



October 13, 2025

Board of State and Community Corrections
Juvenile Regulations Revision Executive Steering Committee

Via email:

Dear Executive Steering Committee Members:

I write on behalf of Prisma Legal Center for Youth Justice (Prisma Legal) regarding the 2022 Juvenile Titles 15 and 24 Regulations Revision. Prisma Legal is public interest, movement law firm that partners with and supports youth justice leaders and organizations.

We commend the Executive Steering Committee's efforts to modernize these the Minimum Standards for Juvenile Facilities to improve the lives of incarcerated young people. However, several aspects of the drafts warrant further clarification or amendment to ensure youth safety, well-being, and successful rehabilitation.

Information and support for these comments was previously provided to the ESC and working groups, and for the sake of expediency, two prior letters are attached for reference and incorporation in this comment: the July 7, 2022, Youth Law Center Letter (Letter 1) and the September 24, 2024, Prisma Legal Center for Youth Justice Letter (Letter 2).

While we believe there is still much work to be done to bring California juvenile facilities in line with best practices and common decency, we also understand that this process has been lengthy, and youth are awaiting the proposed changes. For this reason, we want to highlight some important items for clarification and amendment:

- **Chemical Agents:** The ESC should recommend the elimination of chemical agents in juvenile facilities. If it fails to do so, it must, at a minimum, take significant steps to reduce the use of such weapons, collect data and closely monitor incidents involving chemical agents, and develop a plan to work towards elimination.
- **Physical and Mechanical Restraints:** To bring California in line with modern international standards on the treatment of children, ensure youth safety, and prevent harm, the ESC must 1) prohibit the use of prone restraints, 2) ban use of "the WRAP," 3) evaluate and specify which physical restraints may be used in juvenile facilities, and 4) prohibit 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.

- **Staffing Shortages and Noncompliance:** The ESC must make it plain that staffing shortages do not excuse noncompliance with other regulations in the absence of a documented emergency that meets the definition of and follows the process for suspension in Section 1311.
- **Telephone Access:** The ESC must require that youth in juvenile facilities have regular, no-cost telephone contact with their families, and must prohibit facilities from conditioning telephone access to behavior and discipline programs.
- **Visitation:** Section 1374 must be clarified to ensure that the minimum weekly visitation requirements are per youth, and not merely the minimum required for a facility's general visiting hours per week.
- **Food Quality and Quantity:** The ESC should prohibit the use of jail-based food service or contracts to provide meals to youth in juvenile facilities. It should additionally require that any contract for the provision of food specifically refers to and requires compliance with the minimum standards for juvenile facilities.
- **Programs, Recreation, and Exercise- Outdoor Access:** Address the drafting error in the current proposal that inadvertently changed the outdoor access requirement weekly rather than daily.
- **Oversight and Inspection:** The ESC should specify that regulations are subject to inspection and oversight by the BSCC, and that local inspections do not replace BSCC inspections required pursuant to Welfare and Institutions Code § 209.

Elimination of Chemical Restraints

We strongly urge the Board to prohibit the use of chemical agents in juvenile facilities. Across the country, facility administrators have moved away from these practices due to the severe physical and psychological harm they cause to youth and staff, the damage they inflict on staff–youth relationships, and the demonstrated reality that they are unnecessary to maintain safety. By continuing to permit their use against young people, California remains out of step with fundamental rights, national best practices, and a developmentally appropriate approach to supporting youth. The use of chemical agents is inherently harmful and undermines the rehabilitative mission of the juvenile justice system. Such practices are incompatible with the legal requirement that juvenile halls not operate as penal institutions, but instead provide a safe, supportive, and homelike environment.¹

Information previously provided to the ESC detailed the reasons supporting the elimination of chemical agents and the harms associated with them. (Letter 1 pp 1-3; Letter 2 pp 1-3). These include: the physical harms associated with the use of chemical agents, the risk that exposure presents to youth with respiratory conditions and other specific populations, the overwhelming number of states that prohibit use, investigations of California facilities that found chemical agents were disproportionately used against youth with disabilities, investigations of California juvenile facilities finding chemical agents used in response to non-violent acts, and the serious impediments that such agents pose to safety and rehabilitation.

¹ Welfare and Institutions Code § 851.

If the ESC fails to recommend the elimination of these weapons, it must, at a minimum, regulate how and when they are used, who may use them, and how data and information about use will be gathered and reviewed. We suggest at least the following limitations:

- Prohibit officers from carrying chemical agents on their service belts or in the ordinary course of activities. All chemical agents should be stored in a central location and clear, written protocols must be maintained for their use.
- Require supervisor approval for use.
- Collect and report data on the use of chemical agents including the number of incidents per month, number of youth impacted per incident, reason given for deployment, and outcome of incident review.
- Prohibit use except in instances where other de-escalation efforts have failed or are insufficient without harm to others and there is imminent risk of harm to one or more persons. Risk of property alone should not be a permissible basis for the use of chemical agents.

Regulate and Prohibit the Use of Physical and Mechanical Restraints

We urge the ESC to consider the range of physical and mechanical restraints currently utilized and establish clear, enforceable regulations governing the use of physical, mechanical, and other restraints on children in juvenile facilities. The use of restraints poses profound risks to youths' physical safety, psychological well-being, and long-term development. Numerous studies and investigations have documented that restraints are often applied in response to staff frustration or inadequate training, rather than imminent threats to safety. Youth subjected to restraint experience trauma, physical injury, and lasting emotional harm—outcomes entirely inconsistent with a system intended to promote safety, healing, and rehabilitation.

At present, California lacks consistent standards, oversight, and reporting requirements for the use of restraints in juvenile facilities. This regulatory gap leaves children vulnerable to unnecessary and harmful practices, while leaving staff without clear guidance or accountability mechanisms. Regulations do not even specify which mechanical restraints are allowable, which has left facilities to adopt their own policies and experiment with the use of harmful devices without meaningful state oversight. To date, the Board has not undertaken a survey and review of the mechanical devices used to restrain children in juvenile facilities throughout the state, and it has not limited the types of devices facilities can use. The current regulation prohibits restraint chairs and affixing youth to walls or furnishings, but a facility may allow any other device. This means that devices never considered or reviewed by the Board are both allowed and in use. The regulation must specify which devices are allowed and any additional device proposed should be submitted to the Board for review.

Specifically, we ask the ESC to take the following steps: 1) prohibit the use of prone restraints, 2) ban use of "the WRAP," 3) evaluate and specify which physical restraints may be used in juvenile facilities, and 4) prohibit 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.

In our prior letter to the Medical and Mental Health Workgroup we specifically described the harms associated with prone restraints and “the WRAP.” (Letter 2, prone restraints pp 4-5 and the WRAP pp 5-7). We incorporate those comments and the referenced attachments here. We will not restate each of the harms and risks associated with these restraints here, but we do ask that you review our prior letter and its attachments. However, to highlight the serious issues with the WRAP, which has been adopted for use in several California juvenile facilities, we once again draw your attention to the March 2020 decision from the United States District Court for the Southern District of Iowa.² 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 stated:

“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.”³

We urge the ESC to recommend decisive action to ensure that no child in California is subjected to unnecessary or harmful restraint. By establishing clear standards, transparent oversight, and trauma-informed practices, the ESC can help build systems that truly promote safety, dignity, and healing for all youth in juvenile facilities. The well-being of children in state care demands nothing less than a full and transparent review of restraint practices. We urge the ESC to act swiftly to establish safeguards that reflect a commitment to protecting youth and advancing trauma-informed, developmentally appropriate care.

Make Clear that Staff Shortages Do Not Excuse Regulatory Noncompliance Absent an Emergency

We ask the ESC to take a step to protect youth in the face of a serious and ongoing statewide concern regarding staffing shortages in juvenile facilities. Across California, counties report persistent difficulties in recruiting and retaining qualified staff, resulting in inadequate supervision ratios, reduced programming, and, in some instances, the restriction or suspension of youth services and privileges required under the regulations. While we recognize the operational challenges these shortages present, we are deeply concerned that some jurisdictions have interpreted these conditions as grounds to waive or suspend compliance with state regulations—actions that are not permitted under existing law. Just as concerning, even where counties acknowledge that such suspension of services or failure to meet

² C.P.X. through his next friend S.P.X., 450 F.Supp.3d 854 (S.D. Iowa 2020)

³ Id. 911-912.

regulatory obligations amounts to noncompliance, the Board fails to document and notice the facility for noncompliance with the regulations. In some cases, it cites the facility for noncompliance with staffing alone and fails to demand correction of the noncompliance with other regulations. In other instances, it merely notes the issue and fails to require correction at all.

The minimum standards establish the baseline protections necessary to ensure the safety, health, and well-being of youth in custody. Allowing compliance to lapse due to staffing conditions undermines the statutory intent of Welfare and Institutions Code section 209, which assigns the Board responsibility for ensuring that every juvenile facility in the state meets its regulatory obligations at all times—not merely when convenient or fully staffed.

We respectfully urge the ESC to issue clear recommendations reaffirming that compliance with minimum standards cannot be suspended or reduced due to staffing shortages, except in narrowly defined emergencies consistent with existing regulations and procedures. This clarification should be accompanied by a directive in the staffing section requiring counties to develop contingency plans that preserve youth rights and safety during periods of short staffing. The ESC should also recommend the Board collect data on staffing levels and their operational impacts to inform policy solutions and technical assistance aimed at improving workforce stability.

California's juvenile facilities must remain safe, rehabilitative, and developmentally appropriate environments regardless of workforce fluctuations. Clear and consistent enforcement of the Board's standards is essential to that goal. We ask the ESC to take clear action to ensure that staffing shortages never become a pretext for diminishing the care or legal protections owed to young people in custody.

Require Daily, No-Cost Telephone Contact

Daily telephone contact is a lifeline for incarcerated youth. Regular communication with family members and other supportive adults helps preserve critical emotional bonds that are often strained or severed during confinement. For children—especially those separated from parents or caregivers—daily phone contact provides reassurance, stability, and a sense of belonging that mitigates the isolation, anxiety, and trauma of incarceration. It allows families to remain engaged in the youth's education, mental health treatment, and case planning, and it reinforces the youth's identity as a loved and valued member of a family and community. Research consistently shows that youth who maintain strong family connections during confinement experience better behavioral outcomes, improved mental health, and lower rates of recidivism.

In addition to its emotional and developmental importance, daily telephone contact advances the rehabilitative goals of the juvenile justice system. Maintaining open lines of communication between youth, families, and service providers strengthens coordination of care, facilitates smoother reentry planning, and supports accountability in facility operations. When phone contact is limited, restricted as part of a discipline system, or accessible only as a reward, youth are cut off from the very relationships that help them succeed upon release. Providing and reliable daily phone access is not a privilege but a developmental necessity—and an essential component of a humane, trauma-informed, and family-centered approach to juvenile rehabilitation.

California recently took the important step of guaranteeing free telephone access to youth in juvenile facilities. Unfortunately, some juvenile facilities have failed to grasp the necessity of telephone contact with family and continue to significantly restrict phone access in other ways. Other facilities provide daily access to telephone calls, which illustrates the feasibility of doing so. Despite the research and testimony provided to the legislature when it passed the law mandating no cost telephone access, there remains wide variation in youths' access to telephones to communicate with family. Absent a clear regulatory requirement, some youth will continue to have minimal access to this critical lifeline.

We urge the ESC to recognize daily telephone contact as a fundamental necessity for the health, safety, and rehabilitation of incarcerated youth. Ensuring that every young person has free, reliable access to daily communication with family and supportive adults is a simple yet profound step toward making our juvenile facilities more humane and developmentally appropriate. We ask the ESC to adopt regulations that guarantee this access as a matter of right, not privilege—affirming California's commitment to keeping children connected to the people who love and sustain them, even during the most difficult periods of their lives.

Guarantee Minimum, Weekly Visitation Opportunities for Each Youth

We request the ESC clarify facilities' visitation obligations in section 1374. Specifically, we seek confirmation that the requirement for "minimum weekly visitation opportunities" applies to each individual youth, rather than serving merely as a general minimum for the facility's visiting schedule.

The distinction is critical. The intent of visitation standards is to ensure that every young person has the opportunity to maintain consistent, meaningful contact with family and other supportive adults—a right that cannot be realized if visitation is treated only as a facility-level obligation. When visiting hours are limited or shared among multiple youth, many children are effectively deprived of visits through no fault of their own. This outcome undermines the rehabilitative purpose of confinement, disrupts family bonds, and contradicts the principles of trauma-informed and family-centered care that guide California's juvenile justice system.

We urge the ESC to clarify, through policy guidance or regulatory amendment, that the minimum weekly visitation standard must be interpreted and implemented as an individual entitlement for each youth. We suggest adding a subsection to make this clear such as, "general visiting hours alone cannot satisfy this the minimum opportunity requirement if a youth's family communicates that it is unable to visit during those hours." This clarification will promote consistency across counties, reduce confusion among facility administrators, and ensure that all children in state and county custody have equitable access to the family contact essential to their well-being and rehabilitation.

Prohibit the Use of Jail-Based Food Service and Ensure Inspection for Food and Nutrition Compliance

We strongly urge the ESC to prohibit the use of jail-based food service systems or contracts for youth in juvenile facilities. The practice of providing food to children through adult jail kitchens or correctional food service contracts is fundamentally inconsistent with the rehabilitative and developmental mission of California's juvenile justice system. Food is not simply a logistical necessity—it is a reflection of how a system values the people in its care. When children are served the same mass-produced, low-quality meals designed for adult incarceration settings, the message conveyed is one of punishment rather than care, dignity, or restoration.

Numerous studies have shown that nutrition is directly tied to youth health, behavior, and emotional well-being. Meals provided through jail systems are typically designed to meet adult caloric needs at the lowest possible cost, not the developmental and dietary needs of adolescents. They often lack fresh fruits and vegetables, contain excessive sodium and preservatives, and fail to accommodate medical, cultural, or religious dietary requirements. For many youth, these meals reinforce the stigma of confinement and erode trust in facility staff. This approach is especially troubling given California's statutory and constitutional mandate that juvenile facilities not operate as penal institutions but instead provide safe, supportive, and homelike environments conducive to rehabilitation.

We urge the ESC to establish clear standards requiring that all meals for incarcerated youth be prepared and served through systems designed for youth—or at least not provided through adult jail kitchens or jail food contracts. Facilities should prioritize partnerships with youth-serving food providers, local school districts, or community-based nutrition programs that can offer balanced, fresh, and culturally appropriate meals. Such a policy would affirm the developmental distinction between juvenile and adult systems, promote health and dignity, and advance the state's commitment to trauma-informed, youth-centered care.

Additionally, food and nutrition must become a part a regular part of the Board's inspection process, and not left to the local, county inspectors. At present, the Board does not routinely evaluate nutrition, meal quality, or the adequacy of food access. Instead, it relies on local inspectors that are not obligated to evaluate facility nutrition programs for Title 15 regulatory compliance. In addition to not local inspectors not being legally required to assess Title 15 compliance, the reports are also sporadically provided and reviewed. Indeed, when regulatory violations are found they are not reported to the Board or public, not corrected through the required legal process, and compliance is not subsequently confirmed by the Board. This leaves a gaping hole in facility oversight. We ask that you close this gap by adopting the suggestion in the section below titled "Require Complete Inspections for Compliance with All Minimum Standards Regulations."

Correct a Drafting Error in that Reduces Outdoor Access from Daily to Weekly

We want to bring to the ESC's attention an apparent drafting error in the current proposal for Section 1371, which appears to have inadvertently changed the required frequency of outdoor access for incarcerated youth from daily to weekly. This change is inconsistent with longstanding standards, established best practices, and the Board's own stated intent to ensure youth in custody have regular opportunities for physical activity, fresh air, and sunlight essential to their health and well-being.

Daily access to outdoor recreation is a foundational element of humane confinement and youth development. It supports mental health, reduces tension and behavioral incidents, and promotes physical fitness—factors that are critical in rehabilitative environments. A shift from daily to weekly outdoor time would represent a substantial reduction in youth rights and care standards, with potentially serious consequences for health, safety, and compliance with constitutional and developmental requirements. We believe this revision was unintended, likely the result of a drafting or formatting error, as there is no indication in the record or the ESC’s discussions of a policy decision to reduce outdoor access for youth.

For these reasons, we believe that a simple correction will resolve the matter. To correct the issue, in proposed section 1371 (b), we suggest adding the words “a day” before the second occurrence of the phrase “during the week,” which will mirror the language in the first part of subsection (b) and correct the ambiguity.

Require Complete Inspections for Compliance with All Minimum Standards Regulations

We would like to express our deep concern regarding the Board’s current inspection practices for juvenile facilities—specifically, the Board’s **failure to conduct or ensure inspections for compliance with critical standards relating to health and behavioral health care, environmental health and sanitation, food and nutrition, and education.** Under Welfare and Institutions Code § 209, the bears the legal responsibility to inspect juvenile facilities for compliance with all minimum standards adopted by the Board. The law contains no exception to the inspection requirement for areas also covered by other regulations and subject to other local inspections. Nonetheless, instead of direct review and verification by the Board or Board staff, these core areas are being deferred to local inspectors and agencies who are neither trained in, nor obligated to assess, compliance with the Board’s own regulations.

This practice undermines the integrity of the state’s oversight system and leaves some of the most important aspects of youth care unmonitored by the state agency tasked with inspection and oversight. The standards in these areas are not optional; they exist to protect the physical and mental health of children in confinement and to ensure that facilities operate in a manner consistent with law and developmental best practice. Local health or environmental inspectors may review for general code compliance and for compliance with other laws and regulations that they are mandated to inspect, but they do not—and are not required to—apply the Board’s detailed regulatory standards governing the adequacy of health care services, mental health screening and treatment, nutritional requirements, or access to education. As a result, the Board’s statutory duty to ensure uniform, statewide compliance with minimum standards is effectively unfulfilled in these domains.

To make matters worse, local inspections are not always provided to the Board or its staff or not provided timely. In some instances, there is indication that a local inspection did not take place or simply no record indicating whether or not an inspection occurred. Perhaps most alarmingly, even when local inspectors document noncompliance, there is no written documentation, or any indication whatsoever, that the Board followed up to ensure correction. It is clear that the Board is relying on the local inspections rather than independently inspecting for compliance, but despite relying on local inspectors to meet its statutory obligations it does not follow the legally mandated process for notification and correction of any noncompliance identified.

The consequences are profound. Juvenile facilities may fail to meet minimum standards in these areas for years without consequence or correction. Without consistent inspections, serious deficiencies in health care delivery, sanitation, nutrition, or educational access may go undetected and uncorrected—exposing youth to preventable harm and facilities to legal and ethical risk. Moreover, this gap deprives the Board, the public, and policymakers of accurate information about facility conditions and systemic compliance. The Legislature entrusted this duty to the BSCC—not to local agencies—precisely to ensure uniform, statewide enforcement and accountability.

