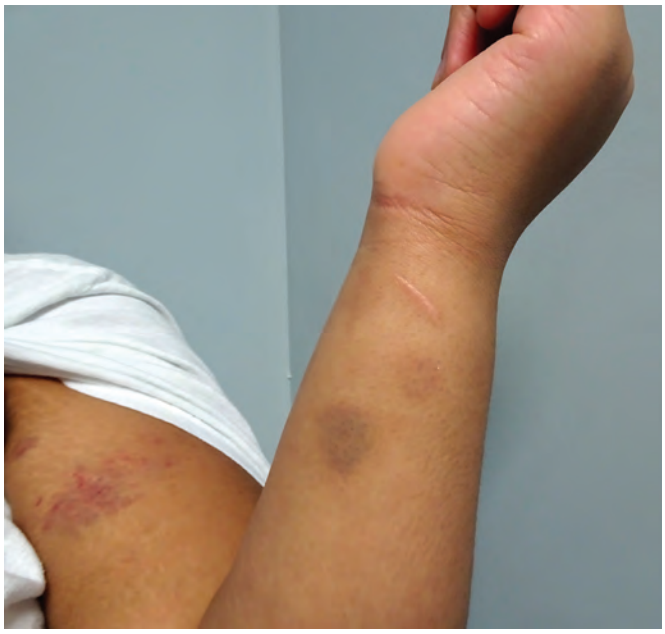


Photo of injury to young person taken after physical management by DYC staff.

Youth from Lookout Mountain also universally confirmed the numerous complaints previously received by the Coalition regarding excessive force by "day programming" staff, who provide security at the school. Five different young people reported that some of these staff are "MMA" or "mixed martial arts" fighters and stated that this is "common knowledge."[129] One youth reported that staff "showed us video of their fights."[130] Another reported that two different staff members spoke to him about their training in fighting.[131] Young people reported that these staff had "anger issues,"[132] went "way overboard,"[133] and "basically use us as punching bags, as practice."[134]

Several young people noted that staff are free to use excessive force at the school because there are no cameras there. One youth said, "All my restraints on the unit have been 'proper' but in the school they have no cameras. They do what they're not supposed to. They take it further."[135] A second youth confirmed that "If you're going to be restrained, you'd rather have it happen on the unit than at school...because school staff will [mess] you up because there are no cameras. When there's no cameras, staff are...grimy."[136]

Injury to Youth and Staff

The punitive techniques used in DYC result in injury to both young people and staff. DYC records confirm that, after being physical managed by staff, youth suffered from head injuries, concussions, rug burns, shoulder separation, bruises, bleeding, and more.[137] One medical record documented bruising and pain to the buttocks, where the staff struck the youth with their knees.[138] The same record documented pain behind the right ear from the use of pressure points by staff.[139] Another record documents injuries to the "medial portion of the upper arm" and the back of the neck, both locations where DYC staff are trained to use pressure points. [140]

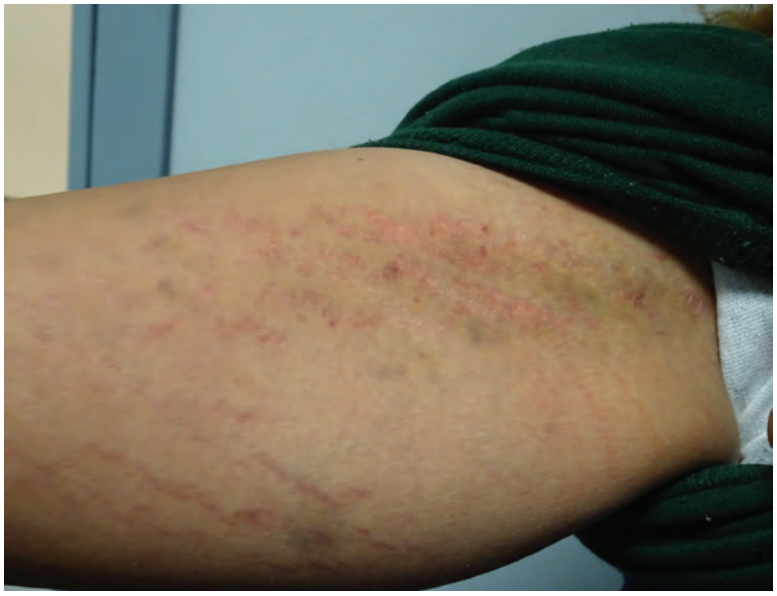


Photo of injury to young person taken after physical management by DYC staff.

Closed head injuries to young people during staff restraints pose a major concern. DYC records repeatedly document head injuries, including visible bumps on the head and concussion symptoms like dizziness and nausea.[141] These records repeatedly note that young people were placed on concussion protocol after staff restraints.[142] Of the youth our coalition interviewed, nine reported having their heads slammed by staff into the ground, a wall, or furniture; five reported losing consciousness.[143] One youth reported being taken to the emergency room after throwing up and reporting dizziness; multiple other youth also reported being put on "concussion protocol."[144]

One youth explained, "When [staff] see how much damage they do, they say, 'Can I clean your face? Can I get you a new shirt?' When they see how much they actually hurt you."

Young people explained that after causing injury, staff would often treat them nicely. One youth explained, "When [staff] see how much damage they do, they say, 'Can I clean your face? Can I get you a new shirt?' When they see how much they actually hurt you." He went on to explain, "When they are nice to you I feel like it's because they don't want you to tell anyone."[145] Another youth reported that after the use of force staff "just try to kiss your ass. They will give you food or just like talk to you, treat you different from all the other kids, to try to make it seem like they are your friend, but they really are just trying to cover up what they did so you don't tell on them."[146] This youth reported a staff member bringing him McDonalds in isolation after using force

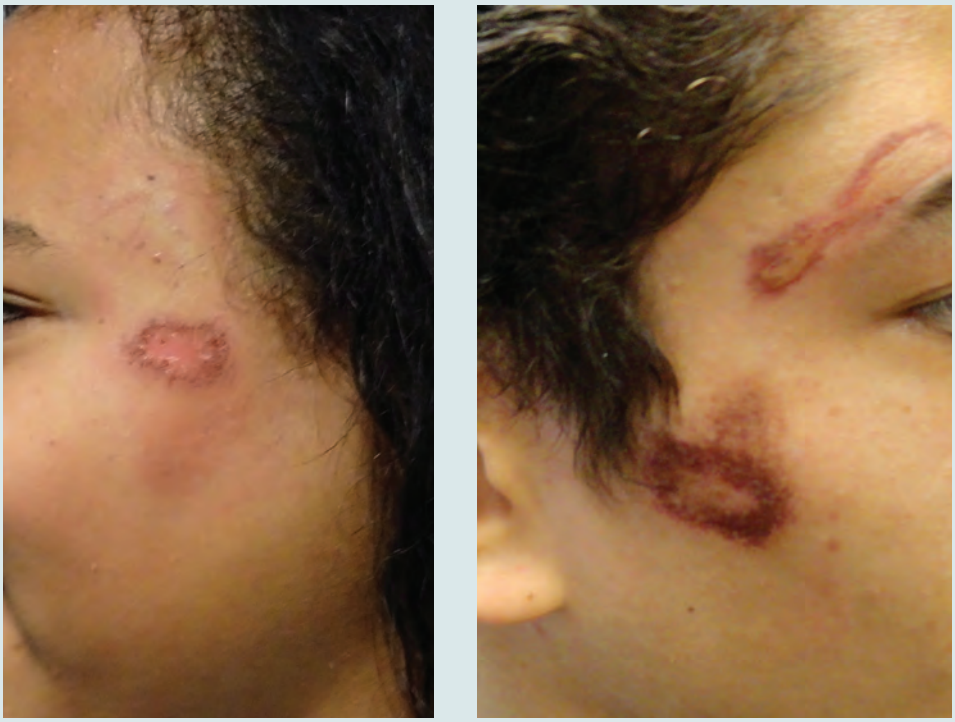
against him.[147] A different youth at a different facility also reported that upon her return from the hospital after a physical management, the staff member involved brought her food that was considered "contraband."[148]

The violent culture in DYC facilities also causes injury to staff. While our Coalition did not have access to staff medical records, it is clear from some Incident Reports that staff were struck by young people prior to and during some physical managements. One Incident Report noted that photographs were taken of injury to staff.[149] After some physical managements, children were charged with crimes for causing injury to staff. The rate of injury to staff in DYC facilities is consistently much higher than the goal set by DYC leadership, and the rate of staff injury increased between 2015 and 2016.[150]

Rug Burns

"I think rubbing the face against the carpet to give you a burn is a little reminder of what happened and who did this to you."

Multiple young people reported that staff would purposely rub their faces on carpet to cause rug burn injuries. One youth stated, "The staff members intentionally rug burn youth."[151] Another reported that staff pushed her head into the ground and "slid my head on the carpet and I started screaming. I had a big circle on my cheek from that."[152] Of the youth interviewed, eight reported suffering from rug burns or observing them on a peer. One concluded, "If I see a kid with rug burn on their face, I assume they got restrained."[153]



Photos of rug burn injuries to young people taken after physical management by staff.

Dante's Story

Dante Jones was in class and left the book his mother had given him on his desk when he went to ask the teacher a question. When he returned, the book was missing. Dante's teacher called security staff to see if they could help find the book. Dante recalls the staff member saying, "I'm not going to search the class just because Dante lost his fucking book." Dante admits that he got angry, and he began to accuse another youth of taking the book. The staff member then ordered Dante to go to isolation for a "time out." Dante responded by swearing at the staff member, and calling him a "punk."

Next, as Dante's teacher puts it, staff "just took him down." Dante remembers other staff members coming in the room to restrain him, and staff members striking him in the face with their knees. Dante was put into handcuffs. A classmate remembers that staff picked Dante up and threw him down on the floor on his back, "and his shoes fell off his feet. And his shoes were tied too. Both shoes came off, one flew in the air....We were all talking about it because his shoes came off and no one had seen that happen before."

Dante's teacher remembers that Dante was in handcuffs when he said he was going to have staff fired. Staff responded by throwing Dante on his face. Dante was cuffed with his hands behind his back, so he could not brace his fall.

Dante recalls that staff then took him to a "time out" room in the school, which does not have cameras, and started hitting and choking him and pushed his head into the wall. Staff members then put a jacket over Dante's head, "so the teachers couldn't see my head," and took him to an isolation room on a unit. Dante remembers crusted blood on the back of his head, blood above his eye, bruises, and a swollen eye and face. When Dante's therapist saw him and his injuries, she asked him what happened, took him into her office, and called for medical assistance.

Dante's classmate saw him later and recalls, "he came back and was all bruised up. Had bruises on his face...it didn't seem like that could have happened in the class. It must have happened in the iso room." Dante's teacher saw Dante later that day and recalls that Dante had a black eye and "looked pretty banged up and he was upset that they did that to him because he was already cuffed up."

Medical records confirm that Dante was injured, documenting that during the restraint Dante hit his head on the wall, lost consciousness, and had a headache and nausea immediately after hitting his head. The doctor observed a bruise-like abrasion on Dante's right cheek, a carpet burn on the left side of the forehead, a swollen right cheek, a mark on the upper neck near the collarbone, and a silver dollar sized bump to the head. Dante's wounds were cleaned and he was placed on concussion protocol; an excessive force claim was reported to the county Department of Human Services.

***This account reflects facts reported by Dante, his teacher, his classmate, and medical records. It also includes facts reported by DYC staff in the Incident Report. Though the Incident Report completed by staff contains no information about the type of force used against Dante, it confirms that staff laid hands on Dante because he verbally refused their directions and called the staff member a "punk." The Incident Report then states, "See use of force." Our coalition requested the "use of force" form referred to in the report, but DYC refused to provide it.*

"It's like, is this a treatment center, or a prison?"[154]

Because of DYC's punitive approach, many young people are not forming rehabilitative relationships with DYC staff. Though some of the youth we interviewed were able to form an isolated positive relationship with a specific staff member, young people universally reported negative impressions of DYC staff as a whole. One youth simply stated, "they didn't like me."[155] Another commented that DYC staff are "angry all the time. I don't know how to explain it, they're in a bad mood all the time. They are like 'Grr' you know....They are like bullies."[156] Young people specifically felt that DYC staff showed their lack of care through physical force; one youth stated, "The ones that hurt me or restrain me...I know they do it on purpose. They just think they can do whatever they want to kids."[157]

Many defeated and demoralized young people reported feeling a lack of self-worth because they felt that staff did not like them or believe in them. One youth stated, "I feel like DYC was out to get me. I feel like DYC don't want me."[158] Youth overwhelmingly reported that DYC staff would insult them and swear at them, noting that staff called them, "a bitch," "fat asses," "worthless," "a piece of shit," a "cry baby," and "unwanted."[159] One youth reported crying after staff physically restrained him; the following day a staff member "looked at me and smirked and said, 'we're not crying today, are we?'"

"Here everyone hates me, I hate myself; I'm just not a good person here."[160]

"There was a period where I was doing well and the therapist said, 'this is just his honeymoon period.' They assumed I would do bad again."[161] Rehabilitation is not possible when young people feel that the staff members who are supposed to care for them don't like them and believe that they are worthless.

DYC Staff Who Help Youth Heal

Some young people were able to describe times that DYC staff took another approach: building relationships rather than using physical force. One youth, who described multiple instances of physical management, injury, and being placed in the WRAP, noted "It's not really all the staff. It's most of the staff but not all of them. Cause I mean Coach, every time someone's getting restrained he don't put his hands on nobody." The same youth identified a second staff member who "actually talks to people and listens," noting, "When she works, I never get in trouble."[162]

Another youth was able to describe a specific time that staff refrained from using physical force. The youth explained that he was upset because he was supposed to be allowed to make a phone call and was not permitted to do so for several days. On the fourth day, when the youth saw a peer get to make a phone call, he became angry. He threw a cooler, threw furniture, and punched the wall. This would usually result in a restraint and/or isolation, but the youth reports that a staff member who "had been there for a while, he knew how to talk to me...he said come for a walk

and my hand's bleeding and I go on a walk with him. They don't put me in a holding cell though." Another staff member acknowledged that the youth was probably upset because he didn't get his phone call, admitting that the youth had been asking for his call all week. Staff and the young person walked to another unit together, talked, and no one was physically managed or injured. It is possible to bring this relational approach to DYC to make facilities safer and effectively rehabilitate children.

The Missouri Miracle
A Path to Reform

"To change a system, you must change the culture."
—Missouri Division of Youth Services[163]

The "Missouri Approach," recognized nationally as the gold standard for humane and effective treatment of incarcerated youth, is a trauma-informed therapeutic group treatment approach toward incarcerated youth devised and implemented by the Missouri Division of Youth Services over the course of the past three decades. Like Colorado, Missouri houses youth up to the age of 21 with the rest of its juvenile population,[164] and works with youth who have been found guilty of serious crimes, are gang involved, have demonstrated violent behavior, and have significant histories of trauma.[165]

"If you treat a kid like an inmate, he's going to act like an inmate."
—Statement by youth during MDYS facility tour.

The Missouri approach relies on a culture of caring that builds strong relationships between youth and their peers and between youth and staff. Children are treated like children and placed in home-like environments that promote safety so youth can let their guard down and engage in treatment. In Missouri, young people sleep in dorm style rooms with comforters, wear their own clothing, decorate their personal spaces with items from home. The common spaces are attractive and comfortable. This stands in stark contrast to the prison-like atmosphere in Colorado DYC facilities, where youth wear institutional scrubs or uniforms, are placed in locked cells with prison blankets, and gather in bleak and institutional common areas.

In Missouri, the goal is change, not punishment. Instead of "behavioral compliance," Missouri staff focus on "internalized change."[166] Young people join a closely supervised group of 10 to 12 peers, with two dedicated staff called "youth specialists." Youth spend virtually all day with their group—sleeping, eating, studying, and exercising together. When youth engage in disruptive, disrespectful, or destructive behavior, they are called upon to explain their thoughts and feelings to the group and reflect on how their actions impact others. [167]

The foundation of this supportive and effective environment is safety. Missouri DYS teaches its staff that "Safety and structure are the foundation of treatment—Meeting youth's basic needs and providing physical and emotional safety is the foundation of treatment. Youth need to know that staff cares enough about them to expect them to succeed."[168]

Colorado

Isolation cell at Lookout Mountain Youth Services Center. Photo credit © Richard Ross, www.juvenile-in-justice.com.

Youth room at Lookout Mountain Youth Services Center. Photo credit © Richard Ross, www.juvenile-in-justice.com.

Still from Spring Creek Youth Services Center, Colorado Springs Gazette.

Missouri

MDYS bunk room.

MDYS common area.

MDYS group meeting room.

In February 2017, DYC leadership, along with a representative of this Coalition and Colorado State Representative Pete Lee, spent two days touring MDYS, speaking with MDYS leadership, staff and youth. The following information was shared and learned during the course of that tour.

"Missouri staff are trained to build positive safe relationships with kids by keepings, 'eyes on, ears on, hearts on.'"

—Missouri Division of Youth Services, "Safety Building Blocks."

A mainstay of the Missouri Approach is that staff must never do anything that hurts a child. Thus, Missouri never uses pain compliance techniques, knee strikes, or the WRAP restraint. Missouri DYS staff do not use any mechanical restraints other than handcuffs, and Missouri leadership estimates that handcuffs were last used on a young person in their care six years ago.

Missouri DYS also completely repudiates the use of isolation. Children in MDYS are never placed alone behind a locked door. Missouri leadership reject isolation because it hurts children, is nontherapeutic, and does nothing to help address the issues driving a child's misbehavior. Missouri youth have a saying: "Change doesn't happen in isolation." As one Missouri youth explained during the tour: "You might be giving staff a break when you put a kid in isolation, but that kid is hurting in there. When he comes out of isolation, he's just going to be angrier and more isolated from the group. Then, it will just be harder to figure out what the real problem is."

Missouri believes in the power of relationships amongst peers and between youth and staff to address virtually any problem that arises in the facility. Although restraints do happen in Missouri, children in Missouri universally reported during a recent visit that they have never been hurt during those restraints and that the restraints do not feel punitive. Instead, children expressed feeling guilt over having engaged in behavior that led to the restraint, and feeling closer to the group because of what happened after the restraint. Unlike in Colorado, where restrained children are typically sent to isolation for some period of time and then suffer a punishment such as loss of privileges, children who are restrained in Missouri are urged to consider what was behind their misbehavior immediately after the restraint. As the children in Missouri repeatedly stated during the tour: "Anger is a secondary emotion." Instead of being punished, youth in Missouri are required to do the hard work of taking responsibility before the group for their actions in anger, and then investigating with the group the root causes of that anger so that the youth can begin fundamentally changing that behavior.

"True understanding is built on genuine empathy and care... Demonstrating respect and appreciation for the worth of youth and families is essential."

—Missouri Division of Youth Services, "Safety Building Blocks."

Missouri is one of only two states that utilizes staff-led, *youth assisted* restraints. Missouri does not recommend other states with long-embedded correctional cultures adopt this approach to restraints. Other jurisdictions that have adopted Missouri's approach do *not* use youth assisted restraints. Instead, staff are taught non-punitive, non-harmful restraint techniques that do not involve pain compliance, isolation, or mechanical restraints, such as those utilized in Safe Crisis Management.[169]

Children in Missouri consistently reported a sense of well-being and self-confidence that came from the support of their group, particularly including staff. Staff likewise reported a deep sense of satisfaction in their jobs and connection with the kids. Although MDYS reports that its staff are some of the lowest paid in the country, many nonetheless stay for decades because of the positive, warm culture and the success of the Missouri's approach.

This cultural environment of respect and care, without the painful and isolating "tools" that DYC staff use to control children, actually results in *safer* facilities. Missouri institutions have far fewer assaults against both staff and youth.[170] Colorado incarcerated youth are more than twice as likely to be assaulted compared to Missouri incarcerated youth.[171]

Compared to other states, Missouri incarcerated youth are:

- 4 ½ times less likely to be assaulted;
- 17 times less likely to be placed in mechanical restraints;
- 200 times less likely to be placed in solitary confinement.

Missouri staff are also safer. Compared to other states, Missouri youth corrections staff are 13 times less likely to be assaulted.[172]

While DYC leadership publicly promotes trauma-informed care based on positive reinforcement and relationship based care for youth,[173] DYC policy and practice are not consistent with that vision. Trauma-informed approaches do not use pain compliance, WRAP restraints, or solitary confinement, and do not allow physical management when children are passively non-compliant. The Missouri Division of Youth Services has wholeheartedly rejected these methods because they hurt children, are not trauma-informed, and deter rehabilitation.