We ask the ESC to take important step to close this inspection gap and require Board staff to meet all inspection obligations. Specifically, we suggest adding the following language to Section 1313: “The provision of documentation required by this section does not replace or alter the Board’s inspections or its legal obligation to inspect for compliance with all of the minimum standards adopted by the Board.”

We appreciate the ESC’s ongoing efforts to review and strengthen the Minimum Standards for Juvenile Facilities and urge you to ensure that the revised standards reflect the highest commitment to youth safety, dignity, and rehabilitation. This review presents an opportunity to correct longstanding gaps, align regulations with current law and best practices, and affirm California’s commitment to humane and developmentally appropriate juvenile justice. We thank the ESC for its attention to these critical issues and stand ready to support the development and implementation of standards that truly promote health, healing, and opportunity for every young person in custody.

Sincerely,



Erin Palacios
Prisma Legal Center for Youth Justice

LETTER 1

July 7, 2022

Board of State and Community Corrections
2590 Venture Oaks Way, Suite 200
Sacramento, CA 95833
regulations@bscc.ca.gov

Via email only

Re: 2022 Juvenile Titles 15 and 24 Regulations Revision

Dear Board of State and Community Corrections,

I write on behalf of the Youth Law Center regarding the 2022 Juvenile Titles 15 and 24 Regulations Revision. The Youth Law Center is a public interest law firm that advocates on behalf of children in the foster care and juvenile delinquency systems to ensure they have the supports and services they need to become healthy and productive adults. For decades, YLC advocates have been advancing reforms to protect the safety and wellbeing of young people in detention and confinement settings.

Please find attached with this letter a list of comments and proposed revisions for your consideration. Our comments relate to numerous provisions, so we created a spreadsheet in the hopes that it would be the most useful format. Please let us know if you have any difficulties accessing our recommendations.

In this letter, we wanted to highlight four specific recommendations that are of particular concern for our organization and for the youth and families that we serve.

1. Elimination of Chemical Agents

We strongly urge the Board to eliminate the use of chemical agents in juvenile facilities. The use of chemical agents has been widely rejected by facility administrators across the country due to physical and emotional harm caused to youth and staff, the detrimental effects on staff-youth relationships, and their experience showing the chemical agents are unnecessary to protect the safety of youth and staff. In continuing to allow their use against young people, California is out of step with fundamental rights, best practices, and a developmentally appropriate vision for how to support our youth.

The harmful nature of chemical agents makes their use counterproductive to the rehabilitative goals of the juvenile justice system. Use of chemical agents on youth is inconsistent with the requirement that juvenile halls not be operated as penal institutions and instead “shall be a safe and supportive homelike environment.”¹ Permitting juvenile facility staff

¹ Ca. Welfare & Institutions Code § 851.

to carry and use destructive chemical agents creates a punitive, fear-inducing environment, which impedes the development of trusting, healthy relationships between staff and youth that are essential to facility safety and facilitating successful reentry.

The most common chemical agent used in juvenile facilities is Oleoresin Capsicum, commonly known as “pepper spray.” Pepper spray is so toxic that it is classified in California law as a tear gas weapon.² It works by inflaming the respiratory tract and restricting breathing.³ In juvenile facilities throughout California, this weapon—which can cause not only intense pain but also blistering of the skin, coughing, sneezing, inflammation, respiratory arrest, and an increased risk of strokes and heart attacks—is particularly dangerous for those with cardiovascular or respiratory conditions such as asthma or those using psychotropic medications.⁴ A report by the American Civil Liberties Union Foundations of California, based on public record act requests to all 58 counties, found that officials in California juvenile facilities used this weapon more than 5,000 times between January 2015 and March 2018.⁵ The number of incidents may be much higher, because 13 counties failed to provide data on how often it was utilized.

Thirty-five other states and several California counties (Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and pending in Los Angeles) recognize that chemical agents are not needed to safely operate a facility.⁶ Operated by the City and County of San Francisco, the Youth Guidance Center juvenile facility “does not use these potentially dangerous interventions on youth, and should be a model for other juvenile facilities in this regard.”⁷ A national survey by the Council of Juvenile Correctional Administrators observed that facilities that use pepper spray tend to be systems that adopt an overall more punitive and adult-correctional approach.⁸ This is consistent with experiences of youth at California juvenile facilities.

Investigations into conditions in juvenile facilities in Kern, San Diego, Fresno, and San Francisco counties found that chemical agents are often directed disproportionately against youth with mental health, behavioral learning, and/or developmental disabilities—including many who

² Ca. Penal Code Sections 22810 *et seq.*

³ U.S. Department of Justice, National Institute of Justice. *Oleoresin Capsicum: Pepper Spray as a Force Alternative* (NCJ 181655) (1994).

⁴ Texas Criminal Justice Coalition, *Pepper Spray in the Texas Youth Commission: Research Review and Policy Recommendation* (Nov. 2007), available at: <http://www.nijn.org/uploads/digital-library/pepper.pdf>

⁵ American Civil Liberties Union Foundations, *Toxic Treatment: The Abuse of Tear Gas Weapons in California Juvenile Detention* (May 2019), available at: https://www.aclusocal.org/sites/default/files/aclu_socal_toxic_treatment_report_2019.pdf

⁶ *Ibid.*

⁷ Disability Rights California, *Report on Inspection of the San Diego Juvenile Detention Facilities* (Feb. 2016), available at: www.disabilityrightsca.org/system/files/file-attachments/703001_1.pdf

⁸ Council for Criminal Justice Administrators, *Pepper Spray in Juvenile Facilities* (May 2011), available at: www.ojp.gov/ncjrs/virtual-library/abstracts/pepper-spray-juvenile-facilities

are survivors of significant trauma—and constitutes abuse and neglect of these young people.⁹ Probation staff have been found to use chemical agents “on youth in response to non-violent acts such as verbal defiance and ‘peer friction,’ for symptoms of mental health needs such as self-injury and threats of self-harm, and in a punitive manner after youth had been restrained.”¹⁰ Staff routinely punish these youth—including with isolation, restraint, and chemical force—for behavior related to their disabilities. Excessive use of chemical agents in turn creates significant liability for counties.

Eliminating chemical agents from juvenile facilities is also a matter of racial justice. As compared to white youth, African-American youth are 7.5 times more likely to be ordered to institutional placement, and Latinx youth are 2.5 times more likely.¹¹ The harms of chemical agents in juvenile facilities thus disproportionately impact youth of color, particularly Black, Latinx, and Indigenous youth.

Using chemical agents, which severely impair the respiratory system, is even more dangerous during the current COVID-19 pandemic, given pathological findings that COVID-19 is associated with acute respiratory distress and death. Because physical reactions to chemical agents include intense coughing, sneezing, sputtering, and crying, any use of chemical agents can facilitate the spread of COVID-19 both within the facilities and outside (as infected staff return home to their communities).¹² The COVID-19 pandemic necessitates the elimination of the use of chemical agents in juvenile facilities in order to effectively protect the safety of both youth and staff.

For the reasons above, we urge the Board to eliminate chemical agents from juvenile facilities. With an understanding that elimination of chemical agents may require intermediate steps, we have included in our spreadsheet some recommendations for significantly restricting their use. While we believe that these interim steps would represent an improvement in current practices, we remain steadfast in our position that these agents should not be used against young people. The continued use of chemical agents does not align with creating environments that support the trusting relationships between staff and youth that are essential to promoting healthy and positive growth for young people.

2. Case Planning and Reentry Planning for Long-term Commitments

⁹ For full reports, see: <https://www.disabilityrightsca.org/what-we-do/priorities/adult-and-juvenile-detention-facilities>

¹⁰ Disability Rights California, *Investigation Report: Kern County Juvenile Correctional Facilities* (Jan. 2018), available at: www.disabilityrightsca.org/system/files/file-attachments/2018Feb6KCJCReportFinal_Accessible.pdf

¹¹ Wong, A. & Ridolfi, L., *Unlocking opportunity: How race, ethnicity and place affect the use of institutional placements in California 4* (Jan. 2018), available at: https://burnsinstitute.org/wp-content/uploads/2020/09/Unlocking-Opportunity_compressed.pdf

¹² Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Feb. 2021), available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

The current regulations lack robust standards for the care of young people who will be confined in a juvenile facility for long periods of time. Even before the closure of DJJ, counties across the state have been confining youth in local juvenile facilities for extended periods.¹³ With the closure of DJJ, it is likely that this trend will continue, increasing the need for specific requirements for the provision of care, both during confinement and in preparation for release and reentry back into the community.

The Board should utilize the guiding principles of SB 823 to promulgate robust regulations for both case planning and transition/reentry planning for youth with extended stays in juvenile facilities. In enacting SB 823, the Legislature and the Governor stated the following intent:

“for counties to use evidence-based and promising practices and programs that improve the outcomes of youth and public safety, reduce the transfer of youth into the adult criminal justice system, ensure that dispositions are in the least restrictive appropriate environment, reduce and then eliminate racial and ethnic disparities, and reduce the use of confinement in the juvenile justice system by utilizing community-based responses and interventions.”¹⁴

Importantly, SB 823 provided funding for counties specifically to implement “public health approaches to support positive youth development” within local jurisdictions.¹⁵ The principles of public health and positive youth development must guide more comprehensive regulations impacting youth in long-term confinement.

The BSCC can look to the new codes enacted as part of SB 823 to identify the factors that should be incorporated into the regulations for youth in long-term confinement. For example, as part of their planning for realignment, counties are required to address numerous elements within their local continuum of responses, including: programs or services that promote the healthy adolescent development; family engagement; and reentry, including planning and linkages to support employment, housing, and continuing education.¹⁶ These elements are not limited just to dispositions to the “Secure Track” under Welfare and Institutions Code Section 875. Rather, they are applicable under SB 823 to the entire realigned population, meaning all youth adjudicated to be a ward based on an offense in Welf. & Inst. Code Section 707(b) or Penal Code Section 290.008.¹⁷ These youth will undoubtedly be represented throughout the populations confined in local juvenile facilities, and therefore these elements must be incorporated into the Title 15 and 24 regulations.

¹³ See Pacific Juvenile Defender Center and Youth Law Center, “California’s County Juvenile Lockups: Expensive, Overutilized, and Unaccountable,” November 2020, available at: <https://www.pjdc.org/wp-content/uploads/Californias-County-Juvenile-Lockups-November-2020-Final.pdf>.

¹⁴ Sen. Bill No. 823 (2019-2020 Reg. Sess.), § 1(b)

¹⁵ Sen. Bill No. 823 (2019-2020 Reg. Sess.), § 1(c)

¹⁶ Welf. & Inst. Code § 1995(c)(3)(B)-(D).

¹⁷ Welf. & Inst. Code § 1990(b).

In accordance with the above, the Board must revise its case planning regulation under Section 1355 to address the specific programming and services to be offered to the youth in the facility. Currently, this regulation fails to require anything in the case plan related to family engagement. Section 1355 must be revised to include involvement of family during the time that the youth remains in the facility. This regulation should also be reoriented to a strengths-based approach to youth development.

The Board must also revise its release and transition regulations under Section 1351. Currently, this regulation fails to account for the significant transitional planning that youth will need after long-term stays in confinement. The regulation must be revised to impose a timing requirement so that transition planning is initiated well before a youth will actually be released, ideally with a lead time of least six months. The regulation revisions must also include notice about specific community-based supports for which the youth might be eligible, and how to apply.

3. Free daily phone calls to family members

Youth in juvenile facilities must have regular, no-cost contact with their families while incarcerated. Extensive research has shown the many benefits of family contact when a person is incarcerated, including reduced recidivism and improved health and behavior.¹⁸

With respect to youth, family contact is especially critical. SB 823 specifically acknowledged this fact, stating: “Evidence has demonstrated that justice system-involved youth are more successful when they remain connected to their families and communities.”¹⁹ Yet, across California, families face exorbitant costs just to have phone calls with their incarcerated children. One study found that in 2020, several counties were charging over \$10 for just 15-minutes of phone time.²⁰ This exploitation must end, especially because it works against the rehabilitative goals of the juvenile justice system.

Section 1376, Telephone Access, must be revised to make all phone calls free. Further, youth must have a right of a daily phone call to a family member, and phone calls must not be used as rewards or punishments or to otherwise control youth behavior.

4. Regulations for Secure Youth Treatment Facility commitments

We urge you: do not to simply apply the existing body of regulations in Titles 15 and 24 to the newly establish Secure Youth Treatment Facilities (SYTFs) under Welf. & Inst. Code section 875. Instead, the Board must develop a separate process that allows for additional community input specific to this brand-new type of juvenile facility. The Board has until July 1,

¹⁸ See “Research Roundup: The positive impacts of family contact for incarcerated people and their families,” Prison Policy Initiative, December 21, 2021, available at: https://www.prisonpolicy.org/blog/2021/12/21/family_contact/

¹⁹ Sen. Bill No. 823 (2019-2020 Reg. Sess.), § 1(a).

²⁰ “In California, how much do parents pay to talk to their children who are locked up in county juvenile facilities?” Children’s Defense Fund, Young Women’s Freedom Center, The Financial Justice Project, available at: <https://sfgov.org/financialjustice/sites/default/files/2020-08/%28Community%29%20%23PriceOfJustice%20Juvenile%20Phone%20Calls%20%281%29.pdf>.

2023, to promulgate SYFT regulations, which is more than enough time for a thorough process on this topic.²¹

It is inappropriate simply to apply the existing regulations to SYTFs. The current regulations are designed primarily to address juvenile halls, which, under state law, are detention facilities operated by probation departments.²² In contrast, SYTFs are post-dispositional, treatment facilities operated by any county agency.²³ SYTFs must be able to meet the standards of care for a youth committed to them, which means addressing the treatment, education, and development needs of the youth, and providing “trauma-informed, evidence-based, and culturally responsive care.”²⁴ The Board must promulgate regulations specific to the requirements for SYTFs, including a requirement that staff delivering treatment services be qualified to provide them.

5. Regulations for County Camp and Ranch Facilities

Like the SYTFs, county camps and ranches require their own set of regulations to appropriately address the specific purpose that these facilities serve under state law. The Board’s statutory mandate to promulgate camp/ranch regulations is set out in Welfare and Institutions Code Section 885. This section is separate and apart from the Board’s mandate to promulgate regulations for juvenile halls, set out in Welfare and Institutions Code section 210. The Board’s failure to promulgate regulations specific to camps/ranches has collapsed these two categories of facilities. This result clearly contradicts the statutory framework of separate categories of facilities with separate purposes, goals, and functions.

As with SYTFs, the Board must promulgate a separate set of regulations for camps/ranches that allow such county facility to meet the goal for these facilities. Specifically, camps and ranches are intended to “apply the salutary effect of a safe and supportive home and family environment” and “give better opportunity for reform and self-discipline.”²⁵ At a minimum, counties must have flexibility under the regulations to innovate facility designs, staffing arrays, and programmatic offerings that meet the statutory goals for these facilities.

6. Ombudsperson in Office of Youth and Community Restoration

We understand that the Office of Youth and Community Restoration is in the process of developing the policies and procedures that will apply to the new Ombudsperson, established by SB 823 and codified in Welfare and Institutions Code Section 2200(d). We encourage the Board to develop new regulations to incorporate this new role and ensure that youth in juvenile facilities know about and are able to directly access the Ombudsperson’s office.

²¹ See Welf. & Inst. Code § 875(g)(3).

²² See Welf. & Inst. Code § 850 et seq.

²³ See Welf. & Inst. Code § 875(g)(1).

²⁴ See Welf. & Inst. Code § 875(d)(2)(A)-(C).

²⁵ See Welf. & Inst. Code § 880.

We appreciate the opportunity to provide comments in the regulation revision process and we look forward to continuing to work with you in the next stages of this process. If you have any questions or would like to discuss any of our recommendations further, we would be happy to be in touch. Thank you for your time and consideration.

Sincerely,



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Youth Law Center Comments re Revision of Juvenile Titles 15 & 24 Regulations

Article	Section	Sub-Section(s)	Comment	Proposed Revision
1 - General Instructions	§ 1302. Definitions		<p>The definition of non-binary should also be included.</p> <p>The definition of "Behavioral Health" should specifically include trauma. Under the new CalAIM provisions youth whose conditions places them at high risk for a mental health disorder due to the experience of trauma, are eligible for specialty mental health services to prevent or alleviate the future onset of a mental health disorder. Involvement in the child welfare or juvenile justice system or experiencing homelessness are all sufficient evidence that a youth has experienced trauma. See BHIN 21-073 at https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf. This is part of a statewide effort to ensure that youth receive access to "the right care at the right time," and to recognize the short and long-term effects of trauma on young people. This should be in the definition in keeping with the state's focus on identifying and ameliorating the effects of and poor outcomes associated with experiencing trauma. (See suggested revision.)</p> <p>Human Trafficking -- This definition does not appear to be related to anything else in the regulations as it is not used again. To the extent that it does relate or is otherwise necessary, it should be brought into alignment with so as to be inclusive of the definition of commercially exploited children found in Welfare and Institutions Code Section 300(b)(2).</p> <p>"Linguistically Appropriate" This definition is used in conjunction with the provision of critical information and should require such information to be provided at the reading and comprehension level of the youth, and in accordance with any relevant provisions of the youth's IEP once the IEP is received by probation, or the facility administrator or manager. (See suggested revision.)</p> <p>Non-school day Should include days when education is not provided/ made available to a youth regardless of whether the school is in operation. (See suggested revision.)</p> <p>"Reasonable and Necessary Force" This definition needs to include a component of community standards of reasonableness. Continuing to have the standard defined by only the objective opinions of custodial officers places youth at risk because they are overseen and controlled by a group of individuals who essentially define their own standards for the acceptable use of force on the children in their care. In addition, the definition should define a violation of the regulations governing the use of force as objectively unreasonable as they constitute behavior and actions beneath the minimum standards of care. (See suggested revision as to part.)</p> <p>"Room Extraction" The only place that this comes up again is in the section regarding court ordered collection of specimens. Given that it is a defined use of force, the standards for the application and allowability of use need to be defined. This is particularly true because young people have shared experiences with this procedure that give cause for concern, and because this is an inherently dangerous use of force.</p> <p>"Separation" The definition needs to reflect that not all purposes are acceptable merely because they are specific. (See suggested revision.)</p> <p>"Sexual Abuse" Must be clear that consent is deemed absent when such activity is committed by a staff, employee, contractor, volunteer or other like individual against a youth. Individuals are not able to consent under these circumstances under PREA, CA Penal Code Section 289.6, or any reasonable definition of valid and willing consent. (See suggested revision.)</p> <p>"Sexual Harrassment" This, like sexual abuse, is prohibited under these regulations and by existing law and should also be defined. Absent a definition it is unclear what is prohibited, it should have a definition that tracks encompass at least the legal definition. (See suggested revision.)</p> <p>"Special Visits" The individuals listed here are considered special visits because they are excluded from family visits. This definition, and the exclusion from family visitation, should not encompass immediate family members, grandparents, and other individuals critical to a youth's development, success, and maintenance of community and familial connections. Excluding these persons is not in keeping with the modern understanding of family, undervalues the importance of these connections for a child's development and their rehabilitative success, and unnecessarily limits youths' familial resources and connections. See corresponding comment for Section 1374. (See suggested revision.)</p> <p>"Trauma" The definition should indicate that youth involved in the juvenile justice system are presumed to have experienced trauma. This is important because laws and policies of California's health systems and child serving systems place high importance on identifying, understanding, and treating trauma. Youth in the juvenile justice system should be understood as children who have experienced trauma and receive all of the available and necessary supports that come with such an identification. Emphasizing this in the definition and throughout the regulations will bring these provisions more in line with modern practices and understandings of trauma, and with CA laws and policies. (See suggested revision.)</p> <p>"Use of Force" The definition currently reads as though use of force can involve either "controlling the threat of imminent harm to self or others" or "overcoming resistance." This should be corrected because force should not be used to overcome resistance that does not present a threat of harm to self or others. That could include mere verbal or other passive resistance or failure to follow a command even when such failure poses no threat of harm. Force cannot be allowed unless necessary, which is to say required to prevent imminent harm to self or others. There can be no allowance for such force and no confusion as to whether it is allowed. (See suggested revision.)</p>	<p>"Non-binary" means a gender identity that does not fall within the binary of male or female. It can be a stand-alone gender identity or an umbrella term.</p> <p>"Behavioral health" means mental/emotional well-being and/or actions that affect wellness. Behavioral health problems include: substance use disorders, alcohol and drug addiction, and serious psychological distress, suicide, <u>trauma</u>, and mental disorders.</p> <p>"Linguistically appropriate" means delivered in a manner that effectively communicates with persons of limited English proficiency, those who have low literacy or are not literate, and individuals with disabilities. <u>Additionally, it means delivered in a manner that is consistent with the youth's reading and comprehension level, and that meets the requirements of the youth's IEP and/ or 504 plan as applicable.</u></p> <p>"Non-school day" means a day when school is not in operation, <u>or when it is in operation but not provided or made available to a youth.</u> It also applies when an individual youth is both not enrolled in school and not required to be in attendance.</p> <p>"Reasonable and necessary force" refers to the amount and type of force that an objective, similarly trained, experienced and competent youth supervision staff, faced with similar facts and circumstances, would consider necessary and reasonable to ensure the safety and security of youth, staff, others, and the facility. <u>Force used in violation of these regulations or of existing federal or state statutory or constitutional laws shall not be considered reasonable.</u></p> <p>"Separation" means limiting a youth's participation in regular programming for a specific <u>and allowable</u> purpose.</p> <p>"Sexual abuse" is sexual activity or voyeurism by one or more persons upon another person who does not consent, is unable to refuse, or is coerced into the act by manipulation, violence, or by overt or implied threats. A person who legally cannot consent by reason of age, circumstances, or other reasons does not consent. <u>A youth cannot consent to such activity by a staff member, employee, contractor, volunteer, educator, health worker, service provider, or other like individual associated with the facility.</u></p> <p><u>Sexual Harrassment means severe or repeated conduct that is inappropriate, negative, embarrassing, fear-inducing or unwanted that is directed at a youth based on unlawful reasons. Such reasons include the youth's sex, gender, gender identity, gender expression, marital status, sexual orientation, physical appearance, pregnancy, childbirth, or a condition related to any of the foregoing characteristics. Sexual harassment generally involves negative, inappropriate, or unwanted conduct directed at a worker based on certain unlawful reasons.</u></p> <p>"Special visits" mean visits by persons other than parents or guardians, those standing in loco parentis, <u>and</u> children of the youth, <u>grandparents, siblings, other important family members and supportive adults identified as such in the youth's case plan, and any adult identified as a discharge resource for a youth upon release</u> as outlined in Section 1374 of these regulations.</p> <p>"Trauma" is an experience that causes intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, cognitive, or spiritual well-being. <u>All youth involved with the juvenile justice system shall be understood to have experienced trauma for the purposes of receiving treatment and services, and they shall receive the benefits of trauma-informed care and approaches.</u></p> <p>"Use of force" means an immediate means of overcoming resistance <u>and necessary to</u> controlling the threat of imminent harm to self or others.</p>

		<p>"Voyeurism" This definition needs to make clear that the performance of "official duties" does not always absolve individuals from having invaded a youth's privacy. Official duties must be coordinated, carried out, organized and performed in a manner that does not unnecessarily cause such invasions, does not make or permit such violations to be routine, attempts to avoid such invasions, and that affords youth at least the minimum expectations of bodily privacy guaranteed by these regulations, as well as the laws and constitutions of the State of California and the United States. Honoring physical privacy is critical to treating people in accordance with basic human dignity, and invasions cause harm and fears about safety. This is particularly true during adolescence when youth are often experiencing physical changes and may be struggling with how others perceive or judge them, and it is also particularly true for youth who have experienced trauma and who may experience even minor invasions as "trauma reminders." (See suggested revision.)</p>	<p>"Voyeurism" means an invasion of privacy of a youth by another individual during private activities such as using the toilet or undressing, or by staff for reasons unrelated to official duties, such as peering at a youth who is using a toilet in his or her room to perform bodily functions; requiring the youth to expose his or her buttocks, genitals, or breasts; or taking images of all or part of a youth's naked body or of a youth performing bodily functions. Exceptions would include exigent circumstances or <u>An example of that would not constitute voyeurism would be</u> when such viewing is <u>inadvertent and</u> incidental to routine room safety checks. <u>Official duties must be coordinated, carried out, organized and performed in a manner that does not unnecessarily cause such invasions, does not make or permit such violations to be routine, attempts to avoid such invasions, and that affords youth at least the minimum expectations of bodily privacy guaranteed by these regulations, as well as the laws and constitutions of the State of California and the United States.</u></p>
<p>§ 1303. Pilot Projects.</p>	<p>(a)</p>	<p>Pilot projects provide a critical opportunity for local jurisdictions to implement innovative practices and reduce the harms of youth confinement. Unfortunately, this regulation employs a very narrow definition of a pilot project by requiring that the project exist <i>within</i> an otherwise compliant facility. The narrow definition used here prevents counties from designing new spaces outside of the correctional institutions and hardware that have come to define youth incarceration. A pilot project that is independent of an existing facility can still meet and exceed the safety and security goals of Title 15, for example by using improved staffing ratios, home-like living spaces, and intensive supportive services. Counties must have the flexibility to implement pilot projects in independent spaces that are designed to promote youth well-being.</p>	<p>(a) The Board may, upon application of a city, county or city and county, grant pilot project status to a program, operational innovation or new concept related to the operation and management of a local juvenile facility <u>or to a program, operational innovation, or facility, infrastructure or design of a new local juvenile facility.</u> An application for a pilot project shall include, at a minimum, the following information:</p>
<p>§ 1304. Alternate Means of Compliance.</p>	<p>(a)-(b)</p>		<p>(a) An alternate means of compliance is the long-term method used by a local juvenile facility/system, approved by the Board, to encourage responsible innovation and creativity in the operation <u>and physical or infrastructure design</u> of California's local juvenile facilities.... (b) Applications for alternate means of compliance shall meet the spirit and intent of improving facility management <u>or physical or infrastructure design</u>, shall be equal to, or exceed the intent of, existing standard(s), and shall include reporting and evaluation components.</p>
<p>Article 2. Application of Standards and Inspections</p>			
<p>§ 1310. Applicability of Standards</p>	<p>Entire section</p>	<p>The Board has separate statutory mandates to promulgate regulations for juvenile halls (Welf. & Inst. Code sec. 210) and juvenile ranches, camps, or forestry camps (Welf. & Inst. Code sec. 885). This regulation requires these two categories of facilities to comply with all of the same regulations, despite the fact that juvenile halls serve a different purpose and are subject to many different laws than ranches, camps, or forestry camps (compare, for example, Welf. & Inst. Code secs. 850-873 (for juvenile halls) and Welf. & Inst. Code sec. 880-893 (for camps and ranches). By developing just one set of regulations, with almost no distinctions between the two categories of facilities, the Board has essentially collapsed these two categories into one, in clear contradiction of the statutory intent for these facilities.</p> <p><u>The Board should promulgate a set of regulations that specifically apply to camps, which should have greater flexibility for accomplishing the expanded goals set out in Welf. & Inst. Code sec. 880.</u> This new set of regulations must, at a minimum, ensure that camps can offer the same level of health services as juvenile hall facilities, so that youth with higher-level health needs are not denied the benefit of a less-restrictive camp environment. It must also ensure that counties have the flexibility to operate camps under any county agency and with appropriately-qualified staff, as is contemplated under Welfare & Inst. Code sec. 880.</p>	
		<p>The section should clarify that the regulations contain different categories of provisions that all apply and necessitate a mode of compliance. They include minimum standards which facilities must meet but are encouraged to exceed; requirements and prohibitions with which facilities must specifically comply; and guidelines, parameters, and processes that facilities must follow or include in their policies in order to achieve minimum standards or specific compliance with requirements and prohibitions. While it is not necessary to outline how each regulation or provision fits into this scheme, it is important to reiterate that any minimum requirement is just that – the minimum or floor of expectation. This is increasingly crucial to point out as counties take on supervision and responsibility for additional populations and work to make progress that is in keeping with modern expectations of treatment or understandings of child development and treatment. Where disagreements exist as to how a facility or program should operate, there should be no opportunity for a minimum standard to be misinterpreted as a requirement. For instance, Section 1345 sets a certain prohibitions on the use of room confinement with which facilities must comply (it cannot be used for punishment), it also sets minimum requirements around process, procedures, and documentation. It should not be understood, however, to set a requirement that room confinement be a required option or available for use in every facility. Counties and operating departments are free to further limit or prohibit the use of room confinement and doing so would not be a violation of the regulation. These regulations are sometimes used to argue that the inclusion of standards means that a practice must be allowed to continue. This is not the case, and should not be left open as an argument.</p>	<p>All <u>minimum standards; and specific requirements and prohibitions; guidelines, parameters, and processes</u> contained herein shall apply to any county, city and county, or joint juvenile facility that is used for the confinement of youth. <u>To the extent that a provision sets a minimum standard or basic guidelines or processes, they are meant to be understood as setting a baseline which a facility is encouraged to exceed in order to provide greater treatment or protections for youth. The inclusion of minimum standards, requirements and prohibitions regulating the conduct or practices related to use of force, restraint, separation, discipline, or room confinement shall not be understood as requiring a facility to allow such conduct or practice if it determines that a complete prohibition is warranted.</u></p>

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<p>§ 1311. Emergency Suspension of Standards or Requirements</p>	<p>Entire section</p>	<p>COVID-19 has proven that this regulation is insufficient for addressing an extended emergency situation, such as a pandemic. The regulation should provide more guidance for emergency suspensions, including: 1) requirements for documenting suspensions; 2) requirements for notifying youth, families, defense attorneys, and the court about suspensions impacting young people; 3) requirements for notifying and providing information to the court when an emergency situation appears to warrant expedited release of youth; 4) consultation with health officials to establish protocols related to an extended health emergency; and 5) a heightened standard for suspending regulations pertaining to recreation, visitation, educational programming, or room confinement for an extended period of time, so that youth do not suffer unnecessary isolation or trauma during emergencies.</p>	<p>Nothing contained herein shall be construed to deny the power of any facility administrator to temporarily suspend any standard or requirement herein prescribed in the event of any emergency which threatens the safety of a local juvenile facility, youth, staff, or the public. (a) Any such suspension must comply with the following: (1) Only such regulations directly affected by the emergency may be suspended. (2) Any suspension of regulations shall be documented in writing, including the basis for the suspensions and the specific regulations affected. (3) If a suspension of regulation is expected to continue for 24 hours or more, the facility administrator shall provide written notice of the suspension and its basis to the following: all youth impacted by the suspension, the parent, guardian or person standing in loco parentis of all impacted youth, the attorney of record of all impacted youth, the Juvenile Court, and the Board. (b) If a suspension is related to a public health emergency, the facility administrator shall consult with local public health officials to establish protocols related to the suspension and reinstatement of regulations. (c) The facility administrator shall notify the Board in writing in the event that such a suspension lasts longer than three days. A suspension of regulations may not continue beyond three days unless the facility administrator concludes that there is no less restrictive means to preserve the safety of the juvenile facility, youth, staff, or the public, and documents the regulations suspended and the basis for the continued suspension in writing. (d) In no event shall a suspension continue more than 15 days without the approval of the chairperson of the Board for a time specified by him/her. Notice of a decision to approve a suspension beyond 15 days shall be provided to all Board members and such approval may be terminated by a majority of the Board at a regular or special meeting. A termination of approval shall take effect upon 24 hours notice of the decision to the facility administrator, or at later time designated by a majority of the Board. (e) In the event of a suspension that continues more than 15 days, the facility administrator shall notify the Juvenile Court and provide information to the Juvenile Court to consider expedited release of youth.</p>
<p>Article 3. Training, Personnel, and Management</p>			
<p>§ 1321. Staffing</p>	<p>(b)</p>	<p>In some counties, inadequate staffing has led to non-compliance with other regulations. This subsection should specifically require that staffing is sufficient for regulatory compliance.</p>	<p>(b) ensure that no required services shall be denied and that no regulations shall be suspended because of insufficient numbers of staff on duty absent exigent circumstances that justify suspension of compliance under Section 1311, Emergency Suspension of Standards or Requirements;</p>
<p>§ 1321. Staffing</p>	<p>(h)(1)-(2)</p>	<p>State regulations should conform to the federal standards promulgated under the Prison Rape Elimination Act, which require a ratio of 1 staff per 8 youth during waking hours and 1 staff per 16 youth during sleeping hours. 28 CFR § 115.313</p>	<p>(1) Juvenile Halls (A) during the hours that youth are awake, one wide-awake youth supervision staff member on duty for each 10 <u>8</u> youth in detention; (B) during the hours that youth are confined to their room for the purpose of sleeping, one wide-awake youth supervision staff member on duty for each 20 <u>16</u> youth in detention; (2) Special Purpose Juvenile Halls (A) during the hours that youth are awake, one wide-awake youth supervision staff member on duty for each 10 <u>8</u> youth in detention; (B) during the hours that youth are confined to their room for the purpose of sleeping, one wide-awake youth supervision staff member on duty for each 20 <u>16</u> youth in detention;</p>
<p>§ 1322. Youth Supervision Staff Orientation and Training</p>	<p>(b)</p>	<p>Staff should receive training on sexual orientation, gender identity, and expression (SOGIE) in order to comply with Section 1352.5, Transgender and Intersex Youth. Staff should also receive training on trauma and trauma-informed approaches in order to comply with numerous other sections (for example, Section 1355, Institutional Assessment and Plan).</p>	<p>(b) Prior to assuming any responsibility for the supervision of youth, each youth supervision staff member shall receive a minimum of 60 hours of facility-specific orientation, including: (1) individual and group supervision techniques; (2) regulations and policies relating to discipline and rights of youth pursuant to law and the provisions of this chapter; (3) basic health, sanitation and safety measures; (4) suicide prevention and response to suicide attempts; (5) instruction on cultural competency and sensitivity relating to, and best practices for, providing adequate care for children across diverse ethnic and racial backgrounds, as well as children and related to sexual orientation, gender identity, and expression (SOGIE); (6) trauma informed and responsive approaches; (7) the effects of trauma, including grief and loss, and child abuse and neglect on child development and behavior and methods to behaviorally support children impacted by that trauma or child abuse and neglect; (8) policies regarding use of force, de-escalation techniques, chemical agents, mechanical and physical restraints; (9) review of policies and procedures referencing trauma and trauma-informed approaches; (10) procedures to follow in the event of emergencies; (11) routine security measures, including facility perimeter and grounds; (12) crisis intervention and mental health referrals to mental health services; (13) documentation; and (14) fire/life safety training; (15) an overview of the population and population needs; (16) self-awareness and appropriate boundaries for physical and verbal interactions with youth who have a history of abuse, neglect, or other trauma; (17) positive discipline, youth empowerment, and the importance of self-esteem; (18) adolescent development; (19) teamwork and interpersonal communication with facility personnel, youth, and family members; (20) an overview of the juvenile justice and child welfare systems;</p>