Bringing the Missouri Approach to Colorado

There is way to bring the Missouri Approach to Colorado. The Missouri Youth Services Institute (MYSI), a non-profit dedicated to exporting the Missouri Approach to other states, can bring a pilot program to Colorado and provide a template for broad cultural change within DYC.[174] MYSI's founder and director is Mark Steward, the 17 year former head of the Missouri Division of Youth Services, who pioneered the Missouri Approach. MYSI has successfully partnered with 10 juvenile justice jurisdictions across the country, including Washington DC, to deliver on the promise of trauma-informed care for youth,[175] including increased safety for staff and youth and reduced youth recidivism. MYSI has worked with youth up to age 21, including violent and gang-involved youth, youth who have suffered significant trauma, and youth with mental illness.[176]

MYSI is dedicated to what DYC facilities need most: transforming a correctional culture into a rehabilitative one.

MYSI specializes in meeting local correctional staff and leadership where they are, and then helping transform culture from within by teaching staff a non-punitive, relational, trauma-informed approach to care for incarcerated children. This model can incorporate existing treatment programs in DYC, including the Sanctuary Model and other positive behavior reinforcement systems.[177] MYSI can help DYC leadership finally deliver on its promise to provide effective, trauma-informed care to Colorado's youth, and can do so while keeping youth and staff safer.

Policy Recommendations

To start transforming the culture of violence at DYC into a culture of caring and rehabilitation, and to make young people and staff safer, the Colorado Child Safety Coalition makes the following recommendations.

1. Bring a Missouri Approach pilot program to DYC, under the guidance of Missouri Youth Services Institute, to begin within six months. Colorado's children cannot wait.

2. Prohibit physical management methods that harm and re-traumatize children.
    - Prohibit the WRAP.
    - Prohibit pain compliance techniques.
    - Prohibit the use of leg irons and wrist-to-waist restraints.
    - Prohibit staff from physical contact with disobedient youth who pose no immediate threat of harm to self or others.

3. End the practice of isolating children who act out.

4. Provide intensive training and retraining to all staff in the provision of trauma-informed care and build a positive culture based on relationships, not punishment or control.

5. Provide staff the tools they need to de-escalate and, when necessary, physically manage escalated youth in a manner that does not harm youth or staff, such as the methods taught in Safe Crisis Management.

6. Increase transparency of DYC. The public has a right to know the circumstances under which DYC uses force on the youth in its care. Even with the passage of the DYC transparency law,[178] DYC refuses to provide such information. Should DYC persist in its refusal to disclose information about use of force, the legislature should amend the law to require DYC to provide such information in response to a public information request, without divulging confidential information about individual young people.

Conclusion

The children incarcerated in DYC facilities, as well as staff, are in crisis. They are literally pleading for help. Colorado's current approach is not working. Violence in facilities is increasing, children and staff feel unsafe, and this environment prevents traumatized and vulnerable young people from engaging in the treatment they need. DYC's deeply embedded punitive culture embraces practices that are causing pain and injury to children, increasing risk to staff, and decreasing the likelihood of rehabilitation.

There is an opportunity to implement a better model that makes facilities safer, so that Colorado can fulfill its promise to youth, families and communities: a system that "provid[es] appropriate treatment…" and helps each young person become "a productive member of society."[179] The Missouri Approach is not soft: it's science. Data show that it works to decrease violence and injury while maintaining low recidivism rates and high education outcomes.[180] As one Missouri youth said to DYC leadership and a member of this coalition during a recent Missouri Division of Youth Services tour: "The kids in Colorado deserve as good as the kids in Missouri."

ENDNOTES

[1] Colorado Revised Statutes § 19-2-102(1).

[2] Colorado Department of Human Services (CDHS) press release, "CDHS Releases Statement on Arrest of Spring Creek Youth Services Center Employee," February 10, 2017, available at https://docs.google.com/viewer?a=v&pid=sites&srcid=c3RhdGUuY28udXN8Y2Rocy1jb21tfGd4OjJiMjRiNzQwM2VlNzQ1NjE; *see also* "Youth Corrections Worker Charged With Sexual Assault on Children,"December 20, 2016, available at http://kdvr.com/2016/12/20/youth-corrections-officer-charged-with-sexual-assault-children/.

[3] *See* http://missouriapproach.org/approach/; *see also* http://missouriapproach.org/results.

[4] The young people interviewed had been incarcerated at ten of the twelve secure detention facilities in Colorado: the Gilliam Youth Services Center, Lookout Mountain Youth Services Center, Platte Valley Youth Services Center, Spring Creek Youth Services Center, Grand Mesa Youth Services Center, Mount View Youth Services Center, Marvin W. Foote Youth Services Center, Adams Youth Services Center, Zebulon Pike Youth Services Center, and Betty K. Marler Youth Services Center. We also interviewed youth at Ridge View Youth Services Center, a 500 bed open campus facility. The Coalition did not interview youth held at only two state owned DYC facilities, Robert E. Denier Denier Youth Services Center or Pueblo Youth Services Center. The Gilliam, Adams, Pueblo, and Marvin W. Foote Youth Service Centers are state owned and operated detention facilities. The Platte Valley, Grand Mesa, Spring Creek, and Mount View Youth Services Centers are state owned and operated facilities for both detained (pre-trial) and committed (sentenced) youth. The Lookout Mountain and Zebulon Pike Youth Services Centers are state owned and operated facilities that serve committed (sentenced) boys. The Ridge View, Betty K. Marler, and Robert E. Denier Youth Services Centers are state owned facilities operated by private contractors. The average daily population in secure DYC facilities in 2014-15 was 663 youth (including youth held prior to trial and youth committed to sentences in DYC facilities).

[5] *See* Letter to CDHS Director Reggie Bicha from ACLU of Colorado, Colorado Juvenile Defender Center, and Disability Law Colorado (CJDC), June 18, 2014, available at http://static.aclu-co.org/wp-content/uploads/2017/02/2014-06-18-Letter-to-DHS-Executive-Director-Bicha.pdf.

[6] *See* Letter to CDHS Director of Office of Child, Youth and Families Robert Werthwein from Disability Law Colorado, ACLU of Colorado, and CJDC, Nov. 2, 2016, available at: http://static.aclu-co.org/wp-content/uploads/2017/02/2016-11-02-Werthwein-DLC-ACLU-CJDC-physical-management.pdf.

[7] "Colorado Springs youth service center workers ask for stun guns, pepper stray to counter violence amid release of new video," *The Gazette,* October 31, 2016, available at: http://gazette.com/spring-creek-workers-ask-for-stun-guns-pepper-spray-to-counter-violence/article/1589109

[8] Critical incidents are serious incidents that include an escape from a secure facility, suicide attempts, transporting a juvenile to a

hospital, police being called to the facility, assaults that may result in police contact, an allegation of child abuse, or a facility lock down for more than 4 hours. Colorado Office of the State Auditor, Division of Youth Corrections Performance Audit, September 2016, p. 33, available at: https://leg.colorado.gov/sites/default/files/documents/audits/1557p_division_of_young people_corrections_performance_audit_september_2016.pdf

[9] Colorado Office of the State Auditor, Division of Youth Corrections Performance Audit, September 2016, p. 32, available at: https://leg.colorado.gov/sites/default/files/documents/audits/1557p_division_of_young people_corrections_performance_audit_september_2016.pdf

[10] CDHS FY 2017-18 Joint Budget Committee Hearing Agenda, January 4, 2017, pp. 10-11, available at https://leg.colorado.gov/sites/default/files/fy2017-18_humhrg2_0.pdf

[11] *Id*., pp. 9- 10.

[12] DYC Management Reference Manual, Fiscal Year 2014-15, published March 2016, pp 5, 17, and 20, available at https://drive.google.com/file/d/0B2XNXJqGVfP6Y3k2cmlLbnBHZGc/view. The average daily population of pre-trial youth in secure facilities declined from 353 to 282 between fiscal years 2010-11 and 2014-15; the average daily population of sentenced youth in secure facilities declined from 494 to 381 in the same time period.

[13] The average age of youth at the time of detention has been either 16.0 or 16.1 since fiscal year 2010-11. The average age of youth at the time of commitment to DYC has been either 16.7 or 16.8 since fiscal year 2007-08. *Id*., pp. 11, 23; Division of Corrections Management Reference Manual, Fiscal Year 2010-11, published October 2012, pp. vii, 11; Division of Corrections Management Reference Manual, Fiscal Year 2011-12, published March 2013, pp. 11, 24; all available at https://sites.google.com/a/state.co.us/cdhs-dyc/home/resources-publications/reports-and-evaluations.

[14] The number of young men sentenced to DYC for committing a felony against a person was 20.2%, 17.8%, 21.0%, 22.2%, and 22.3% from fiscal years 2010-11 to 2014-15. The number of young women committed for a felony against a person was 14.6%, 11%, 14.5%, 12.5%, and 13.1%. DYC Management Reference Manual, Fiscal Year 2014-15, published March 2016, p. 26; Division of Corrections Management Reference Manual, Fiscal Year 2011-12, published March 2013, p. 26; both available at https://sites.google.com/a/state.co.us/cdhs-dyc/home/resources-publications/reports-and-evaluations.

[15] The number of youth sentenced to DYC with previous probation involvement has been 83%, 88%, 83%, 81%, 82%, DYC Management Reference Manual, Fiscal Year 2014-15, published March 2016, p. 19, available at https://drive.google.com/file/d/0B2XNXJqGVfP6Y3k2cmlLbnBHZGc/view

[16] *See* note 10, *supra* at p. 16; Budget Package and Long Bill Narrative, State of Colorado, Joint Budget Committee, FY 2016-17, p. 100, available at https://leg.colorado.gov/sites/default/files/16lbnarrative_0.pdf; Budget Package and Long Bill Narrative, State of Colorado, Joint Budget Committee, FY 2015-16, p. 95, available at http://leg.colorado.gov/sites/default/files/15lbnarrative.pdf

[17] *See* note 10, *supra* at p. 16. While other facilities did report reduced violence from fiscal year 2014-15 to 2015-16, the reductions in violence were highly variable (ranging from 9-53% reduction) and independent of staffing improvements. For example, two facilities experienced no change in staffing but reduced violence over 20%. On the contrary, Lookout Mountain improved their staff-to-young people ratio by 18% (12.6:1 vs. 10.3:1) in fiscal year 2015-16, the second largest improvement of all facilities; however, Lookout Mountain was the least improved in violent activity, reporting only a 9% reduction in fights and assaults.

[18] Interview with Lataya. *To protect the identities of the young people in this Report, a unique pseudonym has been assigned to each youth.*

[19] *Id*.

[20] *See* note 7, *supra*.

[21] *Id*.; *see also* Max Siegelbaum, "Colorado Youth Corrections boss leaves after allegations of riots, assaults and sex," Sept. 14, 2016, available at:
http://www.denverpost.com/2016/09/14/colorado-youth-corrections-charles-chuck-parkins-departs/.

[22] Interview with Elijah.

[23] *Id*.

[24] Sue Burrell, "Trauma and the Environment of Care in Juvenile Institutions," Youth Law Center, The National Child Traumatic Stress Network, Aug. 2013, p. 3, available at: http://www.njjn.org/uploads/digital-library/NCTSN_trauma-and-environment-of-juvenile-care-institutions_Sue-Burrell_September-2013.pdf.

[25] Thomas Grisso, "Progress and Perils in the Juvenile Justice and Mental Health Movement," Journal of the American Academy of Psychiatry and the Law, 35, 2007, pp. 158–167, available at: http://www.njjn.org/uploads/digital-library/perils.pdf.

[26] Julian D. Ford, John F. Chapman, Josephine Hawke, and David Albert, "Trauma Among Young people in the Juvenile Justice System: Critical Issues and New Directions," Research and Program Brief, National Center for Mental Health and Juvenile Justice, June 2007, available at: http://www.ncmhjj.com/wp-content/uploads/2013/10/2007_Trauma-Among-Young people-in-the-Juvenile-Justice-System.pdf

[27] *See* note 24, *supra* at p. 1.

[28] *Id*., p. 4.

[29] *Id*., p. 1.

[30] Elwyn LJ, Esaki N, Smith CA, "Safety at a girls' secure juvenile justice facility," Therapeutic Communities: The International Journal of Therapeutic Communities, 2015, available at: http://www.emeraldinsight.com/doi/abs/10.1108/TC-11-2014-0038?journalCode=tc; Marrow MT, Knudsen KJ, Olafson E, Bucher SE, "The value of implementing TARGET within a trauma-informed juvenile justice setting," Journal of Child & Adolescent Trauma, 2012, available at: http://www.tandfonline.com/doi/abs/10.1080/19361521.2012.697105.

[31] *Id*.

[32] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014, p. 9-10, available at: http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf.

[33] *Id.*

[34] *Id.*

[35] *Id.*, p. 11.

[36] *See* note 24, *supra* at p. 4.

[37] Interview with John.

[38] The National Center for Trauma-Informed Care & Alternatives to Seclusion and Restraint (NCTIC) supports the elimination of the use of seclusion, restraints, and other coercive practices, as the use of seclusion, restraint, and other violent interventions actually re-traumatize people and pose a barrier to recovery. See National Center for Trauma-Informed Care & Alternatives to Seclusion and Restraint (NCTIC) available at https://www.samhsa.gov/nctic

[39] CDHS OCYF-27 DYC Questions Regarding the Missouri Approach, Seclusion and Training, Feb. 22, 2017, p. 3.

[40] *Id.*

[41] The document reporting DYC physical management data does not reflect from what facilities the data was derived. *Id.* However, this Coalition understands from recent conversations with DYC leadership that, until very recently, DYC's three state-owned, privately run facilities were not consistently collecting or reporting data regarding staff actions toward youth. For example, in the January 25, 2017 Youth Seclusion Work Group Semi-Annual Report, DYC reported no solitary data on Ridge View Youth Services Center and noted that "Betty Marler and Robert Denier have recently implemented data quality improvement processes; data accuracy prior this implementation is questionable." *See* CDHS Youth Seclusion Working Group, Semi-Annual Report, Jan. 25, 2017, p. 1 n.2, available at: http://static.aclu-co.org/wp-content/uploads/2017/02/Seclusion_COMMITTEE_Mar-Aug16_Report-FINAL_Revised_1-17-17.pdf.

[42] Interview with Julian.

[43] *See WRAP customer list, available at:* http://www.saferestraints.com/site/

[44] *See* http://www.saferestraints.com.

[45] *See* note 39, *supra* at p. 3.

[46] *See* http://www.saferestraints.com/site/CustomerListUSA?Custlist%5Bagency%5D=Juvenile&Custlist%5Blocation%5D=&yt0=Search+US+Customers; http://www.saferestraints.com/site/CustomerListUSA?Custlist%5Bagency%5D=Youth&Custlist%5Blocation%5D=&yt0=Search+US+Customers.

[47] Chad Day, "Youth unit told to scrap restraint, taped helmet." *The Northwest Arkansas Democrat Gazette*, October 9, 2014, available at: http://www.nwaonline.com/news/2014/oct/09/youth-unit-told-to-scrap-restraint-tape/; see also http://www.policestateusa.com/2014/juvenile-detainees-locked-in-controversial-device/

[48] Letter from Juvenile Ombudsman Division to Yell County Juvenile Detention Center, September 18, 2014, available at http://media.arkansasonline.com/news/documents/2014/10/08/letter_from_ombudsman.pdf

[49] Letter from Arkansas Division of Youth Services to Director of Yell County Juvenile Detention Center, September 29, 2014, available at http://media.arkansasonline.com/news/documents/2014/10/08/lettertoYellCojdc.pdf.

[50] *See* note 43, *supra*.

[51] Interviews with Elijah, Dante, Sebastian, Julian, Chris, David, John, Lataya, Alejandro, Camila, Isabella, and Roger. A thirteenth youth, Alice, reported seeing a peer placed in the WRAP.

[52] Interviews with David (17 times), Lataya, and Camila.

[53] *See* note 18, *supra*.

[54] Adams Youth Services Center Incident Report. *Many youth reported credible fear of retaliation should DYC staff know of their complaints about violence in the facilities. To address this fear, when citing to DYC records throughout this Report, we exclude any information that may reveal the identity of the reporter to DYC staff with knowledge.*

[55] Lookout Mountain Youth Services Center Seclusion/Restraint Check Sheet.

[56] *Id.*

[57] *Id.*

[58] *Id.*

[59] Interviews with Elijah, Julian, Dante, Chris, Alejandro, and Camila.

[60] Interviews with Elijah, Dante, Chris, David, John, and Lataya. One youth reported, "It starts at the feet. Your feet go numb. Your legs go numb. Your thighs go numb."

[61] Interview with David.

[62] Interviews with Elijah, Sebastian, Dante, Chris, and Alejandro.

[63] Sebastian stated that this "c curve" created "tons of pain in my back." John reported pain to his hamstring, the back of his thighs, his lower back, his calves, and the bottom of his feet, saying, "it hurts bad."

[64] Lookout Mountain Youth Services Center Incident Reports.

[65] *Id.*

[66] Lookout Mountain Youth Services Center Medical Record.

[67] Interview with Chris.

[68] Interview with John.

[69] *See* note 24, *supra* at p. 4.

[70] *See* note 39, *supra* at p. 2.

[71] See CDHS Youth Seclusion Working Group, Semi-Annual Report, Jan. 25, 2017, p. 2, available at: available at: http://static.aclu-co.org/wp-content/uploads/2017/02/Seclusion_COMMITTEE_Mar-Aug16_Report-FINAL_Revised_1-17-17.pdf;

[72] *Id.*, pp. 3-4.

[73] "Growing Up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States," Human Rights Watch and American Civil Liberties Union, October 2012, pp. 23-37, *available* at http://www.aclu.org/blog/criminal-law-reform-prisoners-rights/growing-locked-down-youth-solitary-confinement.

[74] Dep't of Justice Office of Juvenile Justice and Delinquency Prevention, Juvenile Suicide in Confinement: A National Survey (2009), pp. 11-12, *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/213691.pdf.

[75] *See, e.g.*, Policy Statements: Solitary Confinement of Juvenile Offenders, American Academy of Child & Adolescent Psychiatry, approved April 2012, *available* at http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx.

[76] *See* note 64, *supra*.

[77] *See* note 37, *supra*.

[78] *See* https://legiscan.com/CO/text/HB1328/id/1418368/Colorado-2016-HB1328-Enrolled.pdf; *see also* note 5, *supra*.

[79] *See* note 71, *supra*, at pp. 5-6.

[80] *See* note 9, *supra*, at pp. 27-32.

[81] *See* note 64, *supra*.

[82] Lookout Mountain Youth Services Center written Special Management Plan.

[83] Verbal report from DYC administration to Coalition.

[84] Interviews with Sebastian, Tony, and John.

[85] Interviews with Julian, John, and Lataya.

[86] Lookout Mountain Youth Services Center Grievances.

[87] *See* note 18, *supra*.

[88] Letter to Robert Werthwein from ACLU of Colorado, Colorado Juvenile Defender Center, and Disability Law Colorado, November 2, 2016, available at: http://static.aclu-co.org/wp-content/uploads/2017/02/2016-11-02-Werthwein-DLC-ACLU-CJDC-physical-management.pdf.

[89] Investigation of the Shelby County Juvenile Court, U.S. Dep't of Justice Civil Rights Div., pp. 56-58, 65 (Apr. 2012), available at: https://www.justice.gov/sites/default/files/crt/legacy/2012/04/26/shelbycountyjuv_findingsrpt_4-26-12.pdf.

[90] *See* note 64, *supra*.

[91] *Id.*

[92] *Id.*

[93] *Id.*

[94] *Id.*

[95] Interviews with Elijah, Julian, Sebastian, Dante, Alice, Brandon, Chris, Jamie, Justin, Alejandro, Lataya, John, Isabella.

[96] Interview with Alice, Brandon.

[97] Interview with Brandon (bruised ears) and Chris (fingernails).

[98] "Pressure Points for Law Enforcement: Control and Compliance," published by the Snake Pit: Combat Arts, February 16, 2016, available at https://www.youtube.com/watch?v=3YNRSFYVb5A

[99] *See* note 67, *supra*.

[100] Interview with Sebastian.

[101] Two Lookout Mountain Youth Services Center Incident Reports. (One staff member documents three knee strikes to the femoral nerve point, another staff member documents knee strike to the common peroneal).

[102] Interviews with Elijah, Dante, Sebastian, Alice, Julian, Chris, David, Alejandro, John, Jamie, Anderson.

[103] Interviews with Sebastian, Dante, Chris, Jamie, and Anderson.

[104] Interviews with Elijah, Sebastian, Dante, Chris, and John.

[105] *See* note 96, *supra*.

[106] *See* note 66, *supra*.

[107] DYC Medical records.

[108] Interview with Camila.

[109] Interviews with Dante (staff put hands on youth when he refused to hand them his drawing pencil), Elijah (restraint occurred when youth was sitting down reading, staff told him to move, and he refused to move), Jamie (staff restrained seated peer when peer refused to give staff his book, resulting in knee strikes and rub burn injuries), and Camila (during breakfast "they had took my juice and milk so I went to go get it from the staff desk and I reached across the staff desk to get it and they restrained me").

[110] *See* note 67, *supra*.

[111] Interview with Jaime.

[112] Mount View Youth Services Center Incident Report.

[113] Interviews with Roger and John.

[114] *See* note 64, *supra*.