		<p>CONTINUED FROM ABOVE ROW -----></p>	<p>CONTINUED FROM ABOVE ROW-- <u>(21) restorative justice;</u> <u>(22) mandated reporter training;</u> <u>(23) physical and psychosocial needs of children, including behavior management, de-escalation techniques, and trauma-informed crisis management planning, including the use of emergency interventions;</u> <u>(24) best practices for the care and supervision of adolescents and young adults; and</u> <u>(25) an opportunity to hear from youth with experience in the facility and their families moderated by a community member as defined in WIC 1995</u></p>
<p>Entire Section</p>		<p>It should be clear what each facilities plan is for the training and orientation of new staff, and the continued training of staff on a regular basis. The facility plan should be designed to ensure the provision and use of trauma-informed practices; develop an understanding of the population and population needs; establish high expectations as to the level of care, kindness, and nurturing treatment of children; and to promote a restorative and healing culture within the facility. It should also specify certain required topics and material to be covered related to working with the population, and be designed to establish a more complete understanding of youth as children and people rather than inmates and delinquents. The training plan must take into account the education and skill level of the staff. At a mimum, training needs to include cultural competency and sensitivity, adolescent development, the effects of trauma and best practices for serving children impacted by trauma, engaging youth's family members and community, and the others indicated in the proposed revision.</p> <p>Probation officers and other staff in the facility are mandated reporters and must receive mandated reporter training.</p>	<p>(a) <u>Each facility shall develop, maintain and implement a written plan for the supervision, evaluation, and training of staff who will have responsibility for supervising youth. The facility administrator, behavioral health director, and health administrator shall develop the plan in consultation with the county Juvenile Justice or Probation Commission, and young people with experience in the juvenile justice system and their families. The plan shall be approved by the Chief of Probation. The plan shall, at a minimum:</u> <u>(1) be designed to ensure:</u> <u>(A) an understanding of trauma and the use of truma informed approaches and practices;</u> <u>(B) cultural competency and sensitivity; including but not limited to best practices for providing adequate care, services, and supports for children across diverse ethnic and racial backgrounds, as well as children identifying as lesbian, gay, bisexual, transgender, or nonbinary;</u> <u>(C) methods to behaviorally support children are appropriate for children impacted by trauma or child abuse and neglect; and</u> <u>(D) best practices for addressing the permanence, well-being, and educational needs of children, including children with disabilities</u> <u>(2) provide for the continuing and periodic training of staff;</u> <u>(3) be appropriate to meet the needs of staff and population(s) served;</u> <u>(4) provide staff with the knowledge, skills, and support to ensure the health and safety of children in care and meet the individualized needs of children and families served;</u> <u>(5) include strategies to enhance the well-being, retention, and resilience of staff;</u> <u>(6) develop an understanding of the population and population needs;</u> <u>(7) establish a more complete understanding of youth as children and people rather than inmates and delinquents;</u> <u>(8) establish high expectations as to the level of care, kindness, nurturing, and respectful treatment to be afforded children and youth;</u> <u>(9) and to promote a restorative and healing culture within the facility.</u></p>
		<p>CONTINUED FROM ABOVE ROW -----></p>	<p>CONTINUED FROM ABOVE ROW: <u>(b) The training plan shall provide the following information for each training session:</u> <u>(1) the title of the session</u> <u>(2) the subject matter of the session;</u> <u>(3) the number of hours in the training session;</u> <u>(4) the qualifications of the trainer;</u> <u>(5) the learning objectives and activities of the session;</u> <u>(6) a training evaluation to assess whether the session met learning objectives;</u> <u>(7) a trainer evaluation to determine if the training is meeting the needs of the facility and staff;</u> <u>(8) and a record of written materials provided or used in the session.</u></p> <p><u>(c) Prior to assuming any responsibilities each youth supervision staff member shall be properly oriented to their duties, including:</u> <u>(1) youth supervision duties;</u> <u>(2) scope of decisions they shall make;</u> <u>(3) the identity of their supervisor;</u> <u>(4) the identity of persons who are responsible to them;</u> <u>(5) persons to contact for decisions that are beyond their responsibility; and</u> <u>(6) ethical responsibilities;</u> <u>(7) the training outlined in subsection (d) unless it was completed previously and the individual has maintained continuing training requirements outlined in the training plan.</u></p> <p><u>(d) Prior to assuming any responsibility for the supervision of youth, each youth supervision staff member shall receive a minimum of 60 hours of facility-specific orientation, including: (SEE SUGGESTIONS IN ROW ABOVE)</u></p>
<p>§ 1323. Fire and Life Safety</p>	<p>(d)</p>	<p>Counties have demonstrated a lack of preparation for responding to nearby wildfires. (See Witness LA, "Facing The Inferno, Part 1: Why Wasn't LA County Probation Prepared To Evacuate Kids & Staff At Campus Kilpatrick When A Monster Wildfire Struck?," July 16, 2019, available at: https://witnessla.com/facing-the-inferno-campus-kilpatrick-the-woolsey-fire-part-1/). The regulations should specifically require a wildfire evacuation plan.</p>	<p>(d) an evacuation plan <u>including a plan for evacuation in the event of a wildfire;</u></p>
<p>§ 1324. Policy and Procedures Manual</p>		<p>These manuals and the facility policies in general should be transparent and readily available to youth, family members, youth advocates, and members of the public. This is important for understanding and setting expectations, community monitoring of standards and policies of county facilities, accountability, and public trust.</p>	<p>All facility administrators shall develop, publish, and implement a manual of written policies and procedures that address, at a minimum, all regulations that are applicable to the facility. Such a manual shall be made available to all employees, reviewed by all employees, and shall be administratively reviewed at a minimum every two years, and updated, as necessary. <u>The most current version of manual (and the most current version of all policies and procedures since the last complete review) shall be available on the probation department or county website.</u> Those records relating to the standards and requirements set forth in these regulations shall be accessible to the Board on request.</p>

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<p>§ 1327. Emergency Procedures.</p>		<p>This regulation gives counties the option to maintain confidential policies related to "security of the facility." This is a broad category that could encompass any number of policies. To the extent that there is a need for some portion or portions of the emergency procedures to be kept confidential, it should be clearly specified what may be kept confidential and to what extent.</p>	
<p>§ 1328. Safety Checks.</p>	<p>whole section</p>	<p>The regulation should be revised to ensure that safety checks are minimally intrusive, especially during night hours. The regulation should also include more specificity regarding interval timing, as facility investigations have indicated that this guidance is insufficient to prevent violations.</p>	<p>The facility administrator shall develop and implement policy and procedures that provide for <u>minimally intrusive</u> direct visual observation of youth at a minimum of every 15 minutes, at random or varied <u>non-repetitive</u> intervals during hours when youth are asleep or when youth are in their rooms, confined in holding cells or confined to their bed in a dormitory. Supervision is not replaced, but may be supplemented by, an audio/visual electronic surveillance system designed to detect overt, aggressive or assaultive behavior and to summon aid in emergencies. All safety checks shall be documented with the actual time the check is completed. <u>Safety checks conducted during sleeping hours shall be conducted so as to not disrupt youth's sleep.</u></p>
<p>§ 1329. Suicide Prevention Plan</p>	<p>(b)(1)</p>	<p>The regulation should provide more detailed guidance on when youth should be screened for suicide risk during detention.</p> <p>See generally, for suicide screening section re: need for enhanced procedural requirements "DJJ reports hundreds of incidents of suicidality every year. Between July 2020 and June 2021, there were seven suicide attempts and 467 total instances of suicidality within a population averaging just over 700 youth (CDCR, 2021a). In other words, an average of five youth attempted suicide or were reported as being at high risk for suicide out of every 100 youth in the facilities each month. These numbers represent a modest decline from the prior year (July 2019-June 2020) when suicidality peaked at nearly seven youth out of every 100 in the population each month. Confined youth are at a high risk of experiencing a mental health emergency given the trauma they experience in secure facilities and their underlying psychological needs. In fact, suicide attempts increase as youth move deeper into the justice system (Teplin, et al., 2015). Suicidality includes youth who attempt suicide as well as youth placed on suicide precaution, intervention, or watch." CJC Nov. 2021 Report "On the Brink" http://www.cjc.org/uploads/cjc/documents/DJJ_on_the_brink_2021.pdf.</p> <p>California Department of Justice (DOJ). (2021a). Criminal Justice Data, arrests. At: https://openjustice.doj.ca.gov/data-stories/deathincustody. Teplin, L.A., Stokes, M.L., McCoy, K.P., Abram, K.M., & Byck, G.R. (2015).</p> <p>Suicidal Ideation and Behavior in Youth in the Juvenile Justice System: A Review of the Literature. Journal of Correctional Health Care, 21(3). At: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5704936/</p>	<p>"All youth shall be screened for risk of suicide at intake and as needed during detention." <u>Screening for risk of suicide shall be conducted.</u> <u>(A) for all youth at intake.</u> <u>(B) promptly during detention for any youth who exhibits risk factors of suicide or signs of suicidal ideation, including those risk factors and signs identified during suicide prevention training as required in Section 1322, Youth Supervision Staff Orientation, and Training and the Juvenile Corrections Officer Core Course.</u></p>
<p>§ 1329. Suicide Prevention Plan</p>	<p>(c)</p>	<p>This provision should specify when assessment/services must be provided.</p>	<p>Referral process to behavior/mental health staff for assessment and/or services.</p> <p><u>Prompt assessment and/or services by behavior/mental health staff for youth identified as being at risk of suicide.</u></p>
<p>§ 1329. Suicide Prevention Plan</p>	<p>(d)</p>	<p>This provision should specify particular procedures that must be included for monitoring youth identified at risk for suicide. While we have suggested possible guidelines, we recommend that the Board consult with experts on this issue to develop detailed guidance.</p> <p>See DOJ, National Institute of Corrections, "National Study of Jail Suicide." https://s3.amazonaws.com/static.nicic.gov/Library/024308.pdf.</p> <p>Hayes, L. 2009. "Juvenile Suicide in Confinement: A National Survey." Suicide and Life-Threatening Behavior 39:353-63. https://www.ojp.gov/pdffiles1/ojdp/grants/206354.pdf</p> <p>National Commission on Correctional Health Care. 2008. Standards for Health Services in Jails, 8th Edition. Chicago: National Commission on Correctional Health Care.</p> <p>National Commission on Correctional Health Care recommendations for juvenile facilities. https://www.ncchc.org/suicide-prevention-and-management-in-juvenile-correctional-settings-2019/</p>	<p>Procedures for monitoring of youth identified at risk for suicide <u>that include:</u> <u>(A) increasing the frequency of minimally intrusive documented safety checks, as described in Section 1328, to staggered intervals not to exceed every 10 minutes for youth who are not actively suicidal, but who express suicidal ideation and/or have a recent prior history of self-harming behavior.</u> <u>(B) continuous direct visual supervision for youth who are actively suicidal</u> <u>(C) use of isolation or removal of comfort measures only when determined necessary for safety reasons by clinical staff.</u></p>
<p>§ 1329. Suicide Prevention Plan</p>	<p>(e)</p>	<p>This provision should specify standards for housing separation or other deprivations of privileges.</p> <p>See DOJ, National Institute of Corrections, "National Study of Jail Suicide." https://s3.amazonaws.com/static.nicic.gov/Library/024308.pdf ("When determining the most appropriate housing location for a suicidal inmate, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. Although these responses may be convenient for facility staff, they are detrimental to the inmate because isolation escalates a sense of alienation and further removes the individual from proper staff supervision. Whenever possible, suicidal inmates should be housed in the general population unit, mental health unit, or medical infirmary, and should be located close to facility staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, and straitjackets) should be avoided whenever possible; these measures should only be used as a last resort when the inmate is physically engaging in self-harming behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten dehumanizing aspects of confinement.")</p>	<p>(e) Safety Interventions (1) Procedures to address intervention protocols for youth identified at risk for suicide which <u>may shall</u> include, but are not limited to: (A) Housing <u>consideration that segregates or physically isolates youth only when all less restrictive measures would not effectively protect the health and safety of the youth</u> (B) Treatment strategies including trauma-informed approaches <u>(C) Documented deprivation of personal belongings, including clothing items, only when necessary to protect the health and safety of a youth.</u> (2) Procedures to instruct youth supervision staff how to respond to youth who exhibit suicidal behaviors. <u>(3) Room confinement shall not be used as a safety intervention for youth at risk of suicide.</u></p>

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<p>§ 1329. Suicide Prevention Plan</p>	<p>(f)</p>	<p>This provision should not specify that communications should include suicidal behavior history from previous facilities.</p> <p>See DOJ, National Institute of Corrections, ""National Study of Jail Suicide."" https://s3.amazonaws.com/static.nicic.gov/Library/024308.pdf ("Intake screening should include not only questions about current suicidal ideation and prior suicidal behavior, but also questions about the inmate's suicide risk during any prior confinement in the facility and the arresting and/or transporting officer(s)' belief that the inmate is currently at risk (Hayes 2005; National Commission on Correctional Health Care 2008).")</p> <p>DOJ, National Institute of Corrections, ""National Study of Jail Suicide."" https://s3.amazonaws.com/static.nicic.gov/Library/024308.pdf ("The findings indicate that, although the vast majority of facilities that sustained a suicide had a written suicide-prevention policy, the comprehensiveness of the program was questionable. For example, even though many respondents reported that their facilities maintained an intake screening process to identify the suicide risk of inmates entering the facility, the process for most facilities did not include verification as to whether the arresting and/or transporting officer(s) believed that the newly arrived inmate was at risk for suicide, nor whether the inmate was at risk for suicide during prior confinement.")</p>	<p>(1) The intake process shall include <u>(A) communication with the arresting and/or transporting officer and family guardians regarding the youth's past or present suicidal ideations, behaviors or attempts.</u> <u>(B) a review of health care records received by the facility regarding the youth's past or present suicidal ideations, behaviors or attempts.</u></p> <p>(2) Procedures for clear and current information sharing about youth at risk for suicide with youth supervision, healthcare, and behavioral/mental health staff.</p>
<p>§ 1329. Suicide Prevention Plan</p>	<p>(h)(1)</p>	<p>This provision should specify what information must be documented and how it will be subject to oversight and review.</p>	<p>Documentation processes shall be developed to ensure compliance with this regulation. <u>Sections 1403 and 1406 of these regulations. Such documentation shall include the amount of screenings and assessments and types of treatments provided.</u></p>
<p>§ 1329. Suicide Prevention Plan</p>	<p>(paragraph at the end of the section)</p>	<p>This provision should be revised to include a specific standard and timing requirements.</p>	<p>Youth identified at risk for suicide shall not be denied the opportunity to participate in facility programs, services and activities which are available to other non-suicidal youth, unless deemed necessary for the safety of the youth or security of the facility. Any deprivation of programs, services or activities for youth at risk of suicide shall be documented and <u>pre-approved by the facility manager whenever possible. For circumstances in which obtaining pre-approval for such a deprivation would seriously jeopardize the safety of the youth or security of the facility, it must be approved by the facility manager as soon as possible.</u></p>
<p>Article 4. Records and Public Information</p>			
<p>§ 1340. Reporting of Legal Actions.</p>	<p>Entire section</p>	<p>The term "legal action" is vague. It should be defined and include instances beyond the filing of an action in court. It should also include legal actions against persons responsible for the supervision of youth.</p> <p>Facilities should be required to provide the Board with the outcome of any legal action pertaining to conditions of confinement.</p>	<p>Each facility shall submit to the Board a letter of notification on each legal action, pertaining to conditions of confinement, filed against persons or legal entities responsible for juvenile facility operation <u>or the supervision of youth. Upon resolution of any such legal action, a facility shall submit to the Board a letter documenting the outcome of the action, including any settlement or court order.</u></p>
<p>§ 1341. Death and Serious Illness or Injury of a Youth While Detained.</p>	<p>sub(1)</p>	<p>This regulation should include provisions for external and/or independent investigation of a death of a detained youth.</p>	<p>(a) The facility administrator, in cooperation with the health administrator and the behavioral/mental health director, shall develop written policies and procedures in the event of the death of a youth while detained, which include notifications to necessary parties, which <u>shall (unless it would violate an order of the court) may</u> include the Juvenile Court, the parent, guardian or person standing in loco parentis and the youth's attorney of record.</p> <p>(b) The health administrator, in cooperation with the facility administrator, shall develop written policies and procedures to assure there is a medical and operational review of every in- custody death of a youth. The review team shall include the facility administrator and/or facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident, <u>as well as at least one external medical professional and a medical professional selected by the youth's parent, guardian, person standing in loco parentis or next of kin unless they decline to select one in writing.</u></p> <p>(c) The administrator of the facility shall provide to the Board a copy of the report submitted to the Attorney General under Government Code Section 12525. A copy of the report shall be submitted to the Board within 10 calendar days after the death.</p> <p>(d) Upon receipt of a report of the death of a youth from the administrator, the Board may within 30 calendar days inspect and evaluate the juvenile facility, jail, lockup or court holding facility pursuant to the provisions of this subchapter. Any inquiry made by the Board shall be limited to the standards and requirements set forth in these regulations. <u>The Board may also request that the facility administrator provide for an independent investigation by an outside agency or entity.</u></p>
<p>§ 1341. Death and Serious Illness or Injury of a Youth While Detained.</p>	<p>sub(2)</p>	<p>This regulation should include provisions for internal investigation of any serious injury or illness.</p> <p>In the event of a death or serious illness or injury, the facility should not only ensure proper investigation and correction of any issues, but must also provide for the needs of other young people in the facility who may be traumatized or otherwise impacted. Just as a school would do for such an event at school.</p>	<p>(2) Serious Illness or Injury of a Youth.</p> <p>(a) The facility administrator, in cooperation with the health administrator, shall develop written policies and procedures for the notification to necessary parties, which <u>shall (unless it would violate an order of the court) may</u> include the Juvenile Court, the parent, guardian or person standing in loco parentis and the youth's attorney of record in the case of a serious illness or injury of a youth. <u>(b) The health administrator, in cooperation with the facility administrator, shall develop written policies and procedures to assure there is a medical and operational review of every in- custody serious illness or injury of a youth. The review team shall include the facility administrator and/or facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident.</u></p> <p><u>(3) In the event of a death or serious illness or injury to a youth, the facility administrator shall ensure the availability and provision of additional services including counseling, crisis intervention, and trauma supports to all youth in the facility and to staff as requested.</u></p>
<p>Article 5. Classification and Segregation</p>			
<p>§ 1350. Admittance Procedures.</p>	<p>(a)(1)</p>	<p>This provision should provide for increased access to phone calls upon admittance.</p>	<p>Access to two <u>four</u> free <u>completed</u> phone calls within one hour of admittance in accordance with the provisions of Welfare and Institution Code Section 627;</p>

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<p>§ 1350. Admittance Procedures.</p>	<p>(a)(4)</p>	<p>This provision should include a requirement that food conform to dietary restrictions.</p>	<p>Offer of food <u>consistent with dietary restrictions</u> upon arrival</p>
<p>§ 1350. Admittance Procedures.</p>	<p>(b)</p>	<p>This requirement should apply to all juvenile facilities.</p>	<p>(b) juvenile hall <u>facility</u> administrators shall establish written criteria for detention that considers the least restrictive environment.</p>
<p>§ 1351. Release Procedures.</p>	<p>entire section</p>	<p>The title of this section should be revised to adequately emphasize the transition planning obligation.</p> <p>This provision should be revised to address the following issues: -add requirements to provide youth with their personal/identification documents upon release. -add specification as to when parents/guardians must be notified of release. -add specification as to when the facility health care provider must be notified of release. -add specification as to when school staff must be notified of release. -add specification as to when mental health personnel must be notified of release.</p> <p>This provision should also be clarified to ensure that adequate transition planning occurs for youth. Specifications should be made to require staff to work with youth prior to release to ensure a safe and stable transition and access to all available programs, services and benefits that will aid in re-entry. These requirements should mirror the areas of need and service provision described in the Transitional Independent Living Case Plan (TILP) for youth in the child welfare system. Welf. & Inst. Code sec. 11400.</p> <p>In addition, the regulation must mirror the expectations of reentry planning which should begin at intake and remain an evolving part of a youth's case and services plan. Regulations for reentry and release planning must also ensure compliance with and be designed to take advantage of the services and mandates under CalAIM. See CalAIM for Reentry and Justice-Involved Adults and Youth: A Policy Implementation Guide available at: https://secureservercdn.net/198.71.233.194/zb0.123.myftpupload.com/wp-content/uploads/2022/05/CalAIM-for-Reentry-and-Justice-Involved-Adults-and-Youth-A-Policy-Implementation-Guide-FINAL.pdf</p>	<p>§ 1351. Release and <u>Transition Planning</u> Procedures.</p> <p>(a)The facility administrator shall develop and implement written policies and procedures for release of all youth from custody which provide for: (a)(1) verification of identity/release papers; (b)(2) return of personal clothing, <u>and</u> valuables <u>and personal documents, including those used for identification purposes</u>; (c)(3) notification to the youth's parents or guardian <u>as soon as possible, but no later than 2 hours after the release order is received by the facility</u>; (d)(4) notification to the facility health care provider <u>as soon as possible, but no later than 2 hours after the release order is received by the facility</u>, in accordance with Sections 1408 and 1437 of these regulations, for coordination with outside agencies; and; (e)(5) notification of school staff <u>no later than 6 hours after the release order is received by the facility</u>; and (f)(6) notification of facility mental health personnel <u>as soon as possible, but no later than 2 hours after the release order is received by the facility</u>.</p> <p>(b) for post-dispositional youth <u>and other youth for whom advance notice of release is available, the facility administrator shall develop and implement written policies and procedures which in addition provide for:</u> (1) <u>to coordinate</u> coordination of the provision of transitional and reentry services, <u>beginning at least six months prior to anticipation of release whenever possible</u>, including, but not limited to, medical and behavioral health <u>in accordance with Sections 1408, 1413, 1437, 1438 and 1439 of these regulations</u>, education, probation supervision and community-based services.</p>
		<p>CONTINUED FROM ABOVE ROW -----></p>	<p>CONTINUED FROM ABOVE ROW: (2) <u>notification to youth of potential eligibility and how to apply for</u> (A) a California Identification Card and/or Driver's License (B) Medi-Cal (C) CalFresh and Emergency Food Assistance Program (D) CalWORKs and other CDSS cash assistance programs (E) Transitional Housing and Independent Living programs (F) CDSS Housing and Homelessness Programs (G) CDSS immigration-related services (H) Low Income Home Energy and Water Assistance Programs (I) California Earned Income Tax Credit (J) Chafee and other applicable education assistance programs (K) community-based programs and services (L) extended foster care pursuant to AB 12 (3) <u>any conditions of probation to be clearly communicated and provided in writing to youth.</u></p> <p>(c)The facility administrator shall develop and implement written policies and procedures for the furlough of youth from custody.</p>
<p>§ 1352.5 Transgender and Intersex Youth</p>	<p>(d)</p>	<p>This provision should include access to gender affirming medical care. The denial of gender affirming medical care leads to higher rates of anxiety, depression, and suicidal ideations in youth, and the abrupt discontinuation of hormone replacement therapy can lead to severe, long-lasting health complications.</p> <p>See: U.S. Department of Health & Human Services, "Gender-Affirming Care and Young People," Office of Population Affairs, 2022, https://opa.hhs.gov/sites/default/files/2022-03/gender-affirming-care-young-people-march-2022.pdf. ("Gender diverse adolescents...face significant health disparities compared to their cisgender peers. Transgender and gender nonbinary adolescents are at increased risk for mental health issues, substance abuse, and suicide. Medical and psychosocial gender affirming healthcare practices have been demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life for transgender and gender diverse youth.")</p> <p>Kareem M. Matouk and Melina Wald, "Gender-affirming Care Saves Lives," Columbia University Department of Psychiatry, March 30, 2022, https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives.</p> <p>See also Edmo v. Corizon, Inc., 935 F.3d 757 (C.A.9 (Idaho), 2019), where the Ninth District Court of Appeals held that where "the record shows that the medically necessary treatment for a prisoner's gender dysphoria is gender confirmation surgery, and responsible prison officials deny such treatment with full awareness of the prisoner's suffering, those officials violate the Eighth Amendment's prohibition on cruel and unusual punishment."</p>	<p>(d) Facility administrators shall ensure that transgender, and intersex, <u>nonbinary, and gender nonconforming</u> youth have access to medical and behavioral health providers qualified to provide care and treatment to transgender and intersex youth. <u>Transgender, intersex, nonbinary, and gender nonconforming youth shall have access to gender-affirming medical care, including the continuation of hormone replacement therapies under the supervision of qualified medical professionals.</u></p>
<p>§ 1353. Orientation</p>	<p>Opening paragraph (t) (s)</p>	<p>Information must be linguistically appropriate. While the latter part of the paragraph covers part of that meaning, the term should be included so as to ensure that it's full meaning is applied.</p> <p>Title 15 regulation should not need to be requested, they should be readily accessible to youth in the facility.</p> <p>Youth should receive written and verbal information about their rights in the facility.</p>	<p>The facility administrator shall develop and implement written policies and procedures to orient a youth prior to placement in a living area. Both written and verbal information <u>that is linguistically appropriate</u> shall be provided and supplemented with video orientation if feasible.</p> <p>(t) <u>a process by which youth may request a description of where of how to</u> access to Title 15 Minimum Standards for Juvenile Facilities; (s) <u>both written and verbal information that is linguistically appropriate describing the youth's rights while in the facility.</u></p>

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<p>§ 1354. Separation</p>	<p>(c) and (f)</p>	<p>This provision should be amended to clarify that separated youth must not be denied the standard treatment and care otherwise required under these regulations. In addition, based on certain facility investigation reports, the meaning of "daily review" should be clarified to ensure that a review of any separation is conducted each day and reflects an individualized determination that separation continues to be necessary.</p>	<p>The facility administrator shall develop and implement written policies and procedures that address:</p> <ul style="list-style-type: none"> (a) separation of youth for reasons that include, but are not be limited to, medical and mental health conditions, assaultive behavior, disciplinary consequences and protective custody. (b) consideration of positive youth development and trauma-informed care. (c) separated youth shall not be denied normal privileges available at the facility, except when necessary to accomplish the objective of separation. <u>Separated youth shall not be denied the treatment and care otherwise required under these regulations.</u> (d) when the objective of the separation is discipline, Title 15 Section 1390 shall apply. (e) when separation results in room confinement, the separation shall occur in accordance with Welfare and Institutions Code Section 208.3 and Section 1354.5 of these regulations. (f) policies and procedures shall ensure an <u>individualized daily review is conducted every day for</u> of any separated youth to determine if separation <u>of that youth</u> remains necessary.
<p>Entire Section</p>	<p>Entire Section</p>	<p>This section is written as though separation denies youth added privileges, but it is defined as limiting a youth's participation in regular programming. Given that it is a limitation on programming, it cannot be used for disciplinary consequences or protective custody (which is a term that is not defined and does not appear elsewhere in the regulations). To the extent that the regulations allow for periods of separation-- limitations on access to programming -- they should define the allowable reasons or circumstances for its use, and set parameters, safeguards, documentation requirements, and durational limitations on use.</p> <p>(c) describes the loss of normal privileges in the facility, but separation is not the loss of privileges but rather a limitation on access to programming which cannot be used to accomplish an objective such as discipline. To the extent that the regulation intends to describe a loss of privileges rather than programming for disciplinary purposes, that should be appropriately place in Section 1390 which deals with discipline.</p> <p>Pursuant to the regulations, programming cannot be denied or limited (which is what separation is) for disciplinary purposes, or issues other than those that constitute a threat to the safety of self or others. See Section 1370(b)(7) related to education programming, Section 1390 prohibits limitations or denial of contact with a parent, educational programming, exercise, medical services or counseling, religious services/ programming, mail correspondence, or rehabilitative programming for the purposes of discipline, Section 1371 prohibits the suspension of program, recreation and exercise except "upon a written finding by the administrator/ manager or designee that a youth represents a threat to the safety and security of the facility." This section must be adjusted accordingly.</p> <p>Any separation should consider the availability of less restrictive alternatives. Generally speaking, it is contrary to the stated purpose of these facilities to deny or limit youth participation in programming unless absolutely necessary. It is a disservice to the youth who has been found in need of such rehabilitative programming and also to the community to which that youth belongs and will return.</p>	<p>The facility administrator shall develop and implement written policies and procedures that address:</p> <ul style="list-style-type: none"> (a) separation of youth for reasons that include, but are not be limited to, medical and mental health conditions, assaultive behavior, or other circumstances when those conditions pose a safety risk to self or others. disciplinary consequences and protective custody; (b) consideration of positive youth development and trauma-informed care. (c) a process to ensure that separation shall not be used before other, less restrictive, options have been attempted and exhausted, unless attempting those options poses a threat to the safety or security of any youth or staff. (c)-separated youth shall not be denied normal privileges available at the facility, except when necessary to accomplish the objective of separation. (d) when the objective of the separation is discipline, Title 15 Section 1390 shall apply. (e) when separation results in room confinement, the separation shall occur in accordance with Welfare and Institutions Code Section 208.3 and Section 1354.5 of these regulations. (f) If a youth has been separated staff shall do one of the following on the day following the separation: <ul style="list-style-type: none"> (1) Return the youth to general population. (2) Consult with mental health or medical staff. (3) Develop an individualized plan that includes the goals and objectives to be met in order to reintegrate the youth to general population and return them to regular programming. (g) If a youth is being separated on a second consecutive day or for a third time in a 30 day period, staff shall do all of the following: <ul style="list-style-type: none"> (1) Document the reasons for the separation and the extension, or repeated uses of separation, the date or dates on which the youth was separated, the programming suspensions or limitations during the separation(s), and when he or she is returned to the general population and regular programming. (2) Develop an individualized plan that includes the goals and objectives to be met in order to integrate the youth to general population, return them to regular programming, and avoid further instances of seapartion. (3) Obtain documented authorization and a determination that separation remains necessary by the facility superintendent or his or her designee.
<p>§ 1354.5 Room Confinement</p>	<p>(a)</p>	<p>This provision only specifies purposes for which room confinement may not be used, rather than enumerating the limited circumstances when it may be used.</p> <p>The statute is not limited to confinement of youth in their rooms. It applies to confinement in a locked sleeping room or cell, which covers all confinement in a locked room in the facility with only contact with staff.</p>	<ul style="list-style-type: none"> (a) The facility administrator shall develop and implement written policies and procedures addressing the confinement of youth in their <u>a locked</u> room that are consistent with Welfare and Institutions Code Section 208.3. The placement of a youth in room confinement shall be accomplished in accordance with the following guidelines: <ul style="list-style-type: none"> (1) Room confinement shall not be used before other, less restrictive, options have been attempted and exhausted, unless attempting those options poses a threat to the safety or security of any youth or staff. (2) Room confinement shall not be used for the purposes of punishment, coercion, convenience, or retaliation by staff. (3) Room confinement shall not be used to the extent that it compromises the mental and physical health of the youth <u>or as a safety intervention measure for youth at risk of suicide, pursuant to Section 1329.</u> (4) Room confinement shall only be used to ensure the immediate safety and security of youth.
<p>§ 1354.5 Room Confinement</p>	<p>(b)</p>	<p>This provision should require a log of all instances of room confinement.</p>	<ul style="list-style-type: none"> (b) A youth may be held up to four hours in room confinement. <u>Any instance of room confinement must be documented in a log that includes the name of the youth, the reason for the room confinement, and the start and ending times of the room confinement.</u> After the youth has been held in room confinement for a period of four hours, staff shall do one or more of the following: <ul style="list-style-type: none"> (1) Return the youth to general population. (2) Consult with mental health or medical staff. (3) Develop an individualized plan that includes the goals and objectives to be met in order to reintegrate the youth to general population. (4) If room confinement must be extended beyond four hours, staff shall do each of the following: <ul style="list-style-type: none"> (A) Document the reasons for room confinement and the basis for the extension, the date and time the youth was first placed in room confinement, and when he or she is eventually released from room confinement. (B) Develop an individualized plan that includes the goals and objectives to be met in order to integrate the youth to general population. (C) Obtain documented authorization by the facility superintendent or his or her designee every four hours thereafter. <u>(D) Enter the basis for the extension into the room confinement log.</u>
<p>§ 1355. Institutional Assessment and Plan</p>	<p>Title</p>	<p>The title of this section should reflect a more constructive approach to planning and support for young people.</p>	<p>Institutional Youth Development Assessment and Plan</p>

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<p>§ 1355. Institutional Assessment and Plan</p>	<p>(a)</p>		<p>(a) Assessment:(1) The assessment is based on information collected during the admission process with periodic review, which includes (A) the youth's risk factors, (B) needs and strengths including, but not limited to in the following areas identification of (i) substance abuse history or current substance abuse challenges, (ii) educational, (iii) vocational, (iv) counseling, (v) behavioral health, (vi) consideration of known history of trauma, and (vii) family strengths and needs; (viii) physical health and disability needs (2) the assessment must also include identifying existing services, treatment and supports the youth is receiving and should continue.</p>
<p>§ 1355. Institutional Assessment and Plan</p>	<p>(b) & overall</p>	<p>The requirements for the case plan should be in line with the child welfare case plan at WIC 16501.1 and be a document that "ensures that the child receives protection and safe and proper care and case management.." Unless it is not possible, deemed inappropriate by the court, or in conflict with the express wishes of the youth, family and supportive adults should be included in the development, implementation, and ongoing evaluation and updating of the case plan. A youth should always be included in the case planning process, and should be centered in a strengths-based, team-based approach. This is in keeping with decades of research in the delivery of children's services, and with recent reforms to California laws. See, for example, the Integrated Core Practice Model: https://cdss.ca.gov/Portals/9/ACIN/2018/I-21_18.pdf As a general matter, this regulations should ensure that case planning complies with existing obligations to engage and participate in Child and Family Team requirements, and ensure that case planning is strengths-based and youth and family centered. It should take into consideration the existing recommendations of a CFT and engage the CFT for new and additional case planning. It must also clarify who is responsible for making the assessment, and the qualifications of any such individual. Assessment for some of the indicated services, programs, and treatments requires qualified professionals with experience and knowledge outside that of a probation or corrections-type officer.</p>	<p>Institutional Youth Development Case Plan: (1) A case plan shall be developed for each youth held for at least 30 days or more and created within 40 days of admission. (2) The institutional youth development case plan shall include, but not be limited to, written documentation that provides: (A) objectives and time frame for how the resolution of problems issues identified in the assessment will be addressed through programming and treatment offered at the facility or through community based providers; (B) a plan for meeting the objectives that includes a description of program resources needed and individuals responsible for assuring that the plan is implemented; (3) periodic evaluation of progress towards meeting the objectives, including periodic review and discussion of the plan with the youth; (4) (7) a transition plan, the contents of which shall be subject to existing resources, shall be developed for post dispositional youth in accordance with Section 1351; and, (5) (8) in as much as possible and if appropriate; the plan, including the transition plan, shall be developed with input from the family, supportive adults, youth, and Regional Center for the Developmentally Disabled. (4) a description of the schedule for in-person visitation with family members and kin. (5) description of how the youth will maintain contact with family and kin other than in-person visitation. (6) a description of how family members and kin will be involved with any treatment or services being provided to the youth while at the facility.</p>
<p>§ 1356. Counseling and Casework Services.</p>	<p>(a)</p>	<p>This section needs more specificity and to promote more pro-active casework.</p>	<p>(a) youth will receive assistance with identifying needs or concerns that may arise; including, but not limited to: those identified in the assessment referenced in 1355, and in the areas of health and mental health, education, connections with family and supportive adults, and conditions and treatment in the facility.</p>
<p>§ 1356. Counseling and Casework Services</p>	<p>(b)</p>	<p>This section should more specifically outline the casework responsibilities related to supporting and strengthening family ties.</p>	<p>(b) youth will receive assistance in requesting contact with parents, other supportive adults, attorney, clergy, probation officer, or other public officials and will be provided assistance in developing a plan for contact and visitation and the provision of any services that support family connections and while at the facility and upon release. The plan for contact, visitation and family supports shall be documented in the Youth Development Plan referenced in 1355.</p>
<p>§ 1356. Counseling and Casework Services</p>	<p>(c)</p>		<p>(c) youth will be provided access to connected with available resources, services, and treatment to meet the youth's needs including those identified in the assessment and requested by the youth. The resources, services, and treatment provided or arranged for shall be documented in the Youth Development Plan referenced in 1355.</p>
<p>§ 1357. Use of Force.</p>	<p>(a)</p>	<p>Listing chemical agents as permissible is unnecessary and validates or appears to condone the practice. The use should not be specifically described as allowable any more than any other use of force because highlighting it sends a signal of approval. Policies should emphasize the importance of de-escalation to avoid the use of force on children, explicitly prohibit certain types of force, require staff to physically intervene in an inappropriate use of force, and ensure that the youth's attorney and social worker are notified of any force used. Policies should also require consistent reporting and tracking of uses of force, as well as procedures to ensure the integrity of investigations. For example, investigations into uses of force should not be handled by officers involved in the incident, or their supervisors, but should be elevated to an independent entity, such as the county juvenile justice commission.</p>	<p>The facility administrator, in cooperation with the responsible physician, shall develop and implement written policies and procedures for the use of force, which may include chemical agents Force shall never be applied as punishment, discipline, retaliation, or treatment; and it shall not be used to respond to or overcome disrespectful, noncompliant, or other problem behavior in the absence of a threat of imminent harm to self or others. The duration of any use of force or restraint must cease as soon as the threat of imminent harm to self or others has been averted. (a) At a minimum, each facility shall develop policies and procedures which: (1) Recognize the rights and dignity of each youth and emphasize the sanctity of human life. (2) Require staff to use various de-escalation techniques, including trauma- and disability-informed techniques, in order to minimize or avoid the need for force, and to document such efforts in use of force reports. (3) Restrict the use of force to that which is deemed proportional, reasonable and necessary, as defined in Section 1302, and only after an individual assessment of the need to apply force that includes consideration of non-force alternatives, consideration of a youth's known medical or mental health conditions, and trauma-informed approaches to ensure the safety and security of youth, staff, others and the facility. (4) Outline the force options available to staff including both physical and non-physical options and define when those force options are appropriate. (5) Describe force options or techniques that are expressly prohibited by the facility, which includes pointing a firearm or using a chokehold or other action that restricts a youth's oxygen or blood flow or otherwise inhibits their consciousness. (6) Describe the requirements of staff to report any inappropriate use of force, and to take affirmative action to immediately stop it including verbal and physical intervention. (7) Define a standardized reporting format that includes time period and procedure for documenting and reporting the use of force, including (A) reporting requirements of management and line staff which include the type of force used, the reasons for which force was used, efforts to de-escalate prior to the use of force, youth and staff involved, the date, time and location of the use of force, identification of any injuries sustained as a result of the use of force, and the medical attention provided; and (B) procedures for reviewing and tracking use of force incidents by supervisory and or management staff, which include procedures for debriefing a particular incident with staff and/or youth for the purposes of training, identifying patterns and trends, and as well as mitigating the effects of trauma that may have been experienced by the youth and/or staff and/or the youth involved.</p>
<p>CONTINUED FROM ABOVE ROW -----></p>			<p>CONTINUED FROM ABOVE ROW: (6) Include an administrative review and a system for elevating the investigation of all unreasonable uses of force to an independent entity, such as the county juvenile justice commission, to determine whether the force used was excessive or unnecessary. This shall include procedures for preserving evidence and promptly interviewing involved staff or separating involved staff until they have been interviewed. (7) Define the role, notification, and follow-up procedures required after use of force incidents for medical, mental health staff, and parents or legal guardians, the youth's attorney, and the youth's social worker, if applicable. This shall include mandatory notification to parents, legal guardians, and the youth's attorney. (8) Describe the prohibitions and limitations of use of force on pregnant youth in accordance with Penal Code Section 6030(f) and Welfare and Institutions Code Section 222.</p>