[115] *Id*. (when youth refused to take a time out, staff attempted to transport youth, "youth physically struggled with transition which resulted in physical management"; Mount View Youth Services Incident Report (physical management when youth refused to go into his room).

[116] *See* Shantel D. West, "Student perspectives on how trauma experiences manifest in a classroom: Engaging court-involved youth in the development of a trauma-informed teaching curriculum," Children and Youth Services Review 38 2014, p. 62(noting traumatized youth can be triggered by "certain sights, sounds, words, physical touch").

[117] Interview with Alice.

[118] Interview with Sebastian, Dante.

[119] Two DYC videos recording incidents at Lookout Mountain Youth Services Center.

[120] *See* note 18, *supra*.

[121] Interview with Dante.

[122] *Id*.

[123] Interview with Alejandro.

[124] *See* note 121, *supra*.

[125] *See* note 123, *supra*.

[126] *See* note 67, *supra*.

[127] *See* note 121, *supra*.

[128] *Id*.

[129] Interviews with David, Alejandro, Chris, Dante, and Elijah.

[130] *See* note 121, *supra*.

[131] *See* note 67, *supra*.

[132] *See* note 61, *supra*.

[133] *Id*.

[134] *See* note 120, *supra*.

[135] *See* note 100, *supra*.

[136] *See* note 123, *supra*.

[137] DYC medical records.

[138] *Id.*

[139] *Id.*

[140] *Id.*

[141] *Id.*

[142] *Id.*

[143] Interviews with Elijah (reporting being knocked out staff slammed him to the ground), Sebastian (reporting five knee strikes to the face and having his face pushed into the carpet, then seeing black), Dante (reporting that staff banged his head on a tile floor), Chris (reporting blacking out after staff threw him to the ground), Ashley (who recalling being picked up and thrown on the ground by staff, she later went to the ER), and Elias (reporting being thrown onto the metal bed frame in an isolation room after being thrown to the ground on a hard cement floor),Brandon (reporting that staff slammed his head on tile),Camila (reporting that staff banged her head into the floor and she was put on concussion protocol), and Isabella (reporting her head was banged to the floor and she lost consciousness).

[144] Interviews with Brandon, Chris, and Camila.

[145] Interview with Elijah.

[146] *See* note 67, *supra*.

[147] *Id.*

[148] Interview with Ashley.

[149] Lookout Mountain Incident Report.

[150] *See* note 10, *supra* at p. 10.

[151] *See* note 61, *supra*.

[152] *See* note 117, *supra*.

[153] *See* note 123, *supra*.

[154] *See* note 67, *supra*.

[155] *Id.*

[156] *See* note 121, *supra*.

[157] *See* note 109, *supra*.

[158] *See* note 121, *supra*.

[159] Interviews with Alice, Lataya, Roger, and Camila.

[160] *See* note 121, *supra*.

[161] *See* note 37, *supra*.

[162] *See* note 108, *supra*.

[163] "Missouri Approach," Powerpoint by Missouri Division of Youth Services, p. 5.

[164] *Id*., p. 1.

[165] "The Missouri Model: Reinventing the Practice or Rehabilitating Youthful Offenders," Richard A. Mendel, The Annie E. Casey Foundation, Baltimore, MD, 2010, pp. 8, 19, available at: :http://www.aecf.org/m/resourcedoc/aecf-MissouriModelFullreport-2010.pdf; Missouri Department of Social Services, Division of Youth Services Annual Report Fiscal Year 2015, p. 1, available at: https://dss.mo.gov/re/pdf/dys/youth-services-annual-report-fy15.pdf.
166 *See* http://missouriapproach.org/approach/.

[167] *Id*.., p. 7.

[168] Missouri Division of Youth Services Treatment Beliefs, January 1, 2010.

[169] *See* http://www.safecrisismanagement.com/paypal/. This information was confirmed in conversations between ACLU of Colorado Staff Attorney & Policy Counsel Rebecca Wallace with Phyllis Becker, Director of Missouri Division of Youth Services and Mark Steward, Executive Director of Missouri Youth Services Institute during a February 2, 2017 MDYS site visit; during a January 31, 2017 conversation with Dr. Mary Livers, former 12 year head of Louisiana's Office of Juvenile Justice who oversaw implementation of the Missouri Approach; and during a January 31, 2017 conversation with Professor Vincent Schiraldi, former head of juvenile corrections in Washington, DC who oversaw implementation of the Missouri approach.

[170] *See* http://missouriapproach.org/approach/.

[171] While the rate of assaults in DYC facilities per 100 bed days fluctuated between 0.42 and 0.58 in 2016, Missouri's rate was 0.21 for fiscal year 2016. *Compare* CDHS FY 2017-18 Joint Budget Committee Hearing Agenda, January 4, 2017, p. 8, available at: https://leg.colorado.gov/sites/default/files/fy2017-18_humhrg2_0.pdf; *with* data from Phyllis Becker, Director of Missouri Division of Youth Services, received January 11, 2017. The average assault rate at PbS facilities, a comparison group including over 200 which are a mix of above-average facilities seeking to optimize results and more problematic facilities seeking to address safety issues and other serious problems, is 0.42 per 100 bed days.

[172] *See* note 166, supra at p. 9. This data was compiled in 2008-09 for the Council of Juvenile Correctional Administrators' Performance-based Standards (PbS) project. The comparison group includes over 200 PbS facilities, which are a mix of above-average facilities seeking to optimize results and more problematic facilities seeking to address safety issues and other serious problems.

[173] CDHS FY 2017-18 Joint Budget Committee Hearing Agenda, January 4, 2017, pp. 21-24, available at: https://leg.colorado.gov/sites/default/files/fy2017-18_humhrg2_0.pdf.

[174] *See* http://www.mysiconsulting.org/.

[175] "The Missouri Youth Services Institute (MYSI) Approach for Positive Juvenile Justice System Outcomes," Mark Steward, January 13, 2017.

[176] Statements by Mark Steward during Feb. 2017 MDYS site visit.

[177] *Id.*

[178] Colorado Revised Statutes § 19-1-304(8).

[179] *See* note 1, *supra*.

[180] *See* http://missouriapproach.org/approach/

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A PATH FORWARD

There is a path forward to transform DYC's punitive culture into a rehabilitative one — by embracing the Missouri Approach to incarcerated youth.

MISSOURI APPROACH: SAFETY BUILDING BLOCKS

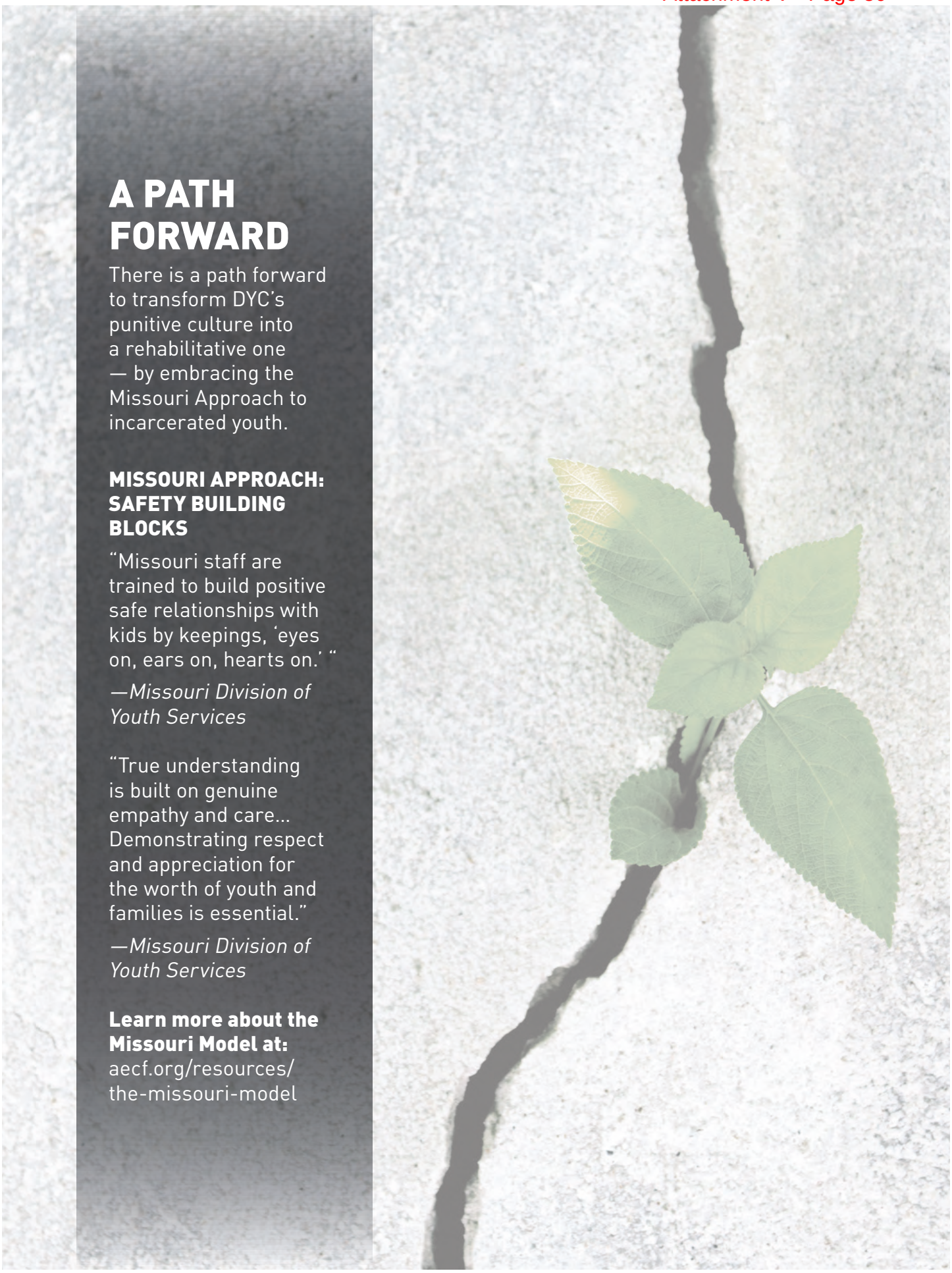
"Missouri staff are trained to build positive safe relationships with kids by keepings, 'eyes on, ears on, hearts on.' "

—Missouri Division of Youth Services

"True understanding is built on genuine empathy and care... Demonstrating respect and appreciation for the worth of youth and families is essential."

—Missouri Division of Youth Services

Learn more about the Missouri Model at:
aecf.org/resources/the-missouri-model



Attachment C

Canada · CBC Investigates

Use of full-body restraint while in youth detention 'left me broken,' Sask. man says

Known as the Wrap, experts and those who've endured the device say it can cause lasting trauma

Jorge Barrera, Joseph Loiero, Michelle Allan · CBC News ·
Posted: Jun 23, 2023 1:00 AM PDT | Last Updated: June 23, 2023

Matthew Michel is shown in Saskatoon on June 5, the day he was released from the Saskatoon Correctional Centre. Michel says his early interactions with the juvenile corrections system, including his time spent in a restraining device known as the Wrap, had a traumatic, lasting impact on him. (Chanss Lagaden/CBC)

WARNING: This story contains offensive language and distressing video.

Sometime between 2 a.m. and 3 a.m., Matthew Michel asked staff at the youth jail in Regina where he was being held to kill him. A motorcycle helmet encased his head and mesh straps with steel buckles and Velcro immobilized his body.

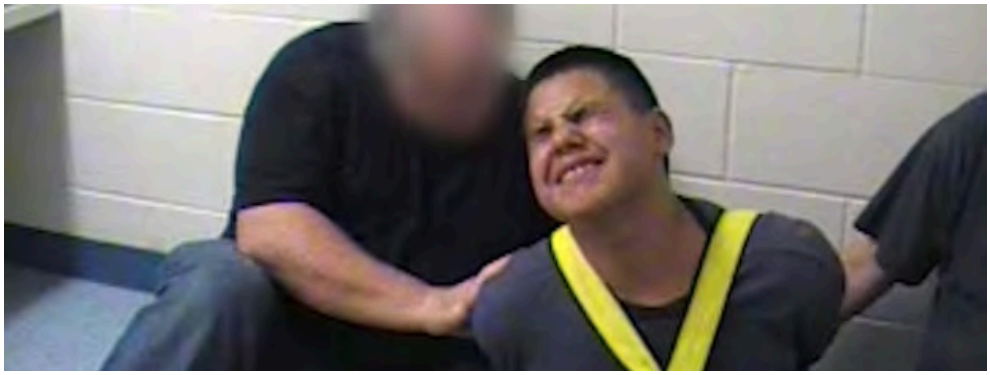
Michel's body was bound by a device called the Wrap — a series of straps binding his torso, legs and ankles, and connected to a shoulder harness to keep his body in a near-45-degree, forward-sitting position. His hands were cuffed behind his back and locked into a carabiner.

Michel, then 15, begged for death after spending two hours in the Wrap at the Paul Dojack Youth Centre, according to internal jail video and files obtained by CBC News.

"F--king strangle me," said Michel. "Kill me already. F--k."

At times, Michel gagged, wept and hyperventilated, the video shows.

Two jail staff sat on either side of him, one reading a book and drinking a juice box. Both appear impervious to his short bursts of breaths and groans of pain.



Video shows youth jails forcing teens into restraint devices

▶ 1 year ago 10:47

A third staff member periodically enters the frame to check on Michel's condition.

"Subject is crying, he's crying. Now, he's settling," said the third staff member, wearing dark gloves.

"I'm not f--king crying, man. I'm f--king trying to f--king suffocate myself to death," Michel says in the video, dated Aug. 17, 2010, and now made public for the first time.

At another moment shown on the video, a staff member shakes Michel by one of the straps. "No sleeping. If I'm not sleeping, you aren't sleeping."

Around 3:20 a.m., Michel, still bound, lay on his side. The helmet had now been removed and replaced with a spit hood, covering half his face.

A staff member wearing a Mötley Crüe shirt, who identified himself as a supervisor, asks Michel if he was willing to co-operate. Michel nods his head weakly. Staff remove the Wrap, shackle his ankles, cuff his now-swollen wrists and pull him up. Michel shuffles forward, his legs shaky.

"You might be a little wobbly for a bit," said the supervisor.

Michel was kept in the Wrap for over three hours that day.

3 provinces allow for use of the Wrap

The Wrap was created by a California-based company nearly 30 years ago, sold to law enforcement as a safe way to restrain individuals acting violently or dangerously,

compared to other methods, such as pinning a subject facedown or using pepper spray or a Taser.

Safe Restraints Inc. says its design, which forcibly places a person into a seated restraint position, ensures the now-immobilized subject can continue to breathe unobstructed.

The company says the device is not intended for punitive or disciplinary purposes.

In Saskatchewan's youth jails, it's meant to be used an hour at a time, unless in exceptional circumstances and under appropriate authorization, according to provincial policy. The policy further says it should only be used as a last resort to stop self-harm or violent behaviour.

CBC News obtained videos depicting 10 incidents involving the use of the Wrap on young offenders inside Saskatchewan correctional facilities between 2009 and 2012.

CBC News obtained videos depicting 10 incidents involving the use of the Wrap on young offenders inside Saskatchewan correctional facilities between 2009 and 2012, including at the Paul Dojack Youth Centre in Regina. (Arielle Zerr/CBC)

Five incidents at two institutions — Paul Dojack Youth Centre in Regina and Kilburn Hall Youth Centre in Saskatoon — involved Michel.

They show Saskatchewan youth jail staff used the Wrap to punish Michel and to force his compliance.

"I feel mentally f--ked up from being placed in the Wrap," wrote Michel in a letter dated April 6, 2021, among hundreds of pages of records obtained by CBC News, charting his path through the correctional system.

"You feel helpless, abused, disgusted with yourself. You feel embarrassed because they make you scream like a girl."

- CBC INVESTIGATES **More than 1 in 5 residents in long-term care given antipsychotics without a diagnosis, data shows**

Saskatchewan is one of three provinces, including Manitoba and New Brunswick, that allow for the use of the Wrap on incarcerated youth.

Manitoba and New Brunswick, too, state the device is only for use on youth as a restraint of last resort to stop self-harming behaviour.

Manitoba said it used the Wrap in its youth facilities 11 times between 2018 and 2023. New Brunswick said it didn't use it at all between 2019 and 2023.

Michel was first detained at the age of 12, sent to Kilburn Hall Youth Centre in Saskatoon. (Chanss Lagaden/CBC)

Saskatchewan couldn't provide any data to CBC News on how many times the Wrap was used in its provincial youth facilities, saying they do not currently track its use.

All three provinces also allow use of the Wrap on adults — though in Saskatchewan, only for women — along with Newfoundland and Labrador and British Columbia.

Newfoundland used it 40 times between April 2022 and March 2023. B.C. used it six times in its facilities over that same time span.

Device akin to 'torture,' expert says

CBC News showed several minutes of video that captured Michel strapped into the Wrap to Gabor Maté, a prominent therapist and author who studies and writes about the relationship between trauma and childhood development.

He said the use of the device reminded him of torture.

"You know what a good analogy is? Abu Ghraib prison in Iraq," said Maté, referring to the images of the U.S. military torturing Iraqi prisoners that emerged in 2004.

"Except these are kids.... Traumatized kids."

WATCH | International expert explains how restraints on youth can lead to lasting trauma:

Restraints used at young age can cause lasting trauma, expert says

▶ 1 year ago 1:13

Trauma expert Gabor Maté explains why Matthew Michel's experience could cause lasting trauma.

The use of restraint devices like the Wrap piles on hurt and pain to already-damaged youth, increasing the chance of future addictions and destructive behaviour, Maté said.

"The so-called correctional system is completely devoid of understanding of brain development, of child development and of the impact of trauma on child development," he said.

CBC News also shared the video with Sen. Kim Pate, a longtime champion of corrections reform.

"If you're having to rely on that kind of device to stop people from acting out, then you're likely dealing with a mental health issue that either pre-existed or one that has been created," she said.

Independent Sen. Kim Pate has advocated for corrections reform for decades. She says youth detention needs special attention. (Mathieu Theriault/CBC)

Pate said watching the video surfaced memories of Ashley Smith, whose 2007 in-custody death triggered an inquest that revealed the system brutalized the young woman, who suffered from mental health illness. Instead of treatment, Smith faced segregation and restraint methods, like The Wrap.

"I don't think it should be used by the system. I think it should be completely outlawed," said Pate.

- FIFTH ESTATE **Issues persist over solitary confinement for Canadian inmates with mental illness**

Detained by 12

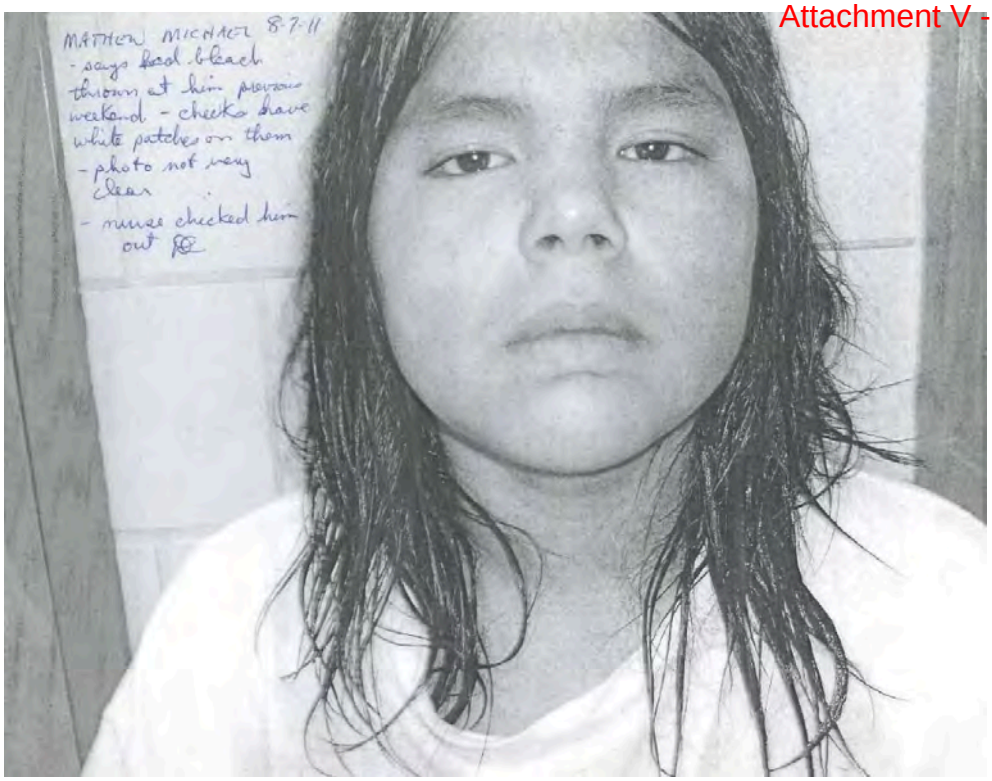
Matthew Michel's family is from Fishing Lake First Nation, where he is a band member. But he grew up in Saskatoon, 230 kilometres to the west.