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<p>§ 1357. Use of Force.</p>	<p>(b)</p>	<p>Chemical agents should not be used against children. However, if a facility is authorized to use chemical agents against children, policies must explicitly prohibit the use of chemical agents in certain circumstances, require an authorization process prior to deploying the chemical agent, and ensure that the youth's attorney and social worker are notified of the use of a chemical agent.</p>	<p>(b)Facilities that authorize chemical agents as a force option shall include policies and procedures that: (1)Identify who is approved to carry and/or utilize chemical agents in the facility <u>the authorization process for utilizing chemical agents</u>, and the type, size and the approved method of deployment for those chemical agents. (2)Mandate that chemical agents only be used when there is an imminent threat to the youth's safety or the safety of others and only when de-escalation efforts have been unsuccessful or are not reasonably possible. <u>Chemical agents shall be prohibited against youth in handcuffs or who are otherwise restrained, youth in enclosed areas, and a group of people that includes youth who do not pose an imminent threat to the safety of themselves or others.</u> (3)Outline the facility's approved methods and timelines for decontamination from chemical agents. This shall include that youth who have been exposed to chemical agents shall not be left unattended until that youth is fully decontaminated or is no longer suffering the effects of the chemical agent. (4)Define the role, notification, and follow-up procedures required after use of force incidents involving chemical agents for medical, mental health staff, and parents or legal guardians, <u>the youth's attorney, and the youth's social worker, if applicable.</u> (5)Provide for the documentation of each incident of use of chemical agents, including the reasons for which it was used, efforts to de-escalate prior to use, youth and staff involved, the date, time and location of use, decontamination procedures applied and identification of any injuries sustained as a result of such use.</p>
<p>§ 1357. Use of Force.</p>	<p>(c)</p>	<p>Training on use of force and chemical agents should be developed with input from individuals with lived experience and include information on the mental and physical harm to children who experience force.</p>	<p>(c)Facilities shall develop policies and procedure which require that agencies provide initial and regular training in use of force and chemical agents, when appropriate, <u>that is developed with input from individuals with lived experience and</u> address: (1)<u>the impact of using force on children, including the potential mental and physical harm;</u> (2)Known <u>known</u> medical and behavioral health conditions that would contraindicate certain types of force; (3)Acceptable <u>acceptable</u> chemical agents and the methods of application. (4)Signs <u>signs</u> or symptoms that should result in immediate referral to medical or behavioral health. (5)Instruction <u>instruction</u> on the Constitutional Limitations of Use of Force. (6)Physical training <u>physical training</u> force options that may require the use of perishable skills. (7)Outlines <u>outlines</u> the facility uses to define regular training.</p>
<p>§ 1358. Use of Physical Restraints</p>		<p>The use of physical restraints poses physical and mental health risks to children. Any policy should not just be in consultation with the responsible medical and mental health professionals, but should be approved by them in addition to the facility administrator. If a policy cannot be approved by the responsible medical and mental health professionals it should not be deemed safe for use.</p> <p>This section should require (1) less restrictive alternatives to be utilized first, if possible, (2) an individual assessment of the need to apply restraints, (3) notification to the youth's parent/guardian, attorney, and social worker when restraints are used, and (4) more documentation of the use of restraints, including who authorized it, what type was used, how long it was used, what the medical opinion and mental health consultation found, and who was notified.</p> <p>This regulation needs to define the maximum length of time that a youth may be held in restraint devices. The notion that a child is medically cleared every three hours indicates that children can be held in restraints for extraordinarily protracted periods of time. No child should ever sit in restraint devices for a period of hours without the review of a medical professional and an assessment for behavioral health interventions.</p>	<p>The facility administrator, in cooperation with <u>and</u> the responsible physician and mental health director, shall develop and implement and approve <u>and</u> written policies and procedures for the use of restraint devices. <u>The facility administrator, the responsible physician, and the mental health director shall implement the approved policies and procedures in their respective capacities.</u> Restraint devices include any devices which immobilize a youth's extremities and/or prevent the youth from being ambulatory.</p> <p>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 should be utilized only after when it appears <u>after</u> less restrictive alternatives <u>have been attempted or when less restrictive alternatives</u> would be ineffective in controlling the youth's behavior.</p> <p>In no case shall restraints be used as punishment or discipline, or as a substitute for treatment. The use of restraint devices 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. The use of restraints on pregnant youth is limited in accordance with Penal Code Section 6030(f) and Welfare and Institutions Code Section 222.</p> <p>The provisions of this section do not apply to the use of handcuffs, shackles or other restraint devices when used to <u>briefly</u> restrain youth <u>solely</u> for movement or transportation within the facility. Movement within the facility shall be governed by Section 1358.5, Use of Restraint Devices for Movement Within the Facility.</p> <p>Youth shall be placed in restraints only with the approval of the facility manager or designee <u>and only after an individual assessment of the need to apply restraints that includes consideration of less restrictive alternatives, consideration of a youth's known medical or mental health conditions, and trauma informed approaches.</u> The facility manager may delegate authority to place a youth in restraints to a physician. Reasons for continued retention in restraints shall be reviewed and documented at a minimum of every hour.</p> <p>A medical opinion on the safety of placement and retention shall be secured as soon as possible, but no later than two-one <u>two-one</u> hours from the time of placement, and <u>and</u> the youth shall be medically cleared for continued retention at least every three <u>three</u> hours thereafter.</p>

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			<p>CONTINUED FROM ABOVE ROW: A mental health consultation shall be secured as soon as possible, but in no case longer than four <u>an</u> hours from the time of placement, to assess the need for mental health treatment.</p> <p><u>Any time a youth is placed in restraints for any period of time, the facility shall promptly notify the youth's parent or guardian, the youth's attorney, and the youth's social worker, if applicable. The facility shall provide the reasons for the use of restraints and, as soon as available, provide the medical opinion and findings from the mental health consultation.</u></p> <p>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. In addition to the requirements above, policies and procedures shall address:</p> <p>(a) Documentation of the circumstances leading to an application of restraints <u>, the name and role of the individual who authorized the use of restraints, the type of restraints used, the length of the time the youth was restrained, the timing and findings of the medical opinion and mental health consultation, and the timing and role of the individuals notified.</u></p> <p>(b) Known medical conditions that would contraindicate certain restraint devices and/or techniques.</p> <p>(c) Acceptable restraint devices.</p> <p>(d) Signs or symptoms which should result in immediate medical/mental health referral.</p> <p>(e) Availability of cardiopulmonary resuscitation equipment.</p>
		CONTINUED FROM ABOVE ROW ----->	
§ 1358.5 Use of Restraint Devices for Movement and Transportation within the Facility	(c), (d)	This section discusses the requirements for an individual assessment that must be made before applying restraints, as well as a requirement for a process for documentation and supervisor approval. For clarity, this should be split into two subsections.	(c) an individual assessment of the need to apply restraints for movement or transportation that includes consideration of less restrictive alternatives, consideration of a youth's known medical or mental health conditions, and trauma informed approaches., and (d) a process for documentation and supervisor review and approval.
§ 1358.5 Use of Restraint Devices for Movement and Transportation within the Facility	(e) [NEW]	This new subsection requires policies to include a process for notifying a youth's parent/guardian, attorney, or social worker when a youth is placed in restraints for movement and transportation.	(e) a process for notifying the youth's parent or guardian, the youth's attorney, and the youth's social worker, if applicable.
§ 1358.5 Use of Restraint Devices for Movement and Transportation within the Facility	(f) [previously (d)]	This subsection focuses on the security of the facility, and should be revised to emphasize the safety of the youth as well.	(d) consideration of safety and security of the youth and the facility, with a clearly defined expectation that restraint devices shall not be used for the purposes of discipline or retaliation.
§ 1359. Safety Room Procedures.	Entire Section	The use of a safety room constitutes room confinement pursuant to Welfare and Institutions Code Section 208.3 because it is confinement in a locked cell. While the term cell is not specifically defined it is commonly understood to mean a room where a person in custody is held. The use of a safety room must therefore comply with any additional provisions in Section 1354.5 and WIC Section 208.3.	See comment and relevant provisions.
§ 1360. Searches	(e)	This subsection should also include documentation of the outcome of a strip search to track the kind of contraband recovered, if any.	(e) Any youth held after a detention hearing shall only be strip searched with prior approval of a supervisor when there is reasonable suspicion based on specific and articulable facts to believe that youth is concealing contraband. The reasonable suspicion and amount of contraband recovered, if any, shall be documented.
§ 1360. Searches	(f)	Add nonbinary and gender nonconforming youth to this subsection.	(f) Searches of transgender, and intersex nonbinary and gender nonconforming youth shall comply with Section 1352.5.
§ 1361. Grievance Procedure.	(a)	Include a requirement to notify youth of the grievance form	(a) linguistically appropriate grievance form and instructions for registering a grievance, which includes provisions for the youth to be made aware of and have free access to the form;
§ 1361. Grievance Procedure.	(c)	Require policies to provide clear guidelines to staff responsible for resolving grievances, in order to ensure that investigations are thorough, fair, and consistent.	(c) resolution of the grievance at the lowest appropriate staff level, with clear guidelines to ensure consistent investigation, analysis, and communication regarding grievances;
§ 1361. Grievance Procedure.	(d)(2)	Allow a youth to have their attorney or another person of their choosing to assist them with filing a grievance and navigate the process.	(d) Provision for a prompt review and initial response to grievances within three (3) business days, grievances that relate to health and safety issues must be addressed immediately; (1) The youth may elect to be present to explain his/her version of the grievance to a person not directly involved in the circumstances which led to the grievance. (2) Provision for a person to assist the youth with filing the grievance and throughout the process, which may be a staff representative approved by the facility administrator or, if the youth requests, the youth's attorney or another person selected by the youth to assist the youth.
§ 1361. Grievance Procedure.	(e)	In the response to the grievance, also include a requirement to explain that the youth has a right to an appeal and how to file an appeal.	(e) Provision for a written response to the grievance which includes the reasons for the decisions and explains the right and the process to appeal;
§ 1361. Grievance Procedure.	closing para	Add attorneys and social workers to the list of individuals whose concerns will be addressed and documented regardless of whether a grievance is filed.	Whether or not associated with a grievance, concerns of parents, guardians, <u>attorneys, social workers</u> , staff or other parties shall be addressed and documented in accordance with written policies and procedures within a specified timeframe.
§ 1362. Reporting of Incidents.		This section should also require a written report of all incidents which result in a youth's separation, confinement, or restraint.	A written report of all incidents which result in <u>separation, confinement, restraint</u> , physical harm, use of force, serious threat of physical harm, or death of an employee, youth or other person(s) shall be maintained. Such written record shall be prepared by the staff and submitted to the facility manager by the end of the shift, unless additional time is necessary and authorized by the facility manager or designee <u>but in no event later than the end of the next shift during which the staff is present.</u>
§ 1363. Use of Reasonable Force to Collect DNA Specimens, Samples, Impressions		This is the only regulation specifically allowing for or discussing the requirements for "cell extraction." The term "cell extraction" was deleted from the definitions during the last update of the regulations, and the term "room extraction" was added. Presumably "room extraction" is the same as "cell extraction" because they share a definition-- the only change was to the name of the term. Given that this is the only regulation that mentions such a procedure, it would be appear that this is the only allowable circumstance under which it may be used. Given the dangers and risks of extraction, the regulation requires that the event be videotaped and the tape maintained. If this is the only allowable use of the procedure that must be indicated in the use of force section, and if its use is contemplated in other circumstances then the procedures should be carried over to those uses as well.	The force shall not be used without the prior written authorization of the supervising officer on duty. The authorization shall <u>be based upon and document the receipt of a written statement, include information that reflects/indicates</u> the fact that the offender was asked <u>in a linguistically appropriate manner</u> , to provide the requisite specimen, sample, or impression and refused <u>including the date, time, location, and maker of the request.</u> (1) If the use of reasonable force includes a cell extraction, the extraction shall be videotaped. <u>Immediately prior to the extraction, the youth shall again be asked and given an opportunity to comply with the request, which shall be videotaped or will be deemed not to have occurred.</u> Video shall be directed at the cell extraction event. The videotape shall be retained by the agency for the length of time required by statute. Notwithstanding the use of the video as evidence in a court proceeding, the tape shall be retained administratively.

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Article 6. Programs and Activities	§ 1370. Education Program.	(b)(1)	This provision should be amended to incorporate the requirements under the Education Code.	(1) The course of study shall comply with the State Education Code and shall include, but not be limited to, courses required for high school graduation and courses that prepare youth for participation in postsecondary academic and career technical courses, such as A-G courses, dual enrollment courses, or career and technical education courses.
		(b)(8)	This provision should be added to define when credit recovery is appropriate, with the definition derived from Education Code section 1983.	(8) Credit recovery assistance shall be available for students for courses that the student previously attempted, but for which the student was unsuccessful in earning academic credit towards graduation.
		(b)(3)	This provision should be revised to incorporate the standards of Education Code Section 48647.	(3) In accordance with the State Education Code, youth shall be informed of post-secondary <u>academic and career technical opportunities and support services offered in the facility and in the community, as well as state and federal financial aid programs.</u>
		(b)(3)	This provision should be revised to include the provisions of Welf. & Inst. Code section 851.1.	(b)(3)(8) Students shall have access to computer technology and the internet for educational purposes.
		(c)(1)	This provision must ensure that school discipline decisions are made by school personnel, not probation staff.	(1) Positive behavior management will be implemented to reduce the need for disciplinary action in the school setting and be integrated into the facility's overall behavioral management plan and security system. Probation staff cannot suspend or expel a youth from school. All instances of probation removal of youth from the education setting for behavioral management shall be documented.
		(d)	This provision should be revised to ensure that education rights of students with IEPs are protected.	(1) State and federal laws and regulations shall be observed for all individuals with disabilities or suspected disabilities. This includes but is not limited to child find, assessment, continuum of alternative placements, manifestation determination reviews, and implementation of Section 504 Plans and Individualized Education Programs. The facility administrator shall work with education staff to ensure that all required members of an IEP team are able to attend IEP meetings, which could include providing space for an IEP meeting in the facility or transporting a youth to a space outside the facility. IEP attendance by family members or other approved visitors shall not be counted towards minimum visitation hours. (2) Youth identified as English Learners (EL) shall be afforded an educational program that addresses their language needs pursuant to all applicable state and federal laws and regulations governing programs for EL students.
§ 1370. Education Program.	(g) Transition and Re-entry planning	This provision should be revised to include the standards under Education Code section 48647.	(g) Transition and Re-Entry Planning (1) The Superintendent of Schools and the Chief Probation Officer or designee, shall develop policies and procedures to meet the transition needs of youth, including the development of an education transition plan, in accordance with the State Education Code and in alignment with Title 15, Minimum Standards for Juvenile Facilities, Section 1355. 2) The transition policies and procedures shall include collaboration with relevant local educational agencies to improve communication regarding dates of release and to coordinate immediate school placement and enrollment. 3) Transition planning shall consider the academic, behavioral, social-emotional, and career needs of the student, as well as the identification and engagement of programs, including higher education programs, services, and individuals to support transition. 4) In accordance with State Education Code, the youth's education rights holder shall be given a copy of their educational records upon the youth's release from the facility, including school transcripts, the youth's individualized learning plan, IEP or 504 plan (if applicable), academic or vocational assessments, an analysis of credits completed and needed, and any certificates or diplomas earned by the youth. 5) Transition planning shall begin no later than the 20th consecutive day that a student is enrolled in the juvenile court school, and must begin in time to ensure that all students in custody for 20 consecutive school days have a transition plan in accordance with the State Education Code. 6) Education staff should collaborate with postsecondary partners to ensure that postsecondary and financial aid applications, such as the Free Application for Federal Student Aid, Cal Grant, Chafee, California Dream Act Application, or other aid applications are completed in a timely manner that maximizes the youth's financial aid and ensures that financial aid is available to the youth as soon as youth begin attending class on a postsecondary campus.	
	(h) Post-Secondary Education Opportunities	This section should be revised to be consistent with WIC 16501.1 (g)(22) and to clarify the expectations so youth are supported in pursuing postsecondary programs. In its current form, it understates the extent of legal obligation to provide postsecondary education under WIC 858.	(h) Post-Secondary Education Opportunities (1) The school and facility administrator shall ensure that youth with a high school diploma or California high school equivalency certificate have access to public postsecondary academic and career technical courses and programs offered online or in person, that fulfill the requirements for transfer to the University of California and the California State University and prepare them for career entry, respectively. (2) The school and facility administrator may also partner with a public postsecondary institution to offer youth who have not yet completed their high school graduation requirements the opportunity to concurrently participate in postsecondary academic and career technical education programs, such as dual enrollment courses. The school and facility administrator should, whenever possible, collaborate with local post-secondary education providers to facilitate access to educational and vocational opportunities for youth that considers the use of technology to implement these programs. (3) The school and facility administrator should collaborate with postsecondary partners to ensure that a qualified individual has been identified for youth who are age 16 or older who is responsible for assisting the youth with applications for postsecondary education, including career or technical education, and related financial aid.	