His childhood unfurled without his parents present. He was shuffled between family members and the child welfare system, according to his files.

Michel said the only stabilizing presence in his life came from his grandmother, Cecile.

"My grandma was basically my mother, my father figure at the same time. She did what she could to provide for me whatever she could," he said.

"She either went to day school or residential school. I never asked about that because when she talked about her past, when she would drink alcohol, she would cry about it."



Matthew Michel is shown at age 12 in this undated photo. (Government of Saskatchewan files)

As he grew older, his life moved between the streets of Saskatoon and the walls of the province's youth correctional system.

Michel's file begins when he lands at Kilburn Hall, at age 12, facing a handful of charges, including breaking a window of a Toys "R" Us and stealing a bicycle, stealing chocolate bars, breaking the back window of two cars with rocks, and chasing his brother and a friend with a 2x4.

"New admit to KH. Made no call to family because of no contact number," reads an entry from a March 25, 2008, staff report on MIchel. "Went straight to his room to sleep."

The report makes no mention of any mental health or psychological assessment.

Jail cells and walls would frame much of his young life from here.

Michel is shown as a teen in this undated image. (Matthew Michel/Facebook)

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Throughout his life, Michel told CBC News, he suffered from auditory hallucinations.

He said he first realized this was happening when he was nine; he was sitting in his room, deep in a conversation with these voices, when his uncle walked in. His uncle asked him who he was talking to and Michel said his "friends." His uncle told him those voices weren't real.

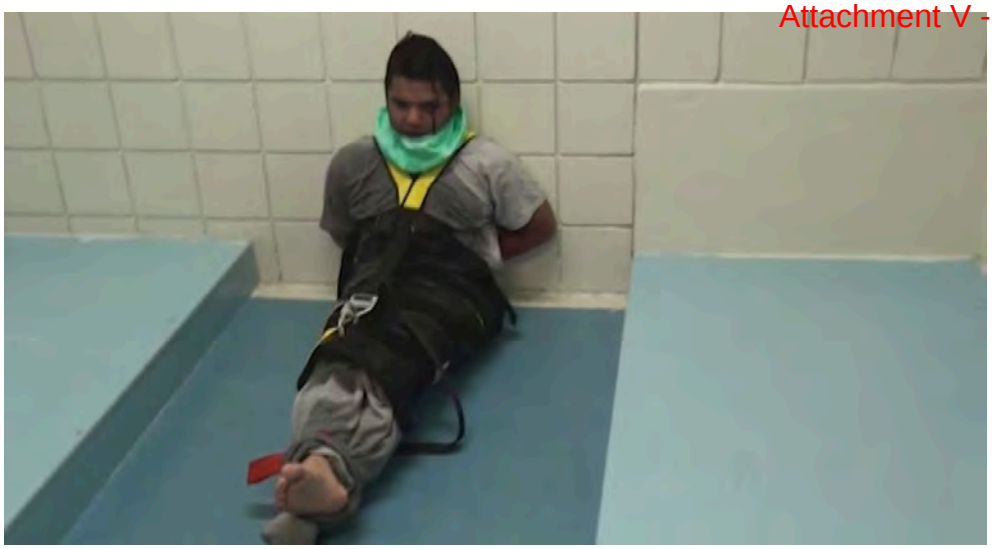
"I still thought everyone heard voices," wrote Michel in the April 6 letter contained in his file.

Sometimes, when locked in his cell in youth jail, Michel said he would hear mocking voices and believed it was jail staff, triggering fits of fury.

"I would get mad and bang on the door and say, 'F--k you. Quit talking s--t, man.' Then I would hear laughing, thinking the staff and correctional workers were laughing at me," wrote Michel.

"But I would keep kicking the door, because that's what would stop me from hearing voices. But, meanwhile, staff would be getting ready to rush me."

He wouldn't undergo a psychiatric assessment until 2013 and was eventually put on medication to deal with the issue.



Michel is shown restrained by the Wrap at Saskatoon's Kilburn Hall Youth Centre in this video from Nov. 25, 2010. (CBC)

More than 3 hours in the Wrap

The incident on video that unfolded in the Paul Dojack Youth Centre began with Michel kicking his door shortly before midnight on Aug. 16, 2010.

Just one day earlier, staff had reported positively on Michel's behaviour, writing that he helped out and communicated well with staff and other residents, according to a report.

As the day wound down on Aug. 16, staff reported it was largely uneventful, except that Michel swore at a staff member just before bed, according to the record.

Then around 11:35 p.m., Michel began banging on his cell door and covered the window with a towel, comforter and mattress.

"Night supervisor was notified. Prior to this, I asked if he was going to settle down. He said, 'Bring it on,'" said a staff report.

WATCH | 2010 video shows teen forced into the Wrap at Sask. youth detention centre:

Teen forced into the Wrap in Sask. youth detention centre

▶ 1 year ago 1:59

Matthew Michel, then 15, is placed into the full-body restraint known as the Wrap at Regina's Paul Dojack Youth Centre in this video from August 2010. WARNING: This video contains offensive language and distressing images.

At 11:45 p.m., five staff entered his cell and pinned Michel to the ground. Within five minutes, Michel was bound in the Wrap, according to the record.

He would remain restrained in the device until about 3:25 a.m. the next day.

This pattern runs through the majority of the at least 12 times staff trussed him in the Wrap in three different institutions between 2009 and 2012 — anywhere from under an hour to over three hours.

"You think thoughts of suicide, things like that, because that's how much pain you're in," said Michel, now 28, in an interview with CBC News.

"You're like, kill me already, you know."

Michel said he would sometimes bite his tongue or the inside of his cheek until it bled to try to stop himself from screaming while in the Wrap.

"I can still taste the blood to this day. That's how I learned to handle pain," he said.

Device used appropriately, province says

According to the record, in all instances, save one — when Michel was restrained after he struck a staff member, a headbutt — he was either acting out alone in his cell (banging, kicking the door, breaking a sprinkler or shouting) or refusing orders and causing disturbances in the unit.

Michel was classified as "defiant" in each of the 12 incidents, according to a 2020 internal investigation of his cases. In some incidents, he was classified as "active aggressive" or "passive aggressive" and "disrespectful."

The investigation did not mention any use of the Wrap on Michel connected to instances involving self-harm or posing a physical threat to another youth inmate.

It concluded the Wrap was used appropriately under provincial policy in each instance.

"In all instances, the use of the Wrap fit the definition of 'extraordinary' as defined in the [provincial policy].... Each incident involved several staff members to safely apply and remove the Wrap," said the investigation report.

"The duration of time that Michel would have been in the Wrap was contingent on his own behaviour and the agreement to 'commit' as per policy.... There was no evidence of abuse, taunting or inappropriate comments toward Michel."

Use of the Wrap previously criticized

The Saskatchewan government has previously faced criticism for its use of the Wrap. In 2018, an adult female inmate at the White Birch Remand Centre in Regina was restrained in the device for five hours.

Saskatchewan Ombudsman Mary McFadyen investigated the issue, determining that the Wrap was not authorized for use in adult facilities at the time and was not used reasonably.

McFayden recommended corrections develop a policy to "ensure basic human dignity would be preserved" and include reasonable time limits, along with proper video and audio recording of when the device was used.

The Wrap has also been connected to at least five police-custody deaths in California.

Between 2014 and 2015, the Hayward Police Department faced three lawsuits following the deaths of three men, all in their 40s, who died after being restrained in the Wrap. In one case, the City of Hayward paid a family a settlement of $1 million US.

In 2018, California recorded two more deaths connected to the Wrap.

An image taken from a training video by Safe Restraints Inc., showing someone placed in the device known as the Wrap. (Safe Restraints, Inc.)

Charles Hammond, president of Secure Restraints Inc., which makes the Wrap, said he is aware of a handful of deaths that have occurred in connection with restraint involving the Wrap. He said many of those deaths were the results of heart attacks, overdoses or other types of intoxication and were not the fault of the device.

With more than 10,000 devices in the field, Hammond said the numbers back his company's claim that the Wrap is safe to use, when deployed properly.

"The frequency is so incredibly low, the chances of preserving life is monumentally higher than any other tool in combative situations," said Hammond.

"Handcuffs, [pepper] spray, batons, Tasers — all of those tools — have nowhere near the safety track record that the Wrap does."

The Wrap ensures an individual is restrained in a sitting position to aid in breathing, he said, but it should also be coupled with attentive health monitoring.

"If the Wrap is being put on somebody for punitive reasons, that absolutely should not happen," said Hammond. "We do not support that."

- **Physical restraints in schools an area of concern in advocate's annual report**

'I don't want that to happen to other youth'

The Saskatchewan government said it could not respond to the specifics in Matthew Michel's case because the matter is before the courts.

In 2020, Michel filed a lawsuit against the province over harms he alleges he sustained after being subjected to the Wrap up to 50 times while incarcerated in youth jails.

"I don't want that to happen to other youth, you know?" said Michel.

Earlier this month, on a hot Monday morning, Michel walked out of the Saskatoon jail after a 16-month stint for assault. He carried clear plastic bags with remains of a life spent moving between streets and steel gates.

His sister and brother arrived to pick him up and they drove to a nearby Tim Hortons, where Michel ordered an Oreo Iced Capp, followed by a BLT.

"We don't have bacon in the correctional, you know," he said. "I'm telling you — bacon, so much better than I thought."

Michel is shown at the Saskatoon home he grew up in on June 5. 'Now I'm in the process of going on a healing journey, finding my life and building it,' he told CBC News. (Chanss Lagaden/CBC)

He later took a drive into Saskatoon's downtown Riversdale neighbourhood, to the house he lived in as a child with his aunt and uncle. It's now condemned, windows, doors boarded up and tagged with the letters "IP" and a "G" impaled by two vertical lines — the markings of the Indian Posse street gang.

Michel has the G-money symbol inked on his neck, but says he's no longer with the gang. There was a falling out after he backed a friend against members. It led to an attack and he was slashed in the head.

Standing in the overgrown, garbage-strewn yard, Michel said he wanted to leave the cycles of his past behind. He can now envision a future he sometimes forgot existed when straps, buckles and Velcro bound his body.

The Wrap ultimately changed the trajectory of his life, he said, as he believes much of his jail time stems from deep resentment and anger toward authority he developed while bound.

"That played a big factor in my life, that still haunts me to this day and that I wish never happened," he said. "I was left broken.

"Now I'm in the process of going on a healing journey, finding my life and building it."

Attachment D

Probation Department
Juvenile Hall

A Tradition of Stewardship
A Commitment to Service

Mary Butler
Chief Probation Officer

POLICY AND PROCEDURE

MANUAL:	POLICY AND PROCEDURE	NUMBER:	4.5.17
SECTION:	JUVENILE HALL	ORIGINAL ISSUE DATE:	5/6/2016
SUB-SECTION:	CLASSIFICATION AND SEGREGATION	REVISED EFFECTIVE DATE:	1/1/2019
		APPROVED BY: Mary Butler CHIEF PROBATION OFFICER	

SUBJECT: USE OF THE WRAP

POLICY: The WRAP provides a safe and quick method of controlling and immobilizing a violent, combative, or overtly suicidal subject. This policy will familiarize department personnel with the capabilities of the WRAP and procedural guidelines for its use.

DESCRIPTION:

The WRAP was designed as a "TEMPORARY" restraining device, when properly used; it can increase officer safety and minimize agency liability due to injuries and in-custody deaths. The WRAP immobilizes the lower torso of the body and restricts the youth's ability to kick or do harm to themselves and others. The WRAP minimizes the time required to secure a person safely, return them to an upright position and prepare for transport, if necessary.

PROCEDURE:

I. A youth shall be placed in the WRAP only with the approval of the Chief, Juvenile Hall Superintendent or designee and only when less restrictive methods of restraints have been ineffective. If a youth is placed in the WRAP, Medical staff and Mental Health staff will be notified immediately so they can check the youth as soon as possible. Every youth placed in the WRAP must be under continuous direct visual supervision.

II. DOCUMENTATION

A WRAP Authorization and Observation Record must be immediately filled out and maintained while the youth is in the WRAP. The Juvenile Hall Superintendent, Assistant Superintendent or designee will authorize the use of the WRAP by signing; dating and noting the time they authorized and who approved the use of the WRAP on the Authorization and Observation Record. The circumstances leading to the application of the WRAP must be documented in an Incident Report and a Critical Incident Review should be completed at the conclusion. The staff member providing the direct visual supervision shall document their observations every 15 minutes on the Authorization and Observation Record. The

Juvenile Hall Superintendent, Assistant Superintendent or designee must physically review youth in the WRAP for retention every hour and make a notation on the Wrap Authorization and Observation record.

A Mental Health professional must evaluate the youth as soon as possible, but in no case longer than after three hours of placement in the WRAP. The evaluation is to assess whether or not the youth needs immediate and/or long-term mental health treatment or be transported to the Hospital in accordance with W & I code, section 5150. This assessment will be documented on the WRAP Authorization and Observation Record. The youth shall be released from the WRAP as soon as the behavior is stabilized. The original copy of the Wrap Authorization and Observation Record shall be attached to the primary incident report. A copy of the record shall be placed in the youth's file.

III. USE OF THE WRAP

The WRAP may be used after a violent/combative youth is controlled using department procedure. It should only be used on the youth's lower torso. Like other restraining devices, the WRAP is not 100% escape proof. Once applied, the youth should never be left unobserved.

The WRAP may be used in the following situations:

- To immobilize a violent/combative youth
- To limit violent/combative youth from causing injury to themselves or others
- To prevent violent/combative youth from causing property damage by kicking
- When conventional methods of restraint are not effective
- In transportation of violent/combative youth
- To prevent suicidal youth from harming themselves
- To assist with room extraction from violent/combative youth

Youth, once properly restrained in the WRAP, can be placed on their side or in a sitting position to increase their oxygen recovery rate, thus reducing the incidence of positional asphyxia often caused by youth being restrained in the prone position. If the restrained subject is placed in a sitting position, back support must be provided. **Failure to supply back support may adversely affect the recovery time of the youth.**

IV. APPLICATION

Although in handling violent/combative youth, the WRAP can be applied by two (2) persons, three (3) or more persons will most likely be needed. Only qualified personnel who have received training in the use of the WRAP should use this restraining device.

A. Prior to using the WRAP, the subject must be initially controlled using departmental procedures. While controlling the subject, the WRAP should be placed on the ground adjacent to the youth's lower torso.

B. Either roll or adjust the youth to allow the WRAP to be slipped under subject's legs or lower torso.

C. Attach and secure the leg bands first, starting with the center band. Tighten straps sufficiently to stop movement of the legs.

D. Once the leg bands have been secured, attach the waistband. Ensure that the waist is placed as close as possible to the hip line and that it does not interfere with the youth's ability to breath. The "D" ring should be to the rear of the subject and centered on back.

E. If the youth is handcuffed, attach the handcuffs to the "D" ring at the rear of the waistband by inserting the chain between the cuffs into the "D" ring and closing the "D" ring bolt. If the youth is not handcuffed, secure the arms with the wrist restraint cuffs located on the side of the waistband. The wristbands should be securely tightened and frequently checked for tightness.

F. Once securely restrained in the WRAP, the youth can be moved into an upright sitting position and the suspenders of the WRAP can be pulled upward and cinched tightly. The youth may be placed against a wall or other available surface to supply back support in the sitting position. If no support is available, either stand behind the youth or lay them on their side.

G. If transportation of the youth is needed, certain cautions are necessary. The youth can be carried, put in a wheel chair, or allowed to shuffle to the mode of transportation.

1. To lift the youth, it is recommended that at least two but preferably three or more personnel be used depending on the size and weight of the youth. Lift the youth by the arms and the ankles. A "log roll" lifting techniques may be used when moving the youth. **Proper lifting techniques should be followed to prevent unnecessary injury.**
2. As an option to lifting, the youth may be moved by means of a shuffle. If the youth has calmed down, the lower WRAP leg strap can be loosened to allow some leg movement below the knees without compromising security or safety concerns. By loosening the suspender straps, the youth can be brought to a standing position with the help of counselors, and then allowed to shuffle to or from a vehicle or holding cell. **If this method is used, appropriate support must be given to the youth to prevent unnecessary injury to the youth.**
3. Prior to transportation, re-check all belts to ensure that they are securely fastened. The use of a seat belt may be helpful in limiting movement, which might cause injury to the youth. Whenever possible, one person should ride as an observer with the youth to ensure all straps remain tight and the subject has no medical problems.
4. To transport the youth by ambulance, the wrist cuffs located on the sides of the waist belt can restrain the youth's hands. Move the free arm to the youth's side and securely tighten the Velcro wrist cuff straps. Once secure, remove the second handcuff and secure the free arm to the remaining wrist cuff.
5. Remove the handcuffs from the "D" ring. Move the youth to the transport gurney using the lift method described above. Once in the ambulance, re-check all straps to ensure they are tight and secure. Access to upper and lower arms should not be restricted with proper use of the WRAP thereby allowing the youth to receive medical attention while restrained.

V. PRECAUTIONS

A. The waistband should never be tightened such that it interferes with the youth's ability to breath.

B. The waistband should never be used on a pregnant youth.

C. The leg bands and wrist cuffs must be checked frequently for tightness and re-tightened as necessary until the WRAP has been removed.

D. If the restrained youth complains of or shows signs of breathing distress (shortness of breath, sudden calmness, a change in facial color, etc.) medical attention should be provided immediately.

E. **THE YOUTH SHOULD NEVER BE LEFT UNOBSERVED**. One staff must always be present while a youth is in the WRAP.

F. Youths should be placed in an upright sitting position or on their side as soon as possible to allow them to recover.

G. Under no circumstances should a youth placed in the WRAP be housed with other youths while still in the WRAP.

VI. TRAINING

Only qualified personnel who have received training in the use of the WRAP should use this restraining device. This training is provided by designated Juvenile Hall staff and is mandatory before being authorized to use the WRAP.

REFERENCES: TITLE 15, SECTIONS 1357 & 1358

ATTACHMENTS: WRAP Authorization and Observation Record

BACKGROUND: Bulletin # 4.5.17
Section: CLASSIFICATION AND SEGREGATION
Original Issue Date: 5/6/2016, rev. 9/21/2018, 1/1/2019

WRAP
AUTHORIZATION AND OBSERVATION RECORD

Date: _____ Time: _____

Building Supervisor Authorization: _____

Name of Youth: _____

Medical Staff Notification:

Time: _____ Name of Staff: _____
Print Sign

Mental Health Staff Notification:

Time: _____ Name of Staff: _____
Print Sign

Circumstances requiring use of WRAP (Attach to Special Incident Report):

_____

_____

_____

_____

_____

PROBATION STAFF 15-Minute Observation Record:

Time/Staff	Location	Observations
Time: Staff:		
Time: Staff:		
Time: Staff:		

WRAP
AUTHORIZATION AND OBSERVATION RECORD

Time: Staff:		
Time: Staff: IS II Hourly Review		

MEDICAL/MENTAL HEALTH OBSERVATION: 1 HOUR OBSERVATION:

TIME/STAFF	LOCATION	OBSERVATIONS
Time: Staff: Time: Staff:		

PROBATION STAFF 15-Minute Observation Record:

Time/Staff	Location	Observations
Time: Staff:		
Time: Staff:		

WRAP
AUTHORIZATION AND OBSERVATION RECORD

Time: Staff:		
Time: Staff:		
Time: Staff: IS II Hourly Review		

MEDICAL/MENTAL HEALTH OBSERVATION: 1 HOUR OBSERVATION:

TIME/STAFF	LOCATION	OBSERVATIONS
Time: Staff: Time: Staff:		

PROBATION STAFF 15-Minute Observation Record:

Time/Staff	Location	Observations
Time: Staff:		

WRAP
AUTHORIZATION AND OBSERVATION RECORD

Time: Staff:		
Time: Staff:		
Time: Staff:		
Time: Staff: IS II Hourly Review		

MEDICAL/MENTAL HEALTH OBSERVATION: 1 HOUR OBSERVATION:

TIME/STAFF	LOCATION	OBSERVATIONS
Time: Staff: Time: Staff:		

WRAP
AUTHORIZATION AND OBSERVATION RECORD

PROBATION STAFF 15-Minute Observation Record:

Time/Staff	Location	Observations
Time: Staff:		
Time: Staff:		
Time: Staff:		
Time: Staff:		
Time: Staff: IS II Hourly Review		

WRAP
AUTHORIZATION AND OBSERVATION RECORD

MEDICAL/MENTAL HEALTH OBSERVATION: 1 HOUR OBSERVATION:

TIME/STAFF	LOCATION	OBSERVATIONS
Time:		
Staff:		
Time:		
Staff:		

MERCED COUNTY JUVENILE JUSTICE COMPLEX

POLICY MANUAL

Subject: Key Control	**Policy Number:** F - 101
Originated: April 27, 2004	**Page:** 1 of 2
Revised: June 27, 2017	**Authority:** Chief Probation Officer and Title 15 Section 1326
	Approved: _____ Chief Probation Officer

General Policy

I. The Supervising Juvenile Institutions Officer (SJIO), or designee, is responsible for issuing and maintaining control of all Merced County Iris Garrett Juvenile Justice Correctional Complex keys.