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<p>§ 1371. Programs, Recreation, and Exercise</p>		<p>This section should be revised to ensure that youth are engaging in positive developmental activities to the greatest extent possible.</p>	<p>§ 1371. Programs, Recreation, and Exercise. (a) The facility administrator shall develop and implement written policies and procedures for programs, recreation, and exercise for all youth. The intent is to minimize the amount of time youth are in their rooms or their bed area maximize the amount of time youth are participating in educational programming and engaging in recreation, exercise, hobbies, and visitation and contact with family. (i) Juvenile facilities shall provide the opportunity for programs, recreation, and exercise a minimum of three hours a day during the week and five hours a day each Saturday, Sunday or other non- school days or days that are non-school days for a given youth, of which one hour shall be an outdoor activity, weather permitting. (ii) A youth's participation in programs, recreation, and exercise may be suspended limited temporarily only upon a written finding by the administrator/manager or designee that a youth represents an immediate threat to the safety and security of the facility that cannot be addressed by any means other than limiting participation. If participation in formal programming is limited, a plan for recreation and exercise shall be developed for the youth that provides at least three hours a day during the week and 5 hours a day during weekends and days that a youth is not in school or an education program with a description of the steps that will be taken to return to formal programming within one week. (b) Such program, recreation, and exercise schedule shall be posted in the living units. There will be a written annual review of the programs, recreation, and exercise by the responsible agency and with the consultation of youth with experience in the facility to ensure content offered is current, consistent, and relevant to the population. (c) Programs. All youth shall be provided with the opportunity for at least one two hours of daily programming to include, but not be limited to, trauma focused, cognitive, evidence-based, best practice interventions that are culturally relevant and linguistically appropriate, or pro- social interventions and activities designed to reduce recidivism. These programs should be based on the youth's individual needs as required by Sections 1355 and 1356. Such programs may be provided under the direction of the Chief Probation Officer or the County Office of Education and can be administered by county partners such as mental health agencies, community based organizations, faith-based organizations or Probation staff. Youth shall be provided the option to receive these services from community based providers with whom they already are receiving services. Programs may include but are not limited to: (1) Cognitive Behavior Interventions; (2) Management of Stress and Trauma; (3) Anger Management; (4) Conflict Resolution; CONTINUED FROM ABOVE ROW: (6) Trauma-related interventions; (7) Victim Awareness; (8) Self-Improvement; (9) Parenting Skills and support; (10) Tolerance and Diversity; (11) Healing Informed Approaches; (12) Interventions by Credible Messengers; (13) Gender Specific Programming; (14) Art, creative writing, or self-expression; (15) CPR and First Aid training; (16) Restorative Justice or Civic Engagement; (17) Career and leadership opportunities; and, (18) Other topics suitable to the youth population (b)(d) Recreation. All youth shall be provided the opportunity for at least one hour of daily access to unscheduled activities such as leisure reading, letter writing, and entertainment. Activities shall be supervised and include orientation and may include coaching of youth. (e)(e) Exercise. All youth shall be provided with the opportunity for at least one hour of large muscle activity each day. The administrator/manager may suspend, for a period not to exceed 24 hours, access to recreation and programs. The administrator/manager shall document the reasons why suspension of recreation and programs occurs.</p>
<p>§ 1372. Religious Program § 1373. Work Program § 1374. Visiting</p>		<p>This provision should be revised to support visitation to the greatest extent possible, given the many positive benefits of visitation documented by research. Sandra Villalobos Agudelo, The Impact of Family Visitation on Incarcerated Youth's Behavior and School Performance Findings from the Families as Partners Project, Vera Institute of Justice, Issue Brief, April 2013, https://www.vera.org/downloads/publications/impact-of-family-visitation-on-incarcerated-youth-brief.pdf</p>	<p>Continued from above row -----></p> <p>All visits shall occur at reasonable times, subject only to the limitations necessary to maintain order and security. Visitation shall not be denied solely based on the visitor's criminal history. Visitation by family members with past criminal convictions shall be denied only if staff determine that the nature of the conviction suggests an immediate threat of violence to the detained youth. The staff shall determine in each case, whether the visitor's criminal history represents a risk to the safety of youth or staff in the facility. Any denial of visitation or limitation on visitations shall be communicated to the youth, person denied and facility administrator. The facility administrator shall develop a process by which the person denied visitation may appeal the denial. Opportunity for visitation shall be a minimum of two hours per week, and for post-dispositional youth shall be increased to a minimum of four hours per week. Visits may be supervised, but conversations shall not be monitored unless there is a specific security or safety need. Visitation spaces shall be as homelike and private as possible.</p>
<p>§ 1376. Telephone Access.</p>	<p>Entire section</p>		<p>The administrator of each juvenile facility shall develop and implement written policies and procedures to provide youth with access to telephone communications. All phone calls shall be free of charge. Youth shall have the right to make at least one daily completed phone call to a family member for a minimum duration of twenty minutes. Access to daily phone calls and communications in general shall not be used as a reward or punishment.</p>
<p>§ 1377. Access to Legal Services.</p>		<p>This regulation should require no-cost access to legal correspondence without caveat.</p>	<p>(c) unlimited postage free, legal correspondence and cost-free telephone access as appropriate.</p>
<p>Article 7. Discipline</p>			

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§ 1390. Discipline	intro	This provision should include a requirement that any discipline imposed on youth shall be both trauma-informed and disability-informed.	The facility administrator shall develop and implement written policies and procedures for the discipline of youth that shall promote acceptable behavior; including the use of positive behavior interventions and supports. Discipline shall be imposed at the least restrictive level which promotes the desired behavior, shall be trauma- <u>and disability-</u> informed, and shall not include corporal punishment, group punishment, physical or psychological degradation.
§ 1390. Discipline	(b)	This provision should ensure that youth cannot be deprived of access to <u>clean</u> drinking fountain, toilet, and personal hygiene items.	(b) <u>Daily</u> shower, access to <u>clean</u> drinking fountain, toilet and personal hygiene items, and clean clothing;
§ 1390. Discipline	(i)	This provision should ensure that youth cannot be deprived of phone calls.	(i) <u>the right to <u>make phone calls and</u> send and receive mail;</u>
new subsection		This provision should be added to ensure that youth cannot be deprived of access to outdoor time.	<u>(j) outdoor time.</u>
§ 1391. Discipline Process.	(d)	There should also be a requirement that policies include disability-informed approaches to discipline.	(d) <u>trauma- <u>and disability-</u>informed approaches and positive behavior interventions;</u>
§ 1391. Discipline Process.	new subsection	There should be a requirement to track and report discipline, including alleged violations, kind of discipline imposed, and outcome of the administrative review process, if any.	<u>(h) <u>tracking and reporting of informal and formal discipline imposed, including a description of the alleged violation(s), the type of discipline imposed, whether an administration review was sought, and the outcome of the administrative review, if any.</u></u>
Article 8. Health Services			
§ 1401. Patient Treatment Decisions.		The current provision does not reference the right to consent to treatment of the youth or their parent/guardian.	Clinical decisions about the treatment of individual youth are the sole province of licensed health care professionals, operating within the scope of their license and within facility policy defining health care services <u>in consultation with the youth and their health care decision maker if the youth does not hold the right to consent to the specific treatment being considered.</u>
§ 1402. Scope of Health Care.	(a)(2)	The current provision does not include the obligation to ensure that care continues for youth who enter with health needs that are already being treated or have needs identified. The current provision focuses on meeting emergency and avoiding deterioration and does not include maintaining health. While the scope of health care provided to youth confined for brief periods may arguably be focused on emergency care and avoiding deterioration, but this cannot be reasonably applied to youth held for longer periods of time. The regulation is one of many that does not easily apply to both brief detentions and longer detentions or commitment facilities. When a youth is held for a longer period the scope of health care should meet the recommended guidelines from medical professionals for screening, diagnosis, treatment, and prevention. At a minimum the standards should align with the recommendations of the American Academy of Pediatrics (See American Academy of Pediatrics Textbook of Pediatric Care; Thomas K. McInerney, MD et al., Second Edition, 2016) and provide for the services available under Medi-Cal.	health care services which meet the minimum requirements of these regulations, applicable professional standards for care, and be at a level to address emergency, acute symptoms and/or conditions and avoid preventable deterioration of health while in confinement, and to ensure continuity of care and treatment for youth who have existing treatment needs or have needs identified while at the facility. For youth who are or are anticipated to be detained for 60 days or more, and for youth committed to a juvenile facility, the services and standards of care shall be at a level to address the requirements described for all youth and shall also be at a level to ensure youth receive care that meets the recommendations of the American Academy of Pediatrics or other equal or greater standard recognized by the State of California, and shall provide for prevention, screening, diagnosis, and treatment services at or above the level provided under Medi-Cal.
§ 1402. Scope of Health Care.	(b)	The current provisions do not reference following applicable professional standards when care is provided in the facility.	When health services are delivered within the juvenile facility, staff, space, equipment, supplies, materials, and resource manuals shall be adequate to the level of care provided <u>and meet all applicable professional standards.</u>
§ 1403. Health Care Monitoring and Audits.		An acceptable system of monitoring and auditing should include external oversight and checks. This section does not contain these elements and includes only the health and facility administrators. This provision should be revised to include external oversight and checks.	
§ 1406. Health Care Records.		The provision does not require that current treatment providers outside of the facility be identified so they can provide continuity of care where possible. This category should be added to the list of records.	<u>(o) <u>Contact information of the youth's community based treatment providers.</u></u>
§ 1407. Confidentiality	(b)	This provision should be amended to include any other applicable state and federal law on confidentiality.	Medical and behavioral/mental health services shall be conducted in a private manner such that information can be communicated confidentially consistent with HIPAA <u>and all other applicable state and federal laws related to information sharing and confidentiality.</u>
§ 1408. Transfer of Health Care Summary and Records.	(c)	The time-sensitive required notification only involves communicable diseases. There are other serious health conditions that would be important for receiving facilities to know prior to intake to allow them to properly care for the incoming youth. Falling to include health conditions that affect the care of the youth disregards the well-being of the transferred youth. The youth's conditions that affect their care should be included in the provision.	notification to health care staff of the receiving facility prior to or at the time of the release or transfer of youth with known or suspected communicable diseases <u>or other health conditions, including but not limited to suicidal tendencies in accordance with Section 1329 of these regulations, dietary restrictions, and all health conditions which may require medical intervention and continuous care, affect mental awareness, or limit physical mobility.</u>
§ 1408. Transfer of Health Care Summary and Records.	(e)	This provision should be amended to include any other applicable state and federal law on confidentiality.	(e) confidentiality of health records is maintained <u>consistent with all applicable state and federal laws.</u>
§ 1408.5 Release of Health Care Summary and Records.	(general section)	Provision requirement for "written authorization" may impede ability of youths to receive treatment in the community The regulation should include necessary provisions for compliance with the mandates and services of CalAIM. https://secureservercdn.net/198.71.233.194/zbo.123.myftpupload.com/wp-content/uploads/2022/05/CalAIM-for-Reentry-and-Justice-Involved-Adults-and-Youth-A-Policy-Implementation-Guide-FINAL.pdf	After youth are released to the community, health record information shall be promptly transmitted to specific physicians or health care facilities in the community, upon request and with the written authorization of the youth and/or parent/guardian. <u>Prior to release, as part of planning outlined in section 1351, health care staff shall work with the youth to get all authorizations signed that are needed, for the youth to access continuous care and treatment upon release, including medication.</u> In special purpose juvenile halls and other facilities that do not have on-site health care staff, policy and procedures shall assure that youth supervision staff forward non-confidential information on medications and other treatment orders prior to or at the time of transfer.
§ 1409. Health Care Procedures Manual		This provision should be revised to require that a body outside of the facility provides review of these critical policies and procedures.	

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<p>§ 1410. Management of Communicable Diseases</p>		<p>This provision does not appear to cover policies related to staff and their potential role in spreading communicable diseases like COVID-19. Additionally, this provision should be updated to reflect the experience of the pandemic and appropriate responses to protect youth. This provision should be informed by pediatricians and clinicians with expertise in the psychosocial implications of the pandemic and treatment for children and youth.</p>	<p>The health administrator/responsible physician, in cooperation with the facility administrator and the local health officer, shall develop written policies and procedures to address the identification, treatment, control and follow-up management of communicable diseases. <u>Policies shall be developed for both youth and facility staff.</u> The policies and procedures shall address, but not be limited to:</p> <ul style="list-style-type: none"> (a) intake health screening procedures; (b) identification of relevant symptoms; (c) referral for medical evaluation; (d) treatment responsibilities during detention; (e) coordination with public and private community-based resources for follow-up treatment; (f) applicable reporting requirements; and, (g) strategies for handling disease outbreaks.
<p>§ 1411. Access to Treatment</p>		<p>This provision should be amended to provide guidance for how youth will access treatment services.</p>	<p>The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to provide unimpeded access to health care, <u>including, but not limited to: (a) how youth will be made aware of the treatment available onsite and in the community in an age-appropriate way; (b) how youth will be supported in accessing treatment services and managing on-going treatment needs; (c) how youth will be made aware of the array of services and activities that will support their wellness; (d) the process by which youth can file a complaint if they believe they have been denied access to treatment or had treatment limited.</u></p>
<p>§ 1413. Individualized Treatment Plans.</p>	<p>Adding to (b) & (c); adding new subsections .</p>	<p>This section lacks specificity to ensure that a comprehensive plan is developed that addresses health needs and promotes wellness. It should be amended to provide a more comprehensive health plan and connect youth health needs to services that the youth has received in the community.</p>	<p>With the exception of special purpose juvenile halls, the health administrator and behavioral/mental health director responsible physician, in cooperation with the facility administrator, shall develop and implement policy and procedures to assure that coordinated and integrated health care treatment plans are developed for all youth who are receiving services for <u>significant</u>-medical, behavioral/mental health or dental health care concerns. Policies and procedures shall assure:</p> <ul style="list-style-type: none"> (a) Health care treatment plans are considered in facility program planning. (b) Health care restrictions shall not limit participation of a youth in school, work assignments, exercise and other programs, beyond that which is necessary to protect the health of the youth or others <u>after providing reasonable accommodations.</u> (c) Relevant health care treatment plan information shall be shared with youth supervision staff in accordance with Section 1407 <u>and applicable state and federal laws related to information sharing</u> for purposes of programming, implementation and continuity of care. (d) for youth who may have special needs when using showers and toilets and dressing/undressing <u>and any activities of daily living.</u> <u>(e) Description of treatment provided in the community to maintain continuity of care.</u> <u>(f) Description of the treatment provided at the facility, including administration of medication.</u> <u>(g) description of any activities or treatment that is being provided to support the youth's wellness and to address the experience of trauma.</u> <p>Treatment planning by health care providers shall address:</p> <ul style="list-style-type: none"> (a) Pre-release and discharge planning for continuing medical, dental and behavioral/mental health care, including medication, following release or transfer, which may include relevant authorization for transfer of information, insurance, or communication with community providers to ensure continuity of care. (b) Participation in relevant programs upon return into the community to ensure continuity of care <u>and wellness.</u> (c) Youth and family participation (if applicable and available). (d) Cultural responsiveness, awareness and linguistic competence <u>of the treatment provider.</u> (e) <u>Strategies to help the youth maintain</u> Physical and psychological safety. (f) <u>Strategies to help the youth address</u> Traumatic stress and trauma reminders when applicable.
<p>§ 1413. Individualized Treatment Plans.</p>	<p>Whole section</p>	<p>Currently there are two separate sections that go (a)-(d) and (a)-(f). Section structure should be corrected to follow formatting that goes from (a)(1-4) and (b)(1-6).</p>	
<p>§ 1413. Individualized Treatment Plans.</p>		<p>This provision should have requirements for staff to actively work with youth to take all steps towards continuity of care that can be taken prior to the youth's release that the youth would otherwise have to complete after release.</p>	<p>Treatment planning by health care providers <u>shall address:</u></p> <ul style="list-style-type: none"> (a) <u>In accordance with section 1351, pre-release and discharge planning for continuing medical, dental and behavioral/mental health care, including medication, following release or transfer, which shall include consulting youth within one week of release as to their preferences on any such services which they currently receive and want to receive from community providers after release and the community providers from which they wish to receive any such services, and ensure that they sign any may include relevant authorization for transfer of information, insurance, or communication with those community providers to ensure continuity of care.</u> (b) Participation in relevant programs upon return into the community to ensure continuity of care. (c) Youth and family participation (if applicable and available). (d) Cultural responsiveness, awareness and linguistic competence. (e) Physical and psychological safety. (f) Traumatic stress and trauma reminders when applicable.
<p>§ 1414. Health Clearance for In-Custody Work and Program Assignments.</p>		<p>This section must be updated to reflect lessons and requirements related to the pandemic to ensure that youth are better protected.</p>	<p>The health administrator/responsible physician, in cooperation with the facility administrator <u>and public health officials,</u> shall develop health screening and monitoring procedures for work and program assignments <u>for all staff that come into contact with youth to reduce the chance that they will pass a communicable disease to staff and youth that have health care implications, including, but not limited to, food handlers.</u> These policies must include requirements related to removing staff from contact with youth if they are at risk for transmitting a communicable disease.</p>
<p>§ 1415. Health Education</p>		<p>The provision should seek to ensure that young people are providing input into the health education provided or that information is provided in languages that youth understand.</p>	<p>With the exception of special purpose juvenile halls, the health administrator for each juvenile facility, in cooperation with the facility administrator, shall develop written policies and procedures to assure that interactive and gender and developmentally appropriate medical, behavioral/mental health and dental health education and disease prevention programs are provided to youth <u>in languages that they comprehend.</u> The education program content shall be updated as necessary to address current health and community priorities that meet the needs of the confined population. <u>The education program content shall also be updated annually after consultation with young people who have experienced confinement.</u></p>