II. Facility keys will remain on site at all times. Facility keys will not be removed from the facility without the approval of the Program Manager or Superintendent.

III. Staff members will immediately notify the shift supervisor if it is discovered that keys are missing.

IV. Keys to exterior doors, perimeter gates, central control and security electronic rooms will not be issued without the approval of the shift supervisor, or designee.

V. Staff members assigned to the housing units will not be issued keys that open exterior doors or gates of the facility.

Procedures

I. Each on-coming SJIO, or designee, will conduct an inventory of the key cabinet with the off-going SJIO, or designee, to ensure that all facility key sets are accounted for.

II. The SJIO, or designee, will record the issuing and collecting of keys on the Key Control Form.

III. Full time staff, extra-help staff, medical staff, maintenance staff, school staff and other personnel as approved by the Program Manager will be issued a set of job-specific keys from Intake at the beginning of their assigned shifts. Each staff member will give his/her personal

keys to the SJIO, or designee, in exchange for a set of facility keys. The staff member's personal keys will be locked away for safekeeping and will be returned to the staff member when the facility keys are returned.

IV. The set of "Emergency Keys" shall only be issued to staff for a specific task and are to be returned immediately upon completion of the specified task.

V. Staff will exercise good judgment and extreme caution in handling facility keys. If any facility keys are lost or stolen, the staff member who was issued the keys will immediately notify the shift supervisor or their designee. The staff member will also notify the shift supervisor, or their designee, if the missing keys are found.

VI. If a key is discovered missing, staff will secure the area in which the key was lost and conduct a thorough search for the missing key. If the key is not located, the search will be extended to all sections of the facility.

VII. If any facility keys are lost and not immediately found, the shift supervisor or their designee will notify the Program Manager, Superintendent, and the Chief Probation Officer.

☐ I have read and understand this policy. Name: _____
Electronic signature – Type name here

MERCED COUNTY
IRIS GARRETT JUVENILE JUSTICE CORRECTIONAL COMPLEX

POLICY MANUAL

Subject: Security Issues	**Policy Number:** F-102
Originated: April 27, 2004	**Page:** 1 of 2
Revised: June 27, 2017	**Authority:** Chief Probation Officer Title 15, Section 1326
	Approved: _____ ____ Chief Probation Officer

Security and Supervision

I. Officers will:

A. Always lock all security doors.

B. Position themselves where they can best supervise all the youth in their charge and never turn their backs to the youth or allow youth to encircle them.

C. During the midnight shift, never open or enter a youth's room without a light source and notifying Central Control.

D. Always ensure that at least two officers are on the unit when a group of youths are released from their rooms to attend school, meals, recreation and showers.

E. Always ensure that two officers are present before unlocking and entering any occupied rooms of youth of the opposite gender or those classified as escape or safety and security risks.

F. Know the assigned group and maintain a constant population count.

G. Always be aware of the youth who are security risks.

H. Do not allow youth to wander around the building or to stray away from recreation or work details unsupervised. (See Policy F-104 for Movement of Youth).

I. Never leave an individual or group of youth unsupervised, unless secured in their sleeping rooms.

J. Always secure the control panel when unsupervised.

K. Do not leave the control panel to respond to an incident when alone in the unit.

Equipment Belts

I. Each officer will wear their equipment belt during their entire shift and will see that it contains the appropriate equipment:

A. Handcuffs, key holder, and assigned keys

B. OC (Oleoresin Capsicum) spray canister and holster

C. CPR mask

D. Protective gloves

E. Radio and holster

F. Belt badge

II. Officers will lock belts and equipment in their lockers when feasible. If removed from the JJCC grounds, equipment is to be safely secured and stored. Extra-help employees will turn their equipment belts into the shift supervisor at the end of their shift.

Badges and Identification

I. Officers will wear their department issued badges at all times while in the facility.

II. Private citizens and professionals who enter the facility for any reason will be required to present proper identification before being allowed to visit youth or conduct any business within the facility.

A. Proper identification for a youth's visitor (parent, guardian, etc.) will consist of photo identification from a reliable source, such as a driver's license, California identification card, passport or similar document.

B. Proper identification for a professional will consist of an official identification from the representative organization, indicating the person has the authority to perform the function for which they are requesting admittance.

III. Representatives from churches and service organizations will be subject to a local records check before being allowed to provide regularly scheduled activities within the facility. Designated, and approved, representatives will be issued and shall wear identification issued by the Probation Department designating them as volunteers.

☐ I have read and understand this policy. Name: _____
Electronic signature – Type name here

MERCED COUNTY
IRIS GARRETT JUVENILE JUSTICE CORRECTIONAL COMPLEX

POLICY MANUAL

Subject: Security Electronics | **Policy Number:** F-103

Originated: April 27, 2004 | **Page:** 1 of 2

Revised: July 26, 2017 | **Authority:** Chief Probation Officer

Approved: _____
Chief Probation Officer

General Policy

I. Staff members will not use the "interlock override" function in Central Control except in an emergency situation without the authorization of the shift supervisor or designee.

II. Staff members will not unlock any electronic door without first confirming the identity of the requesting party by camera and/or by intercom.

III. Staff members will not download program applications or insert MP3 Players, thumb drives, or USB's into the control panel computer modem.

IV. Staff members will not tamper with the control panel.

V. Staff members will not access the control panel cables unless instructed to by the contracted service provider.

VI. Staff members will not turn off the volume on the monitors to the control panels.

VII. Staff members will not enter the security electronics room.

VIII. Staff members will report any malfunctions of the security electronics equipment to the shift supervisor immediately.

Housing Control Panels

I. The control panels in the housing units will operate the housing room doors, multi-purpose room doors and intercoms within the housing unit. The panel will not open any perimeter doors.

II. There are two "Gang Release" buttons on the control panels of each unit. The Gang Release buttons are specific to a designated wing. The "Gang Release" button will only open the cell doors of the designated wing, simultaneously.

Intercoms

I. The control panels in each housing unit will allow a staff person to audibly monitor all rooms within the housing unit.

II. The control panel in Central Control will allow a staff person to audibly monitor the holding cells.

III. Call buttons are located in each youth's room and each holding cell, so a youth can call for assistance.

IV. The safety cell is equipped with a sound-activated intercom device.

V. Approved music may be played from the control panel in to the youths' rooms via the intercom.

Help Buttons

I. Duress buttons are located in various areas throughout the facility including medical, courtroom, and classrooms. When a duress button is activated, the location of the duress will be displayed on the Central Control Panel, highlighted in red or pink, with a message displayed in the comment section below the map with the specific location of the duress, and an audible alarm will sound.

II. When a duress button is activated in a classroom, the location of the duress will also be displayed on the housing unit's control panel, highlighted in red, with a message displayed in the comment section below the map with the specific location of the duress, and an audible alarm will sound.

Shut-Down Buttons

I. The control panel in the housing unit can be shut-down by touching "Panel Shut Down" button. The panel will then display, "Panel Inactive."

II. Central Control can deactivate a unit panel, by selecting the specific housing unit located on the control panel, and touching "Power Panel" button, once. The Power Panel button will highlight in red on Central Controls panel to show that it is deactivated. The housing unit control panel will then display, "Panel Inactive."

III. To reactivate the control panel to the specific housing unit, the "Power Panel" button will be touched a second time. The Power Panel button will then highlight in white to show that it is reactivated.

☐ I have read and understand this policy. Name: _____
Electronic signature – Type name here

MERCED COUNTY
IRIS GARRETT JUVENILE JUSTICE CORRECTIONAL COMPLEX

POLICY MANUAL

Subject: Movement of Youth in the Facility | **Policy Number:** F-104

Originated: April 27, 2004 | **Page:** 1 of 3

Revised: June 27, 2017 | **Authority:** Title 15, Section 1324 and Chief Probation Officer

Approved: _____ _____
Chief Probation Officer

General Policy

I. Staff members will exercise good judgment and be aware of safety and security issues at all times when moving youth throughout the facility.

II. When a youth needs to be moved from one area of the facility to another, the staff member in the youth's starting location is responsible for ensuring the youth arrives safely at the ending location.

III. Unescorted movements of youth between buildings will only be allowed when the youth can be observed directly or by camera from Central Control.

IV. Youth who are classified as Security Restriction (ER1), Suicide Risk (SR), or who are on Administrative Segregation must be escorted when going to and from any location in the facility.

V. Youth who have the additional classifications of Status Offender (RA-1), Non-association (RA-3), and Full Medical Isolation (M-6) may have additional restrictions on their movement within the facility, depending on the reasons and individual conditions of their status.

VI. Groups of two or more youth will not be allowed to move from one location to another without escort.

Procedures

I. When an individual youth needs to be moved from one location to another, the sending staff member will check the youth's security level to determine whether the youth can be sent without an escort.

II. When the youth can be sent without an escort and the youth's movement can be observed directly, or through camera from Central Control:

A. The sending staff member will notify the receiving staff member that the youth is being sent to their location. The sending staff member will wait for a response from the receiving staff member before sending the youth.

B. The receiving staff member will check for any possible security issues before allowing the youth to be sent to his/her location and will not authorize the youth to be sent to his/her location until the security issues have been resolved.

Example: There may be an emergency or conflicting movement in another area of the facility.

C. When communication and security issues have been resolved, the sending staff member will send the youth to the receiving location. Central Control will be notified of any unescorted movement between buildings.

III. If the youth cannot be sent without an escort:

A. The sending staff member will notify the receiving staff member that the youth will be escorted to the receiving location. Central Control will also be notified of the movement.

B. The sending staff member will arrange for someone to escort the youth to the receiving location. If there is no staff available, the shift supervisor will arrange for someone to escort the youth. Depending on available staff, it may be necessary to lock down one housing unit in order to make escort staff available.

C. The escorting staff member will be aware of any possible security issues before and while escorting the youth.

D. The escorting staff member will not allow the youth or to leave his/her physical custody until the receiving staff member has accepted physical custody of the youth.

E. Staff members will not use the closed-circuit cameras alone as a means of supervising movement of a youth who must be escorted throughout the facility. In some cases, a youth may be allowed to move from one location to another without actually being physically escorted, as long as both the sending staff member and the receiving staff member maintain continuous visual contact with the youth throughout the movement.

F. A staff member who escorts a group of youth from one location to another will maintain a count to ensure he/she has the same number of youth in his/her custody throughout the movement.

G. Staff members will escort youth in an orderly fashion. Youth will not be allowed to talk during the movement and will walk single file.

H. When moving youth to and from the yard for recreation activities, staff members will direct the youth to remain in their lines and will not allow activities to begin in the yard or the housing unit, until staff members have ensured all youth are present and accounted for.

☐ I have read and understand this policy. Name: _____
Electronic signature – Type name here

MERCED COUNTY
IRIS GARRETT JUVENILE JUSTICE CORRECTIONAL COMPLEX

POLICY MANUAL

Subject: Weapons Control	**Policy Number:** F-105
Originated: April 27, 2004	**Page:** 1 of 1
Revised: June 27, 2017	**Authority:** Chief Probation Officer
	Approved: _____ Chief Probation Officer

General Policy

I. Firearms, tasers, ammunition, batons, knives or other weapons will not be allowed inside the secured areas of the Merced County Iris Garrett Juvenile Justice Correctional Complex (JJCC).

II. In emergency situations such as riot or hostage-taking incidents, the Chief Probation Officer, Superintendent, or Program Manager acting in their absence, may authorize armed law enforcement officers to enter the facility.

Procedures

I. Before entering the secured areas of the JJCC, all persons carrying firearms, tasers, ammunition, batons, knives or other weapons will secure the weapons in their vehicle or in the weapons locker provided.

II. An officer securing his/her weapons in the weapons locker will remove the key from the weapons locker and carry the key with him/her until their departure.

III. JJCC staff will check to ensure the law enforcement officer entering the facility has secured his/her weapons.

IV. No employee of the Probation Department shall bring any personal weapons into the Merced County Iris Garrett Juvenile Justice Correctional Complex.

☐ I have read and understand this policy. Name: _____
Electronic signature – Type name here

Transgender/Intersex Preference Form

(For Assessed Youth)

Date: _____ File#_____ Admit Date: _____

Youth's Name _____ Date of Birth: _____

Birth Sex: _____ Gender Identification: _____

Name Preference: _____ Pronoun Preference: He/She

Housing Preference

I prefer to be housed with Females: _____ I prefer to be housed with Males: _____

If no preference is selected, youth is to be housed with youth of the same anatomical sex.

Search Preference

Transgender/Intersex youth may request for either a male or female staff member to conduct a pat-down search, strip search and/or visual body cavity search.

I prefer to be searched by a staff member who is: Male _____ Female: _____

If no preference is selected the youth will be searched by a staff member of the same anatomical sex.

****

Youth's signature: _____ Date: _____

Staff Member Name: _____ Date: _____

Supervisor Reviewed: _____ Date: _____

Attachment: A

☐ I have read and understand this policy.

Name: _____
Electronic signature – Type name here

MERCED COUNTY
IRIS GARRETT JUVENILE JUSTICE CORRECTIONAL COMPLEX

POLICY MANUAL

Subject: Searches	**Policy Number:** F-106
Originated: April 27, 2004	**Page:** 1 of 7
Revised: March 14, 2019	**Authority:** Title 15, Section(s) 1352.5, 1360, Penal Code Section 4030, Welfare and Institutions Code Section 871.5
	Approved: _____

General Policy

I. Employees of the Merced County Probation Department who have the legal authority to do so shall conduct searches to maintain the security of the facility, to protect the safety of staff, youth, visitors and the general public by discouraging and preventing the introduction of "prohibited items" into the secure perimeter of the facility.

II. This policy shall be in reference to the following types of searches:

A. Pat-down

B. Metal detector

C. Visual

D. Secure perimeter

E. Unsecure perimeter

III. Searches of persons shall be conducted in a manner that preserves the privacy and dignity of the person being searched, and shall not be conducted for harassment or as a form of discipline or punishment.

IV. All youth who are admitted into the facility will be subject to a pat-down search and a metal detector search. Searches may also include visual body cavity search or strip-search. Visual body cavity searches and strip searches will be in compliance with Section 4030 of the California Penal Code and the Strip Searches of Youth in Custody Policy Number F-108.

V. Staff members shall not conduct physical searches of any youth for the purpose of determining the youth's anatomical sex.

VI. Facility staff shall respect Transgender/Intersex youth's gender preference of the staff member who searches them.

VII. Cross-gender pat-down searches and strip searches shall not be conducted, except in exigent circumstances or when conducted by a medical professional. Such searches must be justified and documented in writing.

VIII. Upon approval of the shift supervisor, any volunteers, contracted staff, and other persons entering the facility may be subjected to a search of person and possessions on a random basis or based upon "reasonable suspicion" of possession of a prohibited item. Searches of these persons may include visual searches, pat-down searches, and the use of devices, such as metal detectors. No volunteer, contractor or person, other than a youth who has been admitted into the facility, shall be subject to a strip search. Volunteers, contracted staff and other persons attempting to enter the facility who refuse to submit to a search of their person or possessions will be denied entry to the secure perimeter of the facility.

IX. Youth returning from court, another facility or any transport shall be searched via pat-down and metal detector. When necessary for the safety and security of the facility, youth may also be strip searched. If a youth is strip searched, staff shall be in compliance with Section 4030 of the California Penal Code and the Strip Searches of Youth in Custody Policy Number F-108.

X. Regular searches will be conducted of sleeping rooms and the youth's personal effects in their room.

XI. Periodically or as needed, searches will be conducted of any area within the secure and unsecure perimeter of the facility.

XII. Prior to taking the youth outdoors for Large Muscle Exercise, a designated staff member will conduct a perimeter check of the recreation area to be used.

XIII. Staff members shall wear protective gloves when conducting any searches.

Definitions

I. "Prohibited items," also known as contraband, includes illegal drugs, alcoholic beverages, regulated drugs, prescription drugs not used or possessed in compliance with a current valid prescription, weapons, unauthorized tools, unauthorized electronic devices, and all other items defined as contraband by the Merced County Probation Department.

II. "Metal detector search" means passing through a metal detector or having a portable wand device passed over the body.

III. 'Pat-down search" means the use of hands to detect any items a person may be concealing on their body that is hidden by clothing or hair.

IV. "Visual search" is a type of perceptual task requiring attention that typically involves an active scan for prohibited items.

V. "Secure Perimeter" is the area where youth are housed or have access to (i.e. Intake Area and any area beyond, such as Building One or Building Two).

VI. "Unsecure Perimeter" is the area where youth are not housed or do not have access, such as the administrative area.

VII. "Cross-gender search" refers to the opposite biological sex. Example: A staff member who pats down a person of the opposite anatomical sex is conducting a cross-gender search.

VIII. "Intersex" is a person who was born with a combination of male and female anatomical characteristics, such as chromosomes or genitals, that can make doctors unable to assign their sex as distinctly male or female. An outdated term for this is "hermaphrodite," which is now considered offensive.

IX. "Transgender" is a person whose gender identity does not correspond with their sex assigned at birth.

Procedure

I. Pat-down searches

A. A staff member will conduct a pat-down search of each youth at the following times:

1. as soon as possible after the youth is accepted for admission to the facility;

2. prior to and after the youth's return from court appearances;

3. after the youth has been outside of the facility with a staff member;

4. after the youth has visited with an outside agency;

5. prior to and after the youth has been to visiting; and

6. at any time when the safety and security of the facility indicates a need.

B. A pat-down search will consist of the following:

1. The staff member will advise the youth of their intent to conduct a pat-down search. The staff member will then ask the youth if they have any questions or concerns regarding the pat-down search. If the youth requests to be patted down in a private area and the request is feasible, the staff member will honor the youth's request. If the youth is Transgender/Intersex, the staff member shall follow the Transgender/Intersex pat-down provisions listed below.

2. The staff member will have the youth remove their shoes, socks, hats and any

outer garments, such as a jacket or sweatshirt. The staff member will feel and look at any hat or outer garment. The staff member will remove any shoe liners and hit the shoes together with the soles facing upward. The staff member will also turn the youth's socks inside out and shake them.

3. The staff member will run their hands over the full length of the youth's shoulders, arms, legs, and torso, paying particular attention to the youth's pocket areas, the waistband, the groin, the neckband or collar, armpits, sleeve bands, hems and cuffs. If the staff member feels anything unusual, they will check the area more thoroughly. If searching more thoroughly compromises the privacy of the youth, the youth will be escorted to an alternative area.

4. If the youth's hair is long enough to conceal any items, the staff member will also pat-down the hair.

5. The staff member will have the youth lift each foot to expose the soles of the feet. They will pay particular attention to the area between the youth's toes.

6. If any contraband is located during the pat-down search, the staff member locating the contraband will take the appropriate disciplinary and/or legal action. Significant findings will be documented in an incident report.

Provisions for Transgender/Intersex Pat-Down Searches

I. Staff members shall respect any Transgender/Intersex youth's preference of the gender of the staff member who searches them.

II. Any youth who indicates they are Transgender or Intersex will be required to complete a Transgender/Intersex Preference Form (See Attachment A).

III. The shift supervisor will review the Transgender/Intersex Preference Form with the youth. Any pat-down search of a Transgender/Intersex youth shall require a secondary staff member of the same anatomical sex as the youth who is being searched. All parties involved in the initial search of Transgender/Intersex youth will be required to submit an incident report.

Procedures for Metal Detector Searches

I. After a youth has been patted down, staff members shall use a metal detector to conduct a more detailed search. If the metal detector indicates the youth is concealing contraband, a strip search will be conducted. The strip search shall be in compliance with Section 4030 of the California Penal Code and Strip Searches of Youth in Custody Policy F-108.

II. Volunteers, contracted staff, and other persons entering the facility may also be subject to a metal detector search randomly or based on suspicion.

Procedures for Room Searches

I. A staff member will conduct a search of a youth's room under the following circumstances:

A. Whenever there is a reason to believe a youth may have contraband in their room.

B. When a youth is released from the facility.

C. At any time when the safety and security of the facility indicates a need.

D. When they are assigned to do so.

1. The night shift supervisor will identify and designate the youth's name and room number to be searched to ensure all youth's rooms are searched regularly. The number of room searches will equate to 20% of each unit's population for the day. The day shift supervisor will designate a staff member to perform room searches at the beginning of their shift.

II. If a room is occupied, the staff member will have the youth exit the room that is to be searched, and conduct a pat-down search of the youth.

III. A room search will consist of a thorough, systematic check of the youth's bedding, clothing, books, magazines, envelopes, and any other loose items in the youth's room. When searching bedding and clothing, staff members will pay particular attention to hems and holes in mattresses. Staff members will also check windows, windows frames, light fixtures, intercom buttons, air conditioning vents, floor drains, and any other areas in which contraband might be concealed. Understanding that searches of any kind can be traumatic, staff members will be respectful of all youth's belongings.

IV. The designated staff member assigned to conduct room searches will email the shift supervisor after they have completed their required searches documenting each youth's name and room number searched. All unusual findings will be documented in the youth's Detention Activities Tree. If any contraband is located during the search, the staff member finding the contraband will take the appropriate steps to secure the item and complete an Incident Report. If any significant contraband such as drugs or weapons are discovered, the shift supervisor, Program Manager and the Superintendent will be notified immediately.

V. The shift supervisor is responsible for completing the room search logs that are kept in the Intake Area. The shift supervisor is ultimately responsible to ensure that all room searches are assigned and searched according to the provisions listed above. Audits of room searches will be conducted at least monthly by a designated supervisor and the supervisor will send a report to the Program Manager as directed.

Procedures for Secure and Unsecure Perimeter Searches

I. Prior to taking the youth out to the recreation area, a designated staff member will conduct a perimeter check of the recreation area to be used. A perimeter check consists of walking along the fence line of the recreation area to ensure there is no damage to the fence and that there is no contraband or weapons for the youth to access. After completing the perimeter check, the staff member will advise central control that the perimeter check has been completed and central control will document the check.

II. A search of the entire facility, or any portion of the facility, will require an operational plan to be completed by a designated Supervising Juvenile Institutions Officer. Facility searches will be conducted randomly and regularly or at the following times:

A. when there is a reason to believe that drugs, alcohol, weapons, or any other significant contraband may be in the facility;

B. when any facility keys, handcuffs, OC (Oleoresin Capsicum) spray, scissors, or other security or potentially dangerous equipment cannot be located or accounted for; or,

C. at any other time when the safety and security of the facility indicates a need.

III. All youth will be secured in a designated location during a facility search.

IV. After each facility search, all unusual findings will be documented in the youth's Detention Activities Tree. Significant findings will be documented in an incident report.

V. If any significant contraband is located, such as drugs or weapons, the supervisor in charge of the operation will notify the Program Manager and Superintendent as soon as possible.

Chain of Custody

I. Any item taken from a youth that may lead to criminal charges will be handled in a manner that protects the chain of custody. In instances of contraband being located during an initial booking pat-down, the item will be turned over to the arresting agency by the staff member who found the item.

II. In the event the arresting officer is not present or the contraband is located after the youth has been admitted, the item(s) will be placed in a sealed bag with the name of the youth, staff member who found the item, and date and time logged on the bag. The bag will be placed in the safe located in the Intake Area until released to the arresting agency or to an Evidence Technician from the Merced County Sherriff's Department. To preserve the chain of custody, control of the item must be accounted for from the time it was found until the time it appears in court.

Search of Youth's Secured Property

I. Once an admission is complete and the youth's personal property is stored, nothing can be removed without the signed consent of the youth, parent, guardian, or persons standing in loco parentis or the presentation of a search warrant.

Procedures for Searches of Outside Agency Visitors

I. It is against facility rules, and sometimes it is a criminal offense for which one can be prosecuted, for anyone to attempt to bring in any item not allowed by the facility. Volunteers, contracted staff and other persons entering the facility are required to follow all rules, regulations, and laws while on facility grounds.

II. To ensure that prohibited items are not brought into the facility, volunteers, contracted staff and other persons entering the secure perimeter may be subjected to a search of their person and possessions on a random basis or based upon "reasonable suspicion" of possession of a prohibited item. Volunteers, contracted staff and persons attempting to enter the facility who refuse to submit to a search of their person or possessions will be denied entry to the secure perimeter of the facility. Volunteers, contracted staff and other persons can elect for a pat-down search in lieu of a metal detector search. No volunteer, contractor or person, other than a youth who has been admitted into the facility, shall be subject to a strip search. Searches of these individuals will be initiated by the shift supervisor or Program Manager.

III. Shift supervisors will initiate a search by having the volunteers, contracted staff, and other persons entering the facility pass their person or belongings or both through the metal detector.

IV. If the metal detector indicates there is contraband present, the shift supervisor will conduct a visual inspection of their belongings.

V. If the metal detector indicates there is contraband present on their person, the shift supervisor will run a wand across the area indicating where the item has been identified. If the metal detector continues to alert to contraband, a pat-down search will be conducted.

☐ I have read and understand this policy.

Name: _____
Electronic signature – Type name here

MERCED COUNTY
IRIS GARRETT JUVENILE JUSTICE CORRECTIONAL COMPLEX

POLICY MANUAL

Subject: Use of Physical Restraints within the Facility **Policy Number:** F-107

Originated: April 27, 2004 **Page:** 1 of 13

Revised: October 30, 2019 **Authority:** Title 15, Section 1358, 1358.5, 1417; Penal Code Section 6030(f); W & I

Approved: _____
Chief Probation Officer

General Policy

I. The facility administrator, in cooperation with the responsible physician and mental health director, shall develop and implement written policies and procedures for the use of restraint devices Hard restraints consist of metal handcuffs or leg shackles. Soft restraints consist of plastic, cloth, and/or the WRAP. Only the below listed agency-approved restraints may be used on any youth in custody.

II. Physical restraints may be used only for those youth who present an immediate danger to themselves or others, who exhibit behavior which results in the destruction of property, or reveals the intent to cause self-inflicted physical harm. Physical restraints are utilized only when it appears less restrictive alternatives would be ineffective in controlling the disorderly behavior. In no case shall restraints be used as punishment or discipline, or as a substitute for treatment or be applied in a manner as to inflict physical pain, undue physical discomfort, or to reduce blood circulation or breathing. The use of physical restraint device that attach a youth to a wall, floor or other fixture, including a restraint chair, or through affixing of hands and feet together behind the back (hogtying) is prohibited.

III. The use of restraints on pregnant youth is limited in accordance with Penal Code Section 6030(f) and Welfare and Institutions code Section 222. For further information, refer to the Pregnant Youth policy.

IV. Staff members who are trained in Cardiopulmonary Resuscitation will carry their assigned equipment at all times and all staff members will be orientated to the location of the Automated External Defibrillator (AED) devices.

V. Only staff who have been identified as completing the required training will utilize the

above mentioned restraints. The training shall include: PC 830.5 et. seq and WRAP.

VI. Staff members must document the circumstances leading to the application of restraints in accordance to the procedures listed below.

Procedure

I. The following circumstances may require a sworn staff member to utilize physical restraints:

A. to control a youth's physically aggressive behavior who is presenting an immediate danger to staff or other youth;

B. to protect a youth from self-inflicted injuries or suicide;

C. to prevent the destruction of property.

Use of Physical Restraint Devices

I. A sworn staff member who applies handcuffs and/or leg shackles on a youth shall do the following:

A. When applying handcuffs or leg shackles, staff shall use caution and appropriate techniques, pursuant to agency approved training, in order to minimize the risk of injury to the youth or the staff member.

B. Staff shall double-lock handcuffs and leg shackles to ensure security and to prevent unnecessary tightening.

C. When utilizing the WRAP, staff shall refer to the below WRAP/Policy/Procedure(s).

D. When safe to do so, the staff member shall move the restrained youth to a location for their protection. If a staff member feels the youth needs to continue to be physically restrained, the youth shall be escorted up to intake. Any time restraints are used and the youth has the ability to walk themselves, staff shall exercise caution and ensure they hold onto the youth's arm to prevent possible injury to the youth.

E. Whenever possible, staff will avoid using physical restraints on a youth who has any known medical condition that would contradict the use of physical restraint devices. To reduce the likelihood of causing harm or injury to the youth the following health problems are indicators that physical restraints should be avoided when reasonably possible.

1. Documented medical history of asthma or other respiratory problems;

2. Documented medical history of heart disease or related problems;

3. Documented medical history of seizures;

4. Current use of psychotropic stimulant medication;

5. Current use of stimulant controlled substances such as cocaine, amphetamines, methamphetamine, PCP, etc.;

6. Medical obesity;

7. Any other known medical condition that might be aggravated by being immobilized in physical restraints.

Use of Physical Restraint Devices for Prolonged Periods

I. A "Prolonged Period" is any amount of time exceeding one hour.

A. The use of physical restraints for prolonged periods may only be approved by the Program Manager. The Program Manager may delegate authority to place a youth in physical restraints to a physician.

B. Any youth who is in physical restraints for a prolonged period of time must remain in I-1 and Use of the Safety Room policy provisions shall be followed.

C. The shift supervisor shall contact the Program Manager hourly to provide an update on the youth's status. If continued use of physical restraints is required, the reasons shall be documented on the one on one observation sheet and in the incident report.

Documentation

I. Any time a staff member utilizes physical restraints a "Physical Restraint Device Assessment for Transportation within the facility" (See Attachment A) form shall be completed and an incident report generated addressing the following criteria:

A. The actual circumstances that lead to the application of the restraint(s).

B. What less restrictive options were considered prior to the placement of the restraint(s).

C. Consideration of the youth's documented medical or mental health conditions.

D. What trauma informed approach was utilized prior to and after application of the restraint(s).

II. Circumstances that require prolonged use of physical restraints shall require all of the above. In addition, the shift supervisor will complete the following:

A. One on One Observation Sheet. (See Attachment B)

B. Documentation of what time medical/mental health was contacted and what time they responded in the incident report.

C. Documentation of the outcome of consultation with medical/mental health regarding the use of prolonged restraints shall also be included in the incident report.

General Policies for the WRAP

I. Description

A. The WRAP, manufactured by Safe Restraints, Inc., was designed as a temporary restraining device. Used properly, it can increase officer safety and reduce risk of liability due to injuries and in-custody deaths. The WRAP immobilizes the body and restricts a youth's ability to do harm to themselves and/or others. The WRAP minimizes the time required to secure a youth safely, restrains the youth in an upright position and has the youth prepared for transport or movement. Once the youth is properly restrained in the WRAP, they can be placed on their side or in a sitting position. This will increase oxygen recovery rate.

B. The WRAP will only be used under extreme conditions in which a youth is in imminent danger of harming themselves and/or others and it appears less restrictive alternatives would be ineffective in controlling the youth's behavior.

C. The WRAP will only be utilized when authorized by the shift supervisor, Program Manager, Superintendent or Chief Probation Officer.

D. Youth must be restrained pursuant to the above Use of Physical Restraint Policy. A youth will remain in the WRAP until they are no longer an active safety or security risk to themselves or others.

E. If a youth requires transport while in the WRAP, staff shall utilize the WRAP Carry Cart to safely transport the youth from one location to another.

F. The WRAP will not be used for the purpose of punishment, coercion, convenience, or retaliation by staff, nor will a youth be threatened with the use of the WRAP to gain compliance.

G. The WRAP will be stored in the Intake Area.

H. Only staff who have been identified as completing the required training will utilize the above mentioned restraints. The trainings shall include: PC 830.5 et seq. and WRAP.

I. The use of restraints on pregnant youth is limited in accordance with Penal Code Section 6030(f) and Welfare and Institutions Code Section 222. For further information, refer to the Pregnant Youth Policy, H-116.

Procedure

I. The WRAP can be applied by 2 to 4 officers via the following four step process:

A. Control and handcuff the youth. Use techniques that do not restrict the youth's breathing.

B. Secure the youth's ankles with the ankle strap. Slide the leg portion of the WRAP under the youth's legs.

C. Quickly secure the leg bands.

D. Apply the harness, securing a snug fit, then connect the harness to the leg restraint.

II. The youth is now fully restrained and can be moved or transported safely.

III. When a youth is placed in the WRAP, the shift supervisor will notify the on-duty medical staff and Behavioral Health and Recovery Services staff immediately.

IV. If medical staff is not on duty, the shift supervisor will contact the medical provider at the John Latorraca Correctional Facility and request immediate response. Medical will assess the youth every thirty minutes thereafter and provide a medical opinion on the safety of placement and retention.

V. If Behavioral Health and Recovery Services staff is not on duty, the shift supervisor will contact the Behavioral Health and Recovery Services Adolescent Service Team and request a worker to respond to the facility as soon as possible. A mental health consultation shall be secured as soon as possible, but in no case longer than four hours from the time of placement to assess the need for mental health treatment.

VI. A youth in the WRAP device will be under direct and continuous supervision of staff. The staff member will document the time the WRAP was applied and record their observations on the One on One Observation form every five minutes and/or when any significant event

occurs.

A. A staff member may also, place a youth in the safety cell while in the WRAP device to prevent further harm to the youth or others.

Transportation while in the WRAP

I. Movement of the youth can be accomplished by utilizing the WRAP Carry Cart.

Precautions

I. The shoulder harness should never be tightened to the point that it interferes with the youth's ability to breathe.

II. The leg bands and shoulder harness must be checked frequently for tightness and retightened or loosened as necessary until the WRAP is removed.

III. If the restrained youth complains of, or shows signs of, breathing distress, (shortness of breath, sudden calmness, a change in facial color, etc.) medical attention should be provided immediately.

IV. **The youth shall never be left unattended.** The youth will be placed on a one-on-one, 5-minute observation until the WRAP is removed. Once the WRAP is removed, a staff member will document the time of removal on the One on One Observation form.

V. The youth should be placed in an upright sitting position or on their side, as soon as possible to allow for respiratory recovery.

VI. The WRAP is a temporary restraining device and is not escape proof.

Use of the WRAP for Prolonged Periods

I. "Prolonged Period" is any amount of time exceeding one hour.

II. The use of the WRAP for prolonged periods may only be approved by the Program Manager or Superintendent.

III. Any youth who is in the WRAP for a prolonged period of time must remain in I-1 and Use of the Safety Room policy provision shall be followed. The shift supervisor shall contact the Program Manager or Superintendent hourly to provide an update on the youth's status. If continued use of the WRAP is required, the reasons shall be documented on the One on One Observation form and in the incident report.

A. Whenever possible, staff will avoid using the WRAP on a youth who has any

known medical conditions that would contradict the use of the restraint device.

B. The following health problems are indicators that physical restraints should be avoided when reasonably possible:

1. documented medical history of asthma or other respiratory problems;

2. documented medical history of heart disease or related problems;

3. documented medical history of seizures;

4. current use of psychotropic stimulant medications;

5. current use of stimulant controlled substances such as cocaine, amphetamines, methamphetamine, PCP, etc.;

6. medical obesity;

7. any other known medical condition that might be aggravated by being immobilized in physical restraints.

C. While the youth is in the WRAP, staff members shall consider the youth's needs for hydration and sanitation. Staff will also consult with medical staff for the youth's ability to exercise their extremities.

D. Facility staff and the medical provider will have the availability of cardiopulmonary resuscitation equipment in case a health issue arises during the time the youth is in the WRAP.

Documentation

I. Any time a staff member utilizes the WRAP, a "Restraint Device Assessment for Transportation within the facility" (See Attachment A) form shall be completed and an incident report generated addressing the following criteria:

A. The actual circumstances that lead to the application of the restraint(s).

B. What less restrictive options were considered prior to the placement of the restraint(s).

C. One on One Observation Form. (See Attachment B)

D. Consideration of the youth's documented medical or mental health conditions.

E. What trauma informed approach was utilized prior to the application of the restraint(s).

II. Circumstances that require prolonged use of the WRAP shall require all of the above.

III. In addition, the shift supervisor will complete the following:

A. Documentation of what time medical/mental health was contacted and what time they responded in the incident report.

B. Documentation of what time medical/mental health was contacted regarding the use of prolonged restraints shall also be included in the incident report.

Training and Maintenance

I. Training

A. A two-hour course will be required annually.

II. Care and Maintenance

A. The WRAP should be inspected by the shift supervisor after each use for signs of wear and/or damage. If any damage is discovered, the WRAP will be given to appropriate personnel for repair or replacement. If cleaning is necessary after use, use a mild soapy solution or disinfectant approved for use on vinyl and nylon materials. If blood is absorbed into any part of the WRAP, that part should be replaced. Thoroughly rinse all disinfectant from the WRAP prior to drying. After cleaning the WRAP, allow it to thoroughly air dry before being returned to its carrying bag.

III. Storage and Preparation for Re-Use

A. It is important that the WRAP is immediately ready for use and prepared for storage in a way that prevents the loop fastening material on the bands from becoming dirty or entangled. This allows the WRAP to be quickly laid out next to the youth and applied without the confusion of having to untangle the bands.

B. To properly prepare the WRAP for storage in the carrying bag:

1. Lay the WRAP on a flat surface with the leg band side up and detach the shoulder harness. Extend each of the leg bands out flat.

2. Individually fold each of the leg bands back onto itself so the fold of the band protrudes an inch or two from the edge of the WRAP body.

3. Be sure the retaining “D” ring on the body of the WRAP and harness is open and ready to use.

4. Keeping the bands inside, roll the WRAP tightly towards the buckle, secure with the ankle strap and place in the carrying bag.

5. Fully extend the harness buckles and tether. Attach buckles to its counterpart, roll the harness up and place it in the carrying bag compartment.

MERCED COUNTY PROBATION DEPARTMENT
Restraint Device Assessment for Movement and Transportation within the Facility

Youth Name: _____ **DOB:** _____

Pursuant to § 1358.5 of Title 15, mechanical restraints may be used on the above-named youth during movement and transportation within the facility based on the following reason(s):

☐ The youth presented an immediate danger to themselves or others.

☐ The youth exhibited behavior which could have resulted in the destruction of property.

☐ The youth engaged in a fight/assault and continued to be physically aggressive thereafter.

☐ The youth revealed the intent to cause self-inflicted physical harm.

☐ Other (see below).

_____
_____
_____
_____
_____

The least restrictive form of restraint used consistent with the legitimate security needs of the youth is:
☐ Handcuffs ☐ Leg shackles

The following additional documentation is required prior to the conclusion of your shift: Incident Report providing the actual circumstances that lead to the application of the restraint(s), what less restrictive options were considered prior to the placement of the restraint(s), consideration of a youth's known medical or mental health conditions and what trauma informed approach was utilized prior to and after application of the restraint(s).

Restraint Applied by **(PRINT)**: _____ Date/Time: _____

Restraint Removed **(TIME)**: _____

Youth moved From: _____ Youth moved To: _____

SJIO/ASJIO **(PRINT)**: _____ Date/Time: _____

Attachment A

ONE ON ONE OBSERVATION

NAME: _____ DATE OF BIRTH: _____

REASON FOR USE OF THE SAFETY CELL: _____

_____

_____

RESTRAINTS APPLIED: YES [ ] NO [ ] TIME ON: _____ TIME OFF: _____

STAFF INVOLVED: _____ _____ _____

SUPERVISOR ON SHIFT: _____ DATE: _____ TIME: _____

NOTE YOUTH'S BEHAVIOR EVERY 5 MINUTES

TIME	NOTES	STAFF SIGNATURE

DATE: _____

TIME	NOTES	STAFF SIGNATURE

Attachment B

☐ I have read and understand this policy.

Name: _____
Electronic signature – Type name here

MERCED COUNTY
IRIS GARRETT JUVENILE JUSTICE CORRECTIONAL COMPLEX

POLICY MANUAL

Subject: Strip Searches of Youth in Custody	**Policy Number:** F-108
Originated: April 18, 2006	**Page:** 1 of 7
Revised: November 2, 2018	**Authority:** Title 15, Section(s) 1360, and 1352.5 and Penal Code Section 4030
	Approved: _____ Chief Probation Officer

General Policy

I. Recognizing the intrusiveness of a strip search on individual privacy, and recognizing that all varying degrees of strip searches may be required, it is the policy of the Department that all strip searches be conducted only with proper authorization and justification and with due recognition and deference for the dignity of those being searched, and in accordance with procedural guidelines for conducting such searches as set forth in this policy. Strip searches shall be conducted in a manner that preserves the privacy and dignity of the youth who is being searched and shall not be conducted for harassment or as a form of discipline.

II. Youth described in Section(s) 300, 601 or 602 of the Welfare and Institutions Code who are admitted into the facility for misdemeanor or infraction offenses except those involving weapons, controlled substances, or violence will not be subjected to a strip search or visual body cavity search unless the staff member has determined there is reasonable suspicion, based on specific and articulable facts to believe that the youth is concealing a weapon or contraband which could threaten the safety and security of the facility, public, visitors, youth or staff.

III. Any youth who is arrested on a misdemeanor or infraction offense or is detained based solely on their status as a 300, 601 or 602 of the California Welfare and Institutions Code shall not be subjected to a physical body cavity search except under the authority of a search warrant issued by a magistrate specifically authorizing the physical body cavity search.

IV. Youth who are admitted into the facility for felonies involving weapons, controlled substances, or violence shall be subjected to a strip search to ensure they are not concealing a weapon or contraband that could threaten the safety and security of the facility, public, visitors, youth or staff.

V. A strip search and/or a visual body cavity search, shall not be conducted without the prior written authorization of the shift supervisor. The authorization shall include the specific and articulable facts and circumstances upon which the reasonable suspicion determination was made by the shift supervisor.

A. Under no circumstances will a staff member conduct a body cavity or physical body cavity search on any youth. Body cavity and physical body cavity searches shall only be conducted by medical personnel.

B. Cross-gender strip searches are prohibited except in exigent circumstances or when conducted by a medical professional. Such searches must be justified and documented in writing.

C. Facility staff shall respect Transgender and Intersex youth's preference regarding the gender of the staff member who conducts any search of them.

D. Facility staff shall not conduct physical searches of any youth for the purpose of determining the youth's anatomical sex.

Definitions

A. Searches

1. "Strip Search" refers to any search which requires a person to remove or arrange some or all of their clothing so as to permit a visual inspection of the underclothing, breasts, buttocks, and genitalia of such person. A strip search includes a thorough search of the clothing removed from the individual being search.

2. "Visual Body Cavity Search" means visual inspection of a body cavity.

3. "Body Cavity Search" means to search only the stomach or rectal cavity of a youth and vagina of a female youth.

4. "Physical Body Cavity search" refers to the physical intrusion into a body cavity for the purpose of discovering any object concealed in the body cavity.

B. Reasonable Suspicion

1. Used in this policy refers to suspicion based on specific and articulable facts that a person is concealing a weapon or other contraband, and that a strip search will result in the discovery of said weapon or contraband.

2. The determining factors to strip search a youth based on "Reasonable Suspicion" will be addressed on a case by case basis. Removal from the home is a traumatic experience and youth will respond differently. Therefore, staff members will consider the aforementioned when determining whether a youth fits the criteria listed below as having "Reasonable Suspicion":

a. Unusual conduct

b. Excessive nervousness

c. Prior history of bringing contraband into the facility

d. Discovery of incriminating matter during pat-down search

e. Evasive or contradictory answers/statements

f. Other (Specific Documentation Required)

C. Other

1. "Cross-gender search" refers to the opposite biological sex. Example: A staff member who pats down a person of the opposite anatomical sex is conducting a cross-gender search.

2. "Intersex" is a person who was born with a combination of male and female anatomical characteristics, such as chromosomes or genitals, that can make doctors unable to assign their sex as distinctly male or female. An outdated term for this is "hermaphrodite," which is now considered offensive.

3. "Transgender" is a person whose gender identity does not correspond with their sex assigned at birth.

Procedures

Strip Search

I. The location of the strip search will take place in a shower area on the units or intake, taking into consideration the privacy and dignity of the youth. All strip searches shall include a secondary staff member of the same anatomical sex as the youth who is being searched standing by outside of direct view of the youth but having a visual of the staff member during the strip search. They will not participate in the search, and will not enter the area unless the staff member who is conducting the search indicates that they cannot control the youth without assistance.

II. The staff member will advise the youth of their intent to conduct a strip search. They will then ask the youth if they have any questions or concerns regarding the strip search and they will thoroughly explain the process of a strip search. If the youth is Transgender or Intersex, the staff member shall follow the provisions for Transgender /Intersex youth strip searches listed below.

III. The staff member will direct the youth to stand and face them.

IV. The staff member will have the youth remove each article of clothing, one piece at a time, and hand it to them.

V. The staff member will carefully examine each article of clothing for contraband, weapons, etc.,

VI. The staff member will conduct a visual search which will begin at the head and work down to the feet, and shall be conducted sequentially, as follows:

A. **Hair & Scalp:** All hair must hang loose. The youth must take out all removable hair accessories. Direct the youth to run their fingers through their hair. Inspect hair, scalp and hairline at the back of the neck.

1. If a youth requires a hairpiece due to medical conditions, it must be cleared through the medical provider and the shift supervisor.

B. **Ears:** Inspect behind the ears, under lobes, and into the ear canal.

C. **Nose:** Direct the youth to tilt their head back and inspect their nasal passages.

D. **Mouth:** Inspect mouth lip area. Direct the youth to open mouth wide, tongue up, down, right and left. Have the youth roll upper lip up and lower lip down.

E. **Upper Torso- Anterior:** As the youth continues to stand and face you, direct them to extend their arms to the side with fingers spread apart. Have them rotate hands front to back.

1. Direct obese youth to raise rolls of excess skin for visual inspection.

2. Direct the youth to extend arms toward you with fingers spread. Inspect between fingers and under their fingernails. Inspect arms and hands for injection sites.

F. **Lower Torso- Anterior:** Direct the youth to stand with legs apart (approximately 24") and inspect the front lower torso. Inspect front of legs and feet. Instruct the youth to spread each toe and inspect between each toe.

G. **Upper Torso-Posterior:** Instruct the youth to turn so their back is facing you. Inspect entire back area beginning at the base of the neck. Direct obese youth to raise layers of excess skin for visual inspection.

H. **Lower Torso- Posterior:** With the youth still facing away from you, visually inspect the back of each leg and instruct them to lift each foot so that the sole of the foot is exposed. Inspect soles of feet and toes.

Visual Body Cavity Searches

I. If at any time during the strip search process a staff member has reasonable suspicion to believe that the youth they are searching may still be concealing contraband and that said contraband could be discovered through a more thorough search, a visual body cavity search will be conducted. The secondary staff member will call the supervisor on the radio requesting permission to proceed. A visual body cavity search will require the shift supervisor's approval and will consist of the following:

A. Males will be instructed to lift their penis and subsequently, their scrotum. If a male is uncircumcised, instruct him to pull foreskin back.

B. Females will be instructed to lift their breasts.

C. Visually inspect the youth's buttocks area, looking for any foreign object such as a string or thread leading into the anus or vaginal cavity. If a female youth is wearing a tampon, it will be removed and the youth will be given a sanitary napkin or tampon when the search is completed.

D. Instruct the youth to hold their arms straight out in front of them, assume a squatting position and cough deeply three times. This should expel most items of contraband concealed in the rectal or vaginal area.

E. Once the visual body cavity search is completed the staff member shall return clothing to the youth and direct them to dress. If the youth is suspected of continuing to conceal contraband, the staff member will secure the youth in a dry room in the Intake Area and advise the shift supervisor of their findings. The shift supervisor will then arrange for the youth to be transported to the hospital.

Body Cavity Searches

I. Body Cavity Searches will only be conducted by a medical professional.

II. The shift supervisor will contact the Program Manager to advise the need for a body cavity search of a youth and will articulate the reasonable suspicion justifying the need.

III. If the contract medical provider is on duty, the shift supervisor will advise them of the situation and the need for a body cavity search. If the contract medical provider is not on duty, the shift supervisor will advise them immediately upon their arrival on shift.

IV. The shift supervisor or if available, the contract medical provider, will contact the Emergency Room by phone to advise them that a youth is being transported and the nature of the required transport.

V. A Juvenile Institutions Officer will be assigned to accompany the youth to the hospital for the body cavity search.

Physical Body Cavity Searches

I. If the Body Cavity Search reveals the youth is concealing contraband, a Physical Body Cavity Search will be conducted.

II. As previously stated, any youth who is arrested on a misdemeanor or infraction offense, or any youth who is detained based solely on their status as a 300, 601, or 602 of the California

Welfare and Institutions code shall not be subjected to a physical body cavity search except under the authority of a search warrant issued by a magistrate specifically authorizing the physical body cavity search. In instances requiring a search warrant for a Physical Body Cavity Search, the Program Manger will contact the Superintendent.

A. If at all possible, prior to the administering of any medical treatment or procedure, the youth's parent, guardian, or person standing in loco parentis will be notified.

1. If the youth's parent, guardian, or persons standing in loco parentis do not have a phone and cannot be contacted during normal working hours, the shift supervisor will contact the youth's probation officer and request that they make contact with them. During non-business hours, the shift supervisor will contact the appropriate law enforcement agency and request for them to attempt to make contact with the youth's parent, guardian, or persons standing in loco parentis at their home, requesting them to call the facility immediately. It may be necessary for the shift supervisor to call a Program Manager for assistance.

B. The Juvenile Institutions Officer will remain with the youth until the youth is cleared to return to the facility.

Provisions for Transgender/Intersex Strip Searches

I. Staff members shall respect any Transgender/Intersex youth's preference of the gender of the staff member who searches them.

II. Any youth who indicates they are Transgender or Intersex will be required to complete a Transgender/Intersex Preference Form (See Attachment A).

III. The shift supervisor will review the Transgender/Intersex Preference Form with the youth. Any strip search of a Transgender/Intersex youth shall require the approval of a Program Manager.

IV. The secondary staff member who is present during the strip search will be of the same anatomical sex as the youth who is being searched.

V. All parties involved in any strip search of Transgender/Intersex youth, including the Program Manager will be required to submit an incident report.

Discovery of Contraband

I. In the event any contraband is discovered during the course of any type of strip search, it shall be processed in accordance with the chain of custody procedures for handling evidence. Any contraband discovered shall also be noted on the Strip Search Authorization Form (See Attachment B), and an incident report shall be completed.

Documentation

I. All Strip Searches will require a completed Strip Search Authorization Form. The Strip Search Authorization Form must include the following:

A. the date, time and location of the strip search;

B. the youth's name, gender, date of birth, and JJCC file number;

C. the reason why the strip search was conducted, articulated reasonable suspicion, and applicable charges;

D. the name of the officer requesting the search, and supervisor, or designee approval;

E. list of weapons/contraband found, the name of the officer conducting the strip search;

F. if a visual body cavity strip search is requested and approved, the supervisor, or designee will sign their name in the authorization section.

G. Any youth who requires transport to the hospital for a Body Cavity Search or a Physical Body Cavity search will require an incident report.

☐ I have read and understand this policy.

Name: _____
Electronic signature – Type name here

Transgender/Intersex Preference Form

(For Assessed Youth)

Date: _____ File#_____ Admit Date: _____

Youth's Name _____ Date of Birth: _____

Birth Sex: _____ Gender Identification: _____

Name Preference: _____ Pronoun Preference: He/She

Housing Preference

I prefer to be housed with Females: _____ I prefer to be housed with Males: _____

If no preference is selected, youth is to be housed with youth of the same anatomical sex.

Search Preference

Transgender/Intersex youth may request for either a male or female staff member to conduct a pat-down search, strip search and/or visual body cavity search.

I prefer to be searched by a staff member who is: Male _____ Female: _____

If no preference is selected the youth will be searched by a staff member of the same anatomical sex.

****

Youth's signature: _____ Date: _____

Staff Member Name: _____ Date: _____

Supervisor Reviewed: _____ Date: _____

Attachment: A

☐ I have read and understand this policy. Name: _____
Electronic signature – Type name here

MERCED COUNTY PROBATION DEPARTMENT

Name of Youth: Gender: Male ☐ Female ☐ *Transgender ☐ * Intersex ☐	D.O.B.:	JJCC File#:
Date:	Time:	Location of Search:

JUSTIFICATION FOR STRIP SEARCH

Current Charges involve weapons, controlled substances or violence? Yes ☐ No ☐ ***If strip search is due to the youth's current charges, officer may skip reasonable suspicion section***	Applicable Charges(s):

Reasonable Suspicion

Mark all boxes that apply below AND provide justification supporting reasonable suspicion (Articulable Facts):

Unusual conduct	
Excessive nervousness	
Prior history of bringing contraband into the facility	
Discovery of incriminating matter during pat-down search	
Evasive or contradictory answers/statements	

Other (Articulable Facts):

Officer Requesting Strip Search (Print Name and title):

Signature:

Shift Supervisor Approving Strip Search (Print name and title):

Strip Search ☐ Transgender/Intersex Strip Search ☐

***Note: Any youth who is Transgender/Intersex shall complete the Transgender/Intersex Preference Form**

Signature:

Officer Conducting Search (Print name and title):

Signature:

Secondary Officer (Print name and title):

Signature:

Visual Body Cavity Search

Articulable Facts to Justify Visual Body Cavity Search:

Shift Supervisor Approving Visual Body Cavity Search (Print name and title):

Signature:

Youth transported to hospital for Body Cavity Search/Physical Body Cavity Search?

Yes ☐ No ☐

Documentation

Strip searches of Transgender/Intersex youth will require an incident report from all officers who are involved. Strip searches resulting in a youth being transported to the hospital for a body cavity search/physical body cavity search and/or strip searches resulting in the discovery of contraband will also require an incident report by all officers who are involved in the incident.

Attachment B

☐ I have read and understand this policy.

Name: _____
Electronic signature – Type name here

Use of Physical Restraints for Movement and Transportation within the Facility

952.1 PURPOSE AND SCOPE

The purpose is to establish and implement written policy and procedures for the appropriate use of physical restraints for movement and transportation of youth within juvenile facilities. This policy applies to all juvenile facility staff.

952.1.1 DEFINITION

Definition related to this policy include:

Physical restraints – Restraints include any devices which immobilize a youth's extremities and/or prevent a youth from being ambulatory. Department authorized restraint devices include handcuffs, shackles, waist chains and the Wrap. These devices are designed to be attached to the human body to limit mobility and/or restrict movement.

952.2 AUTHORITY AND REFERENCES

- Board of State and Community Corrections Title 15 § 1358.5;
- California Penal Code §§ 3407 & 6030;
- Policy 951: Use of Restraints;
- Welfare and Institutions Code § 222.

952.3 POLICY

Physical restraints may be used on detained youth for the purpose of movement and transportation within the facility upon a determination that the physical restraints are necessary to prevent physical harm to the youth, other individuals, or due to a risk of escape/AWOL. Physical restraints are not to be used for the purposes of discipline or retaliation.

Except during exigent circumstances, juvenile supervision staff shall determine and document the reasons for the use of restraints for movement within the facility by completing and submitting for approval, a Restraints for Movement within Facilities Assessment (attached). Once the determination to use restraints has been made, the least restrictive form shall be used consistent with trauma informed approaches and the security status, medical needs, and behavior health factors of each youth. When exigent circumstances exist, such as a use of force incident, staff shall document in their incident report the circumstances for the use of restraints and all movements when restraints are used. Refer to Policy 951: Use of Restraints.

952.4 ASSESSMENT

A Restraints for Movement within Facilities Assessment shall be used to provide an individual assessment of the need to apply restraints to a youth for movement within the facility and shall be completed each time restraints are applied to a youth for this purpose. Youth must have at least

one qualifying factor for the authorization of restraints to be used. Medical and behavioral health factors may disqualify the use of restraints. The duty officer (DO)/supervising probation officer (SPO) shall provide the final approval for the use of restraints.

(a) Staff:

1. Complete the Restraints for Movement within Facilities Assessment, requesting a use of restraints based upon all factors present.
2. Inform the DO or a SPO of the request for the use of restraints, and request approval for the application of restraints.
3. Document the circumstances leading to the application of restraints in the comments section of the Restraints for Movement within Facilities Assessment.

(b) Duty Officer/Supervising Probation Officer:

1. Review the qualifying factors on the assessment and any additional information to provide an approval or denial of the restraint use request.
2. Inform the staff if the use of restraints is approved or denied.
3. Document any additional information and/or justification for the decision in the comment section of the Restraints for Movement within Facilities Assessment.

Refer to Standard of Work for processing and filing of the Restraints for Movement within Facilities Assessment.

952.5 GENERAL SAFETY GUIDELINES

All youth supervision staff shall receive training in the proper use of physical restraints. Staff shall not apply or remove physical restraints until they have completed PC 832 Arrest training.

Staff shall follow the safety guidelines listed below when youth are placed in restraints for movement within the facilities:

(a) Youth who have been placed in physical restraints shall be under continuous direct visual supervision until the restraints are removed;

(b) Youth shall not be left unattended while wearing any form of physical restraints;

(c) Staff shall protect restrained youth from abuse by other youth;

(d) Physical restraints shall not be attached to any stationary object in the juvenile facility;

(e) Physical restraints shall be locked in position to prevent tightening;

(f) Every effort shall be made to minimize the amount of time a youth remains in restraints;

(g) Restraints shall be removed as soon as safety and security allow; and

(h) The safe use of restraint devices during pregnancy must be taken into consideration. Refer to Juvenile Facility Services policy: Care of Pregnant Youth.

952.6 MEDICAL GUIDELINES

Health care staff shall advise staff of any known medical condition(s) which might contraindicate the use of certain restraint devices and/or techniques regarding an individual youth. This information shall be placed in the unit medical log. When requesting restraints, staff shall check the medical log and include medical conditions on the Restraints for Movement within Facilities Assessment.

If a restrained youth displays any sign of medical distress, staff shall immediately contact on-site health care staff and the DO. Staff shall write an incident report listing action taken. Signs of medical distress include but are not limited to the following:

(a) Tingling or numbness of limbs/digits;

(b) Pain, discomfort;

(c) Burning sensation;

(d) Limitation of motion;

(e) Cool, pale, blue-tinged skin;

(f) Altered mental status (confusion, restlessness);

(g) Dry skin, mouth;

(h) Muscle cramps/spasms;

(i) Dizziness/weakness;

(j) Headache;

(k) Dilated pupils;

(l) Loss of consciousness;

(m) No pulse, no respirations;

(n) Swelling;

(o) Itching;

(p) Nausea/vomiting;

(q) Inability or difficulty breathing;

(r) Combativeness, panic; and

(s) Dry cough.

952.6.1 PREGNANT YOUTH

If it is determined restraints should be placed on a pregnant youth, the following procedures shall be in place in accordance with Penal Code Sections 3407 and 6030 and Welfare and Institutions Code Section 222:

(a) A youth known to be pregnant or in recovery after delivery shall not be restrained by the use of shackles, waist chains, or handcuffs behind the body.

Use of Physical Restraints for Movement and Transportation within the Facility

(b) A pregnant youth in labor, during delivery, or in recovery after delivery, shall not be restrained by the wrists, ankles, or both, unless deemed necessary for the safety and security of the youth, the staff, or the public.

(c) Physical restraints shall be removed when a professional who is currently responsible for the medical care of the pregnant youth during a medical emergency, labor, delivery, or recovery after delivery determines that the removal of restraints is medically necessary.

Date last reviewed: 10/30/2019

Date last revised: 10/30/2019

03/07/2016

Created: 10/01/2001

Attachments:

1. Restraints for Movement within Facilities Assessment

RIVERSIDE COUNTY PROBATION DEPARTMENT

Serving Courts • Protecting Our Community • Changing Lives

Restraints for Movement within Facilities Assessment

Youth's Name: _____ CID# _____

At least 1 qualifying factor is required for the use of restraints. Staff should consider the corresponding restraint options when requesting the appropriate restraint for movement. Medical and behavioral health factors may disqualify the use of restraints.

1.0 Medical and Behavioral Health Factors

- Does the youth have a known medical condition that would contraindicate the use of certain restraint devices? ☐ **Yes** ☐ **No**
- Does the youth have a known behavioral health condition that would contraindicate the use of certain restraint devices? ☐ **Yes** ☐ **No**

If "yes" to either of the above questions, list conditions and contraindications in the comments section below.

2.0 Qualifying Factors (Detention Facilities only):	**Restraint Options**
☐ Past escape: Date of escape: _____	*Shackles*
☐ Current threat to escape	*Shackles*
☐ Past threat to harm self or others: Date of incident:_____	*Shackles, Waist Chains, Handcuffs*
☐ Current threats to harm self or others	*Shackles, Waist Chains, Handcuffs*

3.0 Qualifying Factors (AMC-YTEC):	**Restraint Options**
☐ Current threats to escape	*Shackles*
☐ Current threats to harm self or others	*Shackles, Waist Chains, Handcuffs*
☐ Youth is being removed from the program	*Shackles, Waist Chains, Handcuffs*

4.0 Restraint Use Request

Handcuffs Requested: ☐ Shackles Requested: ☐ Waist Chains Requested: ☐

Comments: _____

_____

_____

Staff Name (Printed):_____Staff Signature: _____Date:_____

5.0 DO/SPO Review

Handcuffs Approved: Yes ☐ No ☐ Shackles Approved: Yes ☐ No ☐ Waist Chains Approved: Yes ☐ No ☐

Comments: _____

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_____

DO/SPO

Name (Printed):_____DO/SPO Signature: _____Date:_____

Restraint Devices in Juvenile Detention and Assessment Centers (JDACs) and Treatment Facilities (TFs) (Title 15, Section 1358, 1358.5)

Effective Date:	5/23/2024
Revised Date:	5/23/2024
Issuing Authority: Chief Probation Officer	

520.1 PURPOSE:
To establish guidelines for the use of restraint devices for youth in Juvenile Detention and Assessment Centers (JDACs) and Treatment Facilities (TFs).

520.2 DEFINITION:
Restraint Device: Any device that immobilizes a youth's extremities or prevents the youth from being ambulatory.

A. Ankle Strap: A department-approved tool used to hamper ankle movement used in conjunction with the WRAP Restraint.

B. Handcuffs: A metal mechanical device designed to be fastened around the wrists to restrain free movement of the hands and arms. Only department-approved handcuffs are authorized for use in probation facilities.

C. Waist Restraints: A metal mechanical device designed to be fastened around the waist and used to secure the arms to the sides of the body.

D. Leg Restraints: A metal mechanical device consisting of a chain connecting two leg cuffs designed to be fastened around the ankles to restrain free movement of the legs.

E. Locking Shoulder Harness: A department-approved tool used to allow a subject to be placed in an upright seated position when used in conjunction with the WRAP Restraint.

F. Hobble: A department-approved restraint designed to be fastened around the legs to hamper movement and prevent a subject from kicking. The hobble is to be used only during transportation in a vehicle and cannot be used in concert with leg restraints or ankle straps.

G. Soft Restraints: Padded leather bands designed to be fastened around the wrist or ankle.

H. WRAP Restraint: A department-approved restraint applied to the legs, used to hold a subject in an upright or seated position to hamper movement.

Restraint Devices in Juvenile Detention and Assessment Centers (JDACs) and Treatment Facilities (TFs) (Title 15, Section 1358, 1358.5)

520.3 GUIDELINES:

A. In no case shall restraint devices be used as punishment, discipline, retaliation, or as a substitute for treatment.

B. First aid shall be prioritized above restraint unless the youth's conduct makes first aid hazardous to the youth, officers, or others.

C. The use of restraint devices that attach a youth to a wall, floor, or other fixture (including a restraint chair) or through affixing hands and feet together behind the back (hog tying) is prohibited.

D. The use of restraints on pregnant youth is limited in accordance with Penal Code Section 6030(f) and Welfare Institutions Code Section 222.

520.4 RESPONSIBILITIES:

I. <u>All Staff:</u>

A. Consider known mental, physical, or developmental limitations/disabilities, and medical conditions when applying and continuing the restraint of a youth (e.g. obvious broken bones, profuse bleeding, in progress seizures, obvious respiratory problems, and/or manifestations of psychological or emotional disabilities).

B. Follow training guidelines regarding the application/use of any restraint device.

C. Use department-issued restraints only.

D. Utilize physical restraints only when less restrictive alternatives would be ineffective in controlling the behavior.

E. Remove restraints at the direction of medical personnel if contraindications are identified.

II. <u>Probation Corrections Officers (PCOs):</u>

A. Notify the area supervisor when a youth presents a potential threat to themselves or others, exhibits behavior that results in the destruction of property, or reveals the intent to cause self-inflicted physical harm.

B. Obtain approval from the Incident Commander (IC), Watch Commander (WC), or Treatment Facility Supervisor (TFS)for continued use of restraints.

C. Transport the restrained youth to another area of the facility if other youth are present to ensure their safety.

D. Maintain continuous direct visual supervision of restrained youth to monitor their well-being and to ensure restraints are properly applied.

E. Notify Medical Services as soon as safe.

F. If a youth has been in restraints for longer than fifteen (15) minutes, as soon as it is safe, but in no case longer than four (4) hours from the placement of the restraints, consult with the Forensic Adolescent Service Team (FAST) to assess the need for mental health treatment.

G. Allow youth to move and stretch their limbs for five (5) minutes every thirty (30) minutes.

H. Evaluate the youth in fifteen (15) minute intervals starting from the time restraints were applied and utilize the Restraint Documentation Form (in ProbTools). The documentation shall include:

1. Circumstances leading to the application of restraints.
2. Times restraints were applied and removed.
3. Initial Medical and FAST evaluations, as clinically indicated.
4. Observations of the youth's behavior.
5. Any staff interventions.
6. Offers/provisions for hydration and sanitation needs.
7. Approval of the restraint devices by the Incident Commander (IC), Watch Commander (WC), or Treatment Facility Supervisor (TFS).
8. Check the youth's circulation by checking for tightness of the restraints.
9. Initials and time of the evaluation.
10. Assess the positioning and breathing of the youth.

I. Relay continued restraint information to relieving staff.

J. Collaborate with Medical Services, FAST, IC, and WC/TFS to ensure continued monitoring and documentation of youth in restraints.

K. Complete an Incident Report (IR) for restraints that exceed fifteen (15) minutes.

L. Participate in a debriefing as directed by the IC, WC, or TFS.

III. Probation Corrections Supervisor I (PCSI)/Incident Commander (IC):

A. Ensure the Restraint Documentation Form is initiated when the use of restraints exceeds fifteen (15) minutes.

B. Provide authorization for continued use of mechanical restraints and sign the Restraint Documentation Form when less restrictive alternatives to control the youth's behavior are ineffective.

C. Ensure the incident is electronically recorded and the youth is under constant observation.

D. Inform the WC/TFS of the nature of the incident and the use of restraints as soon as possible.

E. Collect and review all Closed-Circuit Television Security System (CCTSS) footage, handheld videos, incident reports, and original Restraint Documentation Form, and forward to the WC/TFS.

F. Ensure a debriefing is conducted with involved staff unless directed otherwise.

G. In the absence of a facility nurse, transfer the youth to the emergency room for a medical evaluation after one (1) hour of continuous restraint.

IV. Watch Commander (WC)/Treatment Facility Supervisor (TFS):

A. Consult with the IC and evaluate the initial authorization and application of restraint devices.

B. Ensure FAST and Medical Services are contacted.

C. Consult with the IC, FAST, and Medical Services every hour after the initial application of restraint devices regarding continued use of restraints.

D. Evaluate, sign, and document the evaluation, observations, and decision for continued use of restraints on the:

1. Restraint Documentation Form every hour.

2. WC Log Book.

E. Review all IRs, CCTSS footage, and handheld camera video after the incident.

F. Be present at the debriefing when possible.

G. Relay continued restraint information to relieving WC/TFS.

V. Medical Services:

A. Review the health record for contraindications or accommodations that may be required and immediately notify the IC, unit staff, and the Health Services Manager (HSM).

B. In the event the restrained youth has a medical/mental health condition, notify the on-site/on-call physician/provider immediately to obtain appropriate orders.

C. Initiate health monitoring to include the assessment of peripheral circulation and range of motion as soon as possible, but not to exceed one (1) hour from the time of notification, if it is safe to do so.

D. Assess circulation and range of motion every two (2) hours after the initial assessment.

E. Continue health monitoring hourly and provide medical clearance for continued retention every two (2) hours unless contraindicated.

F. Report identified concerns that jeopardize the health of the youth to the IC, WC, TFS, and HSM.

G. Notify the IC and WC/TFS if the youth requires transportation to the emergency department, or if Emergency Medical Services (EMS) (911) should be summoned.

H. Complete medical documentation on the Medical Services Incident Report Addendum (in ProbTools), submit it to the WC/TFS, and document it in the health record.

I. Perform a post-release assessment after release from restraints to determine the next step in the continuum of care and submit it to the WC/TFS by the end of the shift.

J. Participate in a debriefing as directed by the WC/TFS.

K. Upon confirmation of a pregnant youth, advise the youth verbally and in writing of their rights pursuant to Penal Code Section 3407.

L. Sign the Restraint Documentation Form as required.

VI. FAST:

A. When restraints continue for more than fifteen (15) minutes, consult with custody staff as soon as possible, but in no case longer than four (4) hours from the time the youth was placed in restraints.

B. In the event FAST staff are not on-site, upon notification from the WC/TFS, on-call FAST staff will consult with Medical staff regarding the review of the health record to identify existing mental health needs. In the event contraindications or accommodations are required, FAST will:

1. Notify the IC.

2. Notify the assigned Child Psychiatrist.

C. In the event FAST staff are not on-site, upon request from the WC/TFS, on-call FAST staff shall conduct a face-to-face assessment and review the health record when clinically indicated.

D. Monitor the state of the youth's mental health every four (4) hours from the time the youth is placed in restraints until the youth is removed from restraints.

E. Immediately report concerns, if any, to the IC.

F. Sign the Restraint Documentation Form as required.

Sacramento County **Probation Department**

Youth Detention Facility
OPERATIONS ORDER

Use of Restraints - Title XV Section 1358 and 1358.5

Purpose and Scope

The purpose of this policy is to provide staff with general guidelines for the reasonable use of restraints. It is recognized that the use of restraints is a serious responsibility and requires constant evaluation; however, it is also recognized that staff may have to use restraints to humanely and safely control youth in custody or to restore order.

Restraint devices include any devices which immobilize a youth's extremities and/or prevent the youth from being ambulatory.

Just as staff must use objectively reasonable force at times to effectively and humanely bring incidents/situations under control and/or to prevent serious harm to the individual, staff and others, staff must sometimes use a reasonable level of restraint for similar reasons. The decision to apply restraint devices must be based upon a reasonable assessment of the facts and circumstances as perceived by the staff on the scene at the time of the application.

In situations where it is necessary to make arrests within the institutions, Section 835 of the California Penal Code states: An arrest is made by an actual restraint of the person, or by submission to the custody of an officer. The person arrested may be subjected to such restraint as is reasonable for their arrest and detention.

Based upon the nature of the event/incident and where the use of restraints is necessary, staff should be able to identify potential use of restraint situations. Based on how the situation is identified, staff will be able to utilize specified options and techniques to gain youth compliance or safely transport/move a youth within or outside of the institutional setting.

It is the policy of this Department that the least restrictive interventions are to be used in order to minimize the use of restraints. Physical restraints should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the youth's behavior. Whenever possible, the use of restraints shall be avoided and shall cease when control, safety, or safe movement of a resident or situation is achieved.

Affected Personnel
All sworn staff - YDF

Authority
Graham v. Connor, 490 US 386 (1989)

California Penal Code, Sections 296, 298.1, 673, 830.5, 831, 831.5, 832, 835, 835a, 6030(f), 12401-12404 and 12450

Welfare and Institutions Code Sections 222

BSCC, Title 15, Sections 1357, 1358, 1358.5, and 1363

Effective Date
October 1, 2019

I. Definitions

A. ***Command Presence:*** The use of physical presence and official authority to attempt to gain compliance.

B. ***Compressive Asphyxia*:** Limiting the expansion of the lungs by compressing the torso, hence interfering with breathing. Compressive asphyxia can occur when the chest or abdomen is compressed backwards toward the spine.

C. ***Communicative Intervention:*** An option available to staff to deescalate a situation using communication, counseling and/or negotiation.

D. ***Control Position/Control Hold*:**

a. Control Position: Youth in a Control Hold, but no pressure is being applied.
b. Control Hold: Youth in a Control Hold with pressure being applied, or any physical restraint used to gain compliance or overcome resistance.

E. ***Destruction of Property:*** The act of ruining, breaking, tearing down, disabling or rendering property unusable.

F. ***Emergency Situation:*** A situation which a reasonable staff would conclude from the available information that immediate action and/or use of force may be necessary and failure to act or delay action is likely to result in injury to youth, staff or others; an escape; a riotous situation; significant self-inflicted injuries or suicide; or substantial destruction of property.

G. ***Excited Delirium:*** A condition that manifests as a combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent and bizarre behavior, insensitivity to pain, elevated body temperature, and superhuman strength. Excited delirium has been known to

result in sudden death (usually via cardiac or respiratory arrest) an outcome that is sometimes associated with the use of physical control measures.

H. ***Mechanical Restraint:*** A device that restricts the normal movement and function of the body or portion of the body.

I. ***Non-Compliant Situation:*** A situation which a reasonable staff would conclude from the available information that immediate use of force is not necessary and the failure to act or delay action is not likely to result in harm to youth, staff or others; an escape; a riotous situation; significant self-inflicted injuries or suicide; or substantial destruction of property.

J. ***Positional Asphyxia:*** A form of asphyxia which occurs when an individual's position prevents them from breathing adequately. Research has suggested that restraining a person in a face down position is likely to cause greater restriction of breathing. Research measuring the effect of restraint positions on lung function suggests that a restraint which involves bending the restrained person or placing body weight on them, has more effect on their breathing than face down positioning alone. Obesity, prior cardiac or respiratory problems, and/or the use of illicit drugs such as cocaine may increase risk.

K. ***Self-Inflicted Injury:*** A behavior or act by which a youth injures or attempts self-injury by head banging, cutting, self-mutilation or any other form of self-injury.

L. ***Staff Switching:*** The technique of attempting to gain a youth's compliance through counseling while utilizing different staff.

II. Approved Mechanical Restraint Devices

A. Where it becomes necessary to use mechanical restraints upon a youth, custody staff may utilize only the restraining techniques and devices which are approved and provided by the Probation Department.

1. Hard Restraints:

   a. Handcuffs: To be used for temporary restraint to ensure control of a youth. Use should not exceed 15 minutes.
   b. Leg Irons: To be used for transportation purposes.
   c. Leather Waist Restraint: To be used for transportation purposes.
   d. Belly Chain: To be used for transportation purposes.

2. Soft Restraints:

   a. The "WRAP" (see YDF Policy & Procedure entitled "WRAP Usage and Maintenance Procedures").
   b. Soft Restraints.
   c. Flex cuffs (large plastic) for either hands or ankles.

d. Protective head gear: helmet.

III. Factors to Consider Regarding the Use of Restraints

A. Before, during, and after an incident involving the use of mechanical restraints, staff shall make reasonable efforts to take into account the situational, medical, and mental health issues of a youth.

1. Situational Issues:

a. Conduct of the youth as reasonably perceived by the staff at the time;
b. Staff / youth factors: Age, size, relative strength, skill level, sophistication, number of staff to youth;
c. Influence of drugs or alcohol;
d. Proximity to weapons or contraband;
e. Time and circumstances permitting, the availability of other options;
f. Potential for injury to staff, youth, or others;
g. Seriousness of the incident or reason for contact with the youth;
h. Training and experience of staff;
i. Other exigent circumstances such as location, availability of back-up staff, or the youth's history of violence.

2. Medical Related Issues:

a. Pregnancy (see YDF Policy & Procedure entitled "Pregnant/Post-Partum Youth");
b. Bleeding;
c. Dehydration (especially common when taking psychotropic medication);
d. Exhaustion, from struggling;
e. Respiratory collapse (no breathing);
f. Cardiac collapse (no heartbeat);
g. Strangulation;
h. Aspiration;
i. Breathing difficulty;
j. Asthmatic;
k. Muscular injury;
l. Circulatory impairment;
m. Fractures;
n. Kidney damage;
o. Any other known medical condition of the resident.

3. Mental Health Issues:

a. Repeated threats to harm self or others;
b. Actual harm to self or others;
c. Physical evidence of suicidal behavior (e.g. cut wrist);
d. Delusional/bizarre behavior;
e. Youth's admission that their prescribed medication has not been taken;

f. Developmentally disabled.

4. Other Issues to Consider:

   a. Positional Asphyxia;
   b. Excited Delirium;
   c. Compressive Asphyxia.

IV. Prohibitions

A. Mechanical Restraints Will NOT be:

1. Used as discipline or as a substitution for treatment.

2. Used as punishment or as a means to get the youth to follow instructions.

3. Placed around the neck of a youth, nor will restraint equipment be applied in any way so as to inflict physical pain, undue physical discomfort, or to restrict blood circulation or breathing.

4. Used to secure a resident by keyed locking device to any part of a transporting vehicle.

5. Used when a public carrier is transporting a resident; e.g., bus, plane, train, etc. Restraints are to be removed prior to placing residents on a public carrier.

6. Used on youth with injuries to extremities (casts, splints, and bandages) without medical approval.

7. Used on youth with known medical conditions that would contraindicate certain restraint devices and/or techniques.

B. Youth Will NOT be:

1. Restrained to any fixed object.

2. Restrained and attached to a wall, floor or other fixture, including a restraint chair.

3. Restrained by the hands and feet together behind the back (hog tie) or the cradle positions.

4. Restrained for purposes of discipline and/or punishment.

V. Emergency and Non-Compliant Situations

A. The use of mechanical restraints in emergency and non-complaint situations may be done only when reasonably necessary under the following circumstances:

1. To prevent injury to staff or another;
2. To prevent an escape;
3. To protect a youth from self-inflicted injuries or suicide, and
4. To prevent the destruction of property.

B. When encountering Non-Compliant situations involving youth, staff shall not use mechanical restraints on a youth in situations where control of the youth/situation can be gained through other options, including:

1. Command Presence;
2. Communicative Intervention/Staff Switching;
3. Verbal Commands
4. Other Diffusing Options, such as time outs;
5. Mental Health Intervention/Assistance;
6. Control Position.

VI. Transportation Within the Facility

A. The use of mechanical restraints to safely move a resident from one location to another location within the facility may be done only when reasonably necessary under the following circumstances:

1. Consideration of the safety and security of the facility;
2. Consideration of less restrictive alternatives;
3. Consideration of the youth's known medical/mental health conditions;
4. Trauma informed approaches.

VII. Pregnant Residents

A. The use of restraints on pregnant youth is limited in accordance with Penal Code Section 6030(f) and Welfare and Institutions Code Section 222.

B. A pregnant youth shall not be shackled by the wrists, ankles, or both during labor, including during transport to a hospital, during delivery, and while in recovery after giving birth, subject to the security needs described in this section. Pregnant youth temporarily taken to a hospital outside the YDF for the purposes of childbirth shall be transported in the least restrictive way possible, consistent with the legitimate security needs of each youth. Upon arrival at the hospital, once the youth has been declared by the attending physician to be in active labor, the youth shall not be shackled by the wrists, ankles, or both, unless deemed necessary for the safety and security of the youth, the staff, and the public.

C. Extreme caution must be used when dealing with pregnant females, especially in regards to prone positioning. Prone restraint on a pregnant female shall only be used as a last resort option, when the staff has attempted all other lower level use of force options available to them.

VII. Documentation

A. The use of restraints shall be documented by staff in an Institutional Incident Report, to include the circumstances leading to the application of restraints. The Institutional Incident Report will be reviewed by a Supervisor.

VIII. Aftercare

A. Whenever a mechanical restraint device is used upon a resident:

1. The youth shall be referred to medical staff;

2. The youth shall be referred to mental health services when the youth remained in restraints for 15 minutes or more;

3. The incident shall be reviewed and documented by Supervisory level staff to determine if the use of restraints was reasonable given the facts and circumstances of the situation, youth discipline/due process, training issues and other issues as deemed appropriate by Supervisory staff.

IX. Application and Continued Use of Restraints

A. Any continued use of any restraint device for 15 minutes or more must be authorized by the duty supervisor. The authorized continued use of a restraint device from a supervisor shall result in an exchange from hard restraints to an appropriate soft restraint device or WRAP, unless directed otherwise by the supervisor.

B. Contact medical/mental health personnel immediately and have them present during the application. If they are not immediately available, a medical opinion must be obtained no later than two hours from the time of application.

C. Once the restraint device is applied, continuous direct visual supervision shall be conducted to ensure that the restraints are properly employed, and to ensure the safety and well-being of the youth. Observations of the youth's behavior and any staff interventions shall be documented at least every 15 minutes, with actual time of the documentation recorded. During this observation period, staff should continuously assess the need for the youth to remain in restraints and to notify the Duty Supervisor of such assessment.

D. While in restraints, all youth shall be housed alone in the safety cell, a specified housing area for restrained youth or designated housing area which provides protection to the youth from abuse.

E. Should a youth display signs or symptoms of emotional or physical distress staff shall notify the Duty Supervisor for immediate referral to medical or mental health assistance.

F. Should the youth require the aide of cardiopulmonary resuscitation equipment staff should contact the clinic.

G. Proper hydration and sanitation needs of the youth must be met while being restrained.

H. If, at any time during the restraint process, the youth requests medical or mental health intervention, seek appropriate assistance.

I. Staff shall make reasonable efforts to allow for the youth to exercise his/her extremities.

J. Duty Supervisor: At a minimum, if a resident has been in restraints for one (1) hour, the supervisor shall evaluate, review and document reasons for continued use of restraints. The decision to continue restraint shall be made at no greater than one (1) hour intervals.

If Mental Health Services are not available, whenever a resident remains in restraints for more than 15 minutes, the Duty Supervisor shall give consideration and evaluation to determine if a 5150 WIC hold would be appropriate

K. Medical/Mental Health Intervention during Continued Use of Restraint Device:

1. Whenever a youth is restrained for purposes other than transport outside the institution or movement within the institution, the resident must be seen by the medical staff as soon as possible, but no later than two hours from the placement in restraints. Also, a youth must be medically cleared for continued retention at least every fifteen minutes if medical staff are available. If medical staff are not readily available, this clearance cannot exceed three hours after the initial medical opinion.

2. Whenever a youth is placed in physical restraints for purposes other than transport outside the institution or movement within the institution, a mental health consultation to assess the need for mental health treatment is secured as soon as possible; however, in no case will the mental health consultation occur longer than 4 hours from the time the resident was placed in restraints. In the event the restraint occurs outside regular mental health staffing hours, mental health staff shall assess the resident the following morning. During hours when mental health staff are readily available, a mental health consultation with the resident being restrained is required every 15 minutes.
3. Whenever a youth remains in restraints for more than 15 minutes, Mental Health Staff shall give consideration for an assessment to determine if a 5150 WIC hold would be appropriate.

XI. **Corrective Action**

A. The use of restraints shall never be applied or used as punishment, retaliation, treatment, or for disciplinary purposes. Staff must take immediate action to stop the objectively unreasonable use of restraints from occurring. Staff will be subject to administrative discipline, up to and including termination and/or criminal complaints for the following:

1. Objectively unreasonable use of restraints.

2. Failure to report others who use objectively unreasonable use of restraints.

Replaces Previous Order
Use of Restraints 08/30/12

Authorized By _____ **Date** 9/30/19
Dave Semon, Division Chief