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<p>§ 1416. Reproductive Services and Sexual Health.</p>		<p>Young people in facilities should be provided the same information about reproductive services and sexual health as required for youth in foster care pursuant to the Foster Youth Sexual Health Education Act.</p>	<p>For all juvenile facilities, the health administrator, in cooperation with the facility administrator, shall develop written policies and procedures to assure that reproductive and sexual health services are available to all youth in accordance with current public health guidelines.</p> <p>Such services shall include but not be limited to those prescribed by Welfare and Institutions Code Sections 220, 221 and 222, 16501.1(g)(20) & (21), 16521.5, and Health and Safety Code Section 123450.</p>
<p>§ 1417. Pregnant/Post-Partum Youth.</p>	<p>Add a new subsection.</p>	<p>This section should be modified to encompass all parenting youth and it should be clarified that this provision includes fathers.</p>	<p>Pregnant/Post-Partum Youth <u>and Parenting Youth</u>. With the exception of special purpose juvenile halls, the health administrator for each juvenile facility, in cooperation with the facility administrator, shall develop written policies and procedures pertaining to pregnant-and-post-partum youth as required by Penal Code Section 6030(e) and limitations on the use of restraints in accordance with Penal Code Section 6030(f) and Welfare and Institutions Code Sections 220, 221, and 222.</p> <p><u>With the exception of special purpose juvenile halls, the health administrator for each juvenile facility, in cooperation with the facility administrator, shall develop written policies and procedures pertaining to parenting youth, including mothers and fathers.</u></p>
<p>§ 1417. Pregnant/Post-Partum Youth.</p>		<p>Given the increased vulnerability to, and severity of, health complications experienced by pregnant and post-partum youth in detention, regulations should include a requirement to provide information to the Juvenile Court relevant to any request by the youth for release based on circumstances related to being pregnant or post-partum.</p> <p>See Minji Kim BS, Carolyn Sufirin MD, PhD, Kathryn Nowotny PhD, Lauren Beal MPH, Monik C. Jiménez ScD, SMS, "Pregnancy Prevalence and Outcomes in 3 United States Juvenile Residential Systems," Journal of Pediatric and Adolescent Gynecology, Volume 34, Issue 4, August 2021, Pages 546-551, https://www.sciencedirect.com/science/article/abs/pii/S1083318821000073. ("Miscarriages comprised half of the 8 pregnancies that ended in custody, a higher rate than that of the general youth population, in which 65,590 of 448,440 pregnancies among 15-19 year-olds (14.6%) ended in a miscarriage....the transition from JRS to health care providers in the community is crucial to addressing the prenatal health care needs for female youth released from Juvenile Residential System.")</p>	<p>Add the following provision: <u>(e) Provision of information to the Juvenile Court that is relevant to any request by the youth for release from confinement based on circumstances related to being pregnant or post-partum.</u></p>
<p>§ 1417. Pregnant/Post-Partum Youth.</p>	<p>Add two new subsections.</p>		<p><u>(e) Pregnant, post partum, and parenting youth shall be provided information and support in accessing services and benefits for pregnant and post-partum youth to care for their child, including, but not limited to home visiting programs, child care, and public benefits.</u> <u>(f) Post-partum and parenting youth shall be provided frequent in-person visitation.</u></p>
<p>§ 1418. Youth with Developmental Disabilities.</p>	<p>add new section (b)</p>	<p>This section should reference the right to request reasonable accommodations.</p>	<p><u>(b) Policy and procedure shall require that there is a process for youth with disabilities to request reasonable accommodations related to conditions and programming and are provided assistance in making a request.</u></p>
<p>§ 1430. Medical Clearance/Intake Health and Screening</p>	<p>Edits to (b) and (c)</p>	<p>This provision should include behavioral health needs in screening.</p>	<p>Screening procedures shall include but not be limited to: (a) Medical, dental and behavioral/mental health concerns that may pose a hazard to the youth or others in the facility; (b) Health conditions that require treatment while the youth is in the facility; <u>and</u>, (c) Identification of the need for accommodations for any eg- physical, <u>behavioral health or</u> developmental disabilities,</p>
<p>§ 1430. Medical Clearance/Intake Health and Screening 1432 Health Assessment 1432 Health Assessment</p>	<p>Revisions needed in whole section. Introduction</p>	<p>This section should be updated to take into account the experience of the COVID-19 pandemic and similar communicable diseases. We recommend that the Board consult with medical experts to balance safety, health, and mental health needs of the facility.</p> <p>This section should be revised in consultation with medical experts to reflect COVID-19 and similar communicable diseases. There may be a need to adjust the time lines for the assessment, for example.</p> <p>Revisions are recommended to reflect that the health assessment should include identified ongoing care needs that should be addressed while the youth is in the facility.</p>	<p>The health administrator/responsible physician, in cooperation with the facility administrator for each juvenile hall, shall develop and implement written policy and procedures for a health assessment of youth and for the timely identification of conditions necessary to safeguard the health of the youth <u>and ensure continued care and treatment of youth with health care needs.</u></p>
<p>§ 1433. Requests for Health Care Services.</p>	<p>Introduction</p>	<p>The provision should contain requirements related to informing youth about the availability of health care services.</p>	<p>The health administrator, in cooperation with the facility administrator, shall <u>develop age and linguistically appropriate materials to inform youth of the availability of health care services</u> and develop policy and procedures to establish a daily routine for youth to convey requests for emergency and non-emergency medical, dental and behavioral/mental health care services.</p>
<p>§ 1433. Requests for Health Care Services</p>	<p>add new subsection</p>	<p>The provision should include a requirement that youth can ask to contact or see a health care provider in the community that they are already connected with to assure continuity of care.</p>	<p><u>(g) Youth shall be informed of and provided the opportunity to contact and receive health care from a community based care provider.</u></p>
<p>§ 1435. Dental Care.</p>		<p>This section should conform to the standards of the American Academy of Pediatric Dentistry. We recommend that it be reviewed by dental professionals to ensure the appropriate standard of care.</p> <p>See American Academy of Pediatric Dentistry. Adolescent oral health care. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2021:267-76, https://www.aapd.org/globalassets/media/policies_guidelines/bp_adoleshealth.pdf.</p>	
<p>§ 1436. Prostheses and Orthopedic Devices.</p>		<p>We suggest that this section should be reviewed by medical professionals to ensure the appropriate standard of care.</p>	
<p>§ 1437. Mental Health Services.</p>	<p>Introduction</p>	<p>This provision should include requirements related to providing youth information about available mental health services.</p> <p>It must also address the scope of available mental and behavioral health services which, at a minimum, provide the level of care a youth would be entitled to access in the community if covered by Medi-Cal. If the purpose of these facilities is to include rehabilitation then they must provide at least the level of behavioral health services a youth would otherwise be eligible to receive.</p>	<p>The health administrator/responsible physician, in cooperation with the behavioral/mental health director and the facility administrator, shall establish policies and procedures to provide behavioral/mental health services <u>and shall develop youth friendly materials to make youth aware of the treatment and services available and how to access them.</u></p>

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§ 1437. Mental Health Services.	(c)	Youth who are detained and cannot leave the facility must have therapeutic services available if needed without any exception.	(c) therapeutic services and preventive services where resources permit;
	add new subsections	The mental health services provided must include arranging for continued treatment for youth who are already receiving treatment to avoid deterioration and to maintain health and wellness.	<u>(i) Identification of existing treatment needs and treatment providers;</u> <u>(j) making arrangements for youth to continue treatment with existing community based treatment providers for continuity of care to avoid deterioration.</u>
§ 1437.5. Transfer to a Treatment Facility	add new subsection	This section should contain a provision to require that the youth's parent, guardian and attorney are notified of the transfer to a treatment facility.	<u>(c) Provision of notice to the youth's parent, guardian, and attorney of record that the youth has been transferred to a treatment facility within two hours of the transfer.</u>
§ 1438. Pharmaceutical Management			
§ 1438. Pharmaceutical Management	add new subsection	This section should contain a provision to ensure that youth have sufficient medication when they are released and are connected with a community based provider.	<u>(d) in accordance with section 1351, the health administrator and responsible physician shall establish policies and procedures to ensure that youth who are receiving medication at the facility have sufficient medication upon release, have been connected with a community based treatment provider, and that any needed authorizations have been signed to assure continuity of care.</u>
§ 1439. Psychotropic Medications.		We recommend that this section be reviewed by pediatricians and psychiatrists with expertise in prescribing and administering psychotropic medication.	
§ 1439. Psychotropic Medications.	add new subsection	This section should contain a provision to ensure that youth have sufficient medication when they are released and are connected with a community-based provider.	<u>(e) in accordance with section 1351, the health administrator and responsible physician shall establish policies and procedures to ensure that youth who are receiving psychotropic medication at the facility have sufficient medication upon release, have been connected with a community based treatment provider, and that any needed authorizations have been signed to assure continuity of care.</u>
§ 1452. Collection of Forensic Evidence	add a new subsection	A policy should be developed so that youth are informed of the process for the collection of forensic evidence and any right they may have to consent or refuse its collection.	<u>(a) The health administrator, in cooperation with the facility administrator, shall establish policies and procedures assuring that forensic medical services, including drawing of blood alcohol samples, body cavity searches, and other functions for the purpose of prosecution are collected by appropriately trained medical personnel who are not responsible for providing ongoing health care to the youth.</u> <u>(b) The health administrator, in cooperation with the facility administrator, shall establish policies and procedures to assure that youth are informed of the procedures for the collection of forensic evidence and any rights they have to provide or refuse consent.</u>
§ 1453. Sexual Assaults.		This section should include direction to develop policy that will ensure that youth who are victims have access to a supportive adult who they identify. We also recommend that this section be reviewed by professionals and advocates with expertise in the response and treatment of sexual assault to ensure that policies and procedures do not compound the trauma the youth has faced.	The health administrator, in cooperation with the facility administrator, shall develop and implement policy and procedures for treating victims of sexual assaults, preservation of evidence, and for reporting such incidents to local law enforcement, <u>and ensuring that youth who are victims have access to a supportive adult throughout the process of investigation and treatment.</u> The evidentiary examination and initial treatment of victims of sexual assault shall be conducted at a health facility that is separate from the custodial facility and is properly equipped and staffed with personnel trained and experienced in such procedures.
Article 9. Food	Add Section	There should be additions to this article at relevant locations to include: 1. Religious and ethical dietary accommodations 2. To allow for youth participation in menu planning, meal preparation, and other food-related tasks. For committed youth, there must be requirements for their inclusion in these activities as a component of independent living skills development. 3. An acknowledgement of the importance of food to families and in culture. For committed youth, there should be requirements and standards for the inclusion of family members in meals and to allow for youth to dine with family members (subject only to safety issues), and to either have a policy regarding how and when food may be brought in by family or otherwise to allow family members to prepare food within the facility. 4. A prohibition on denial of the day's menu options or of a medical, religious or ethical diet to any particular youth for disciplinary reasons, convenience, or staffing or other non-medical reasons. And a clear statement that regularly available food (meals and snacks) may not be denied for these purposes nor the available food substituted with different food for these reasons. 5. Prohibiting staff from displaying, bringing, storing, or eating food in areas accessible to or viewable by youth unless that food is also available to youth.	
§ 1460. Frequency of Serving		This section should be revised to shorten the length of time between food offerings.	Food shall be offered to youth at the time of initial intake, shall be served to youth if more than 14 6 hours pass between meals, and shall be served to youth on medical diets as prescribed by the attending physician.
§ 1461. Minimum Diet.		This section should be revised so that snacks may complement and supplement a minimum diet, but may not be considered part of the minimum diet. The section should also be revised to conform to the updated USDA's Dietary Guidelines for Americans 2020-2025. According to these guidelines, older adolescent males need more calories than currently required in this section. Specifically, the guidelines state on page 84: " Adolescents Ages 14 Through 18: Adolescent females require about 1,800 to 2,400 calories per day and males require about 2,000 to 3,200 calories per day." https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf To ensure that no youth is under-fed, the regulations should require the upper end of this range be offered for all youth on a daily basis.	The nutritional requirements for the minimum diet are specified in the following subsections. Snacks may be included as <u>a supplement, but may not be considered</u> part of the minimum diet. A wide variety of foods should be served. ... <u>(e) Calories. Recommended daily caloric allowances for both females and males is a minimum of 2500 calories not to exceed 3000, and for males is a minimum of 3,200 calories.</u> Calorie increases with the exception of a medical diet may occur as collaboratively determined by the facility manager, dietician, food service manager and physician.
Article 10. Clothing and Personal Hygiene	Add Section	A section should be added to explicitly clarify that juvenile facilities may develop policies to allow for youth to wear and/ or select their own clothing, and to encourage such policies for committed youth. It should also be made clear that clothing cannot be distributed, selected, withheld or otherwise used for disciplinary purposes or in any manner that intentionally or knowingly causes embarrassment and distress. Relatedly, access to personal care items, personal hygiene, shaving, and hair care service cannot be denied or provided for disciplinary purposes or in any manner that intentionally or knowingly causes embarrassment and distress	

LETTER 2



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 assaulted 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

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.

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 arrhythmia, 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

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 hype¹⁶ 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.

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

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

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 harm 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,

A handwritten signature in blue ink, appearing to read "Erin Palacios", with a stylized flourish at the end.

Erin Palacios
Prisma Legal Center for Youth Justice, Executive Director

Attachment A

Code: Section: [Up^](#) [<< Previous](#) [Next >>](#) [cross-reference chaptered bills](#)[PDF](#) | [Add To My Favorites](#)Search Phrase: **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



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



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 NYC, for a fraction of the cost of the additional funding requested this year by NYC. 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 NYC's thirteen state owned facilities.⁴ The attorneys and social workers in our coalition have collectively represented more than 100 young people housed in NYC 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 NYC staff for speaking out. For some young people, sharing their stories meant revisiting past trauma and re-traumatization caused by NYC'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 NYC and use of force techniques by NYC staff, including the WRAP, pain compliance, and knee strikes.

The Coalition reviewed over a thousand pages of NYC documents regarding use of force in these facilities, including Incident Reports and medical records, as well as several videos of incidents inside NYC 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.

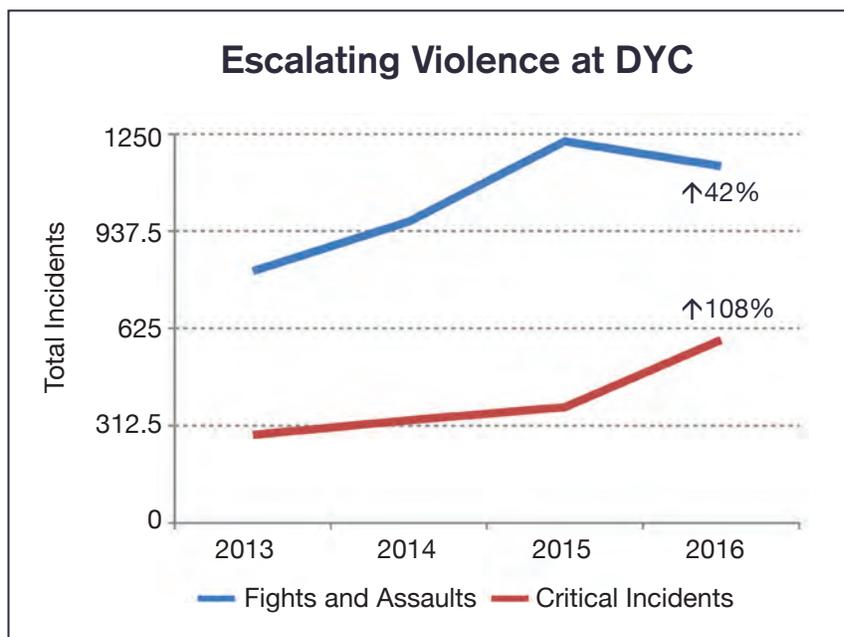
Increased Violence at DYC

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 incidents⁸ 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 NYC 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. NYC 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 Center³⁶

Because pain and fear re-traumatize already traumatized young people and impede the rehabilitation process, NYC’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 NYC produce and reflect a violent culture, and are obstacles to rehabilitation.³⁸ NYC 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 NYC documents strongly suggest that staff commonly use pain compliance as part of physical management, there is currently no publicly available information regarding how frequently NYC uses this technique. However, recently released NYC 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, NYC 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 NYC’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.



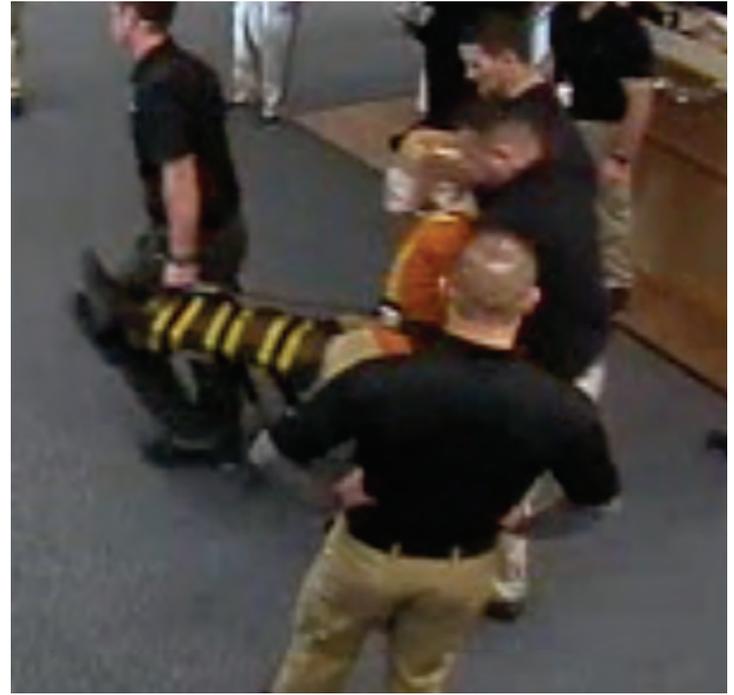
Child being placed in WRAP, spit mask and helmet at NYC facility.

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 NYC facilities.⁴³ The device is a full body restraint akin to a straitjacket.⁴⁴ To place a young person in the WRAP, NYC 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. NYC 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. NYC reports that during the thirteen month period from January 2016 through January 2017, NYC 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 NYC 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 breathe 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 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 January 2017, DYC staff placed a young person 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 NYC 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 NYC 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 NYC after it came to light that NYC 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 NYC’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 NYC 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 NYC 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

NYC also imposes isolation from programming and peers through “special management plans,” raising concerns that NYC 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. NYC 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 NYC 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 NYC 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 NYC calls “sleeping hours.”⁸³ NYC records indicate that, at some NYC facilities, sleeping hours begin at 8:30 pm. NYC 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 NYC 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. NYC 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 NYC 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

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



Photo from instructional pressure point instructional video.⁹⁸

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, NYC 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 NYC 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 NYC 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** NYC 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 NYC records document incidents in which youth refused to go into a locked room alone, and staff responded physically¹¹⁴—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 NYC 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 NYC custody, placement in a locked room is especially traumatic because NYC has previously held them in solitary confinement for long periods of time.

Some young people currently held in NYC facilities were previously subjected to illegal NYC "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 NYC 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 NYC 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

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

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.

After an investigation revealed that NYC was illegally placing youth like David in isolation, NYC 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 NYC 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



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

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

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 NYC 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 NYC facilities is consistently much higher than the goal set by NYC 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 NYC 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 NYC refused to provide it.*

“It’s like, is this a treatment center, or a prison?”¹⁵⁴

Because of NYC’s punitive approach, many young people are not forming rehabilitative relationships with NYC 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 NYC staff as a whole. One youth simply stated, “they didn’t like me.”¹⁵⁵ Another commented that NYC 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 NYC 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 NYC was out to get me. I feel like NYC don’t want me.”¹⁵⁸ Youth overwhelmingly reported that NYC 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 NYC 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 NYC 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 Services¹⁶³

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

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 NYC facilities, where youth wear institutional scrubs or uniforms, are placed in locked cells with prison blankets, and gather in bleak and institutional common areas.

"If you treat a kid like an inmate, he's going to act like an inmate."

—Statement by youth during MDYS facility tour.

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.

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

“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.”

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 NYC 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 NYC leadership publicly promotes trauma-informed care based on positive reinforcement and relationship based care for youth,¹⁷³ NYC 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 NYC.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 NYC 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=c3RhZGUuY28udXN8Y2Rocy1jb21tfGd4OjJiMjRiNzQwM2VlNzQ1NjE>; *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 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 spray 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_humhr2_0.pdf

¹¹ *Id.*, pp. 9- 10.

¹² NYC 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 NYC 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 NYC 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%. NYC 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 NYC with previous probation involvement has been 83%, 88%, 83%, 81%, 82%, NYC 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.njcn.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.njcn.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.saferestrains.com/site/>

⁴⁴ See <http://www.saferestrains.com>.

⁴⁵ See note 39, *supra* at p. 3.

⁴⁶ See <http://www.saferestrains.com/site/CustomerListUSA?Custlist%5Bagency%5D=Juvenile&Custlist%5Blocation%5D=&yt0=Search+US+Customers>; <http://www.saferestrains.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: 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 of 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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The principal drafter and lead researcher is Elizabeth Logemann, ACLU of Colorado Child Safety Attorney. Other contributing researchers, drafters and editors include: Rebecca Wallace, ACLU of Colorado Staff Attorney and Policy Counsel; Mark Ivandick, Managing Attorney of Disability Law Colorado; Kelsey Lesco, Facilities Staff Attorney for Disability Law Colorado; Ivy Palu, Juvenile Social Worker with the Office of the Colorado State Public Defender; and Ann Roan, State Training Director for Juvenile Defense and Complex Litigation for the Office of the Colorado State Public Defender.

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**American Civil Liberties
Union of Colorado**
aclu-co.org

**Disability Law
Colorado**
disabilitylawco.org

**Office of the Colorado
State Public Defender**
coloradodefenders.us

**Colorado Juvenile
Defender Center**
cjdc.org

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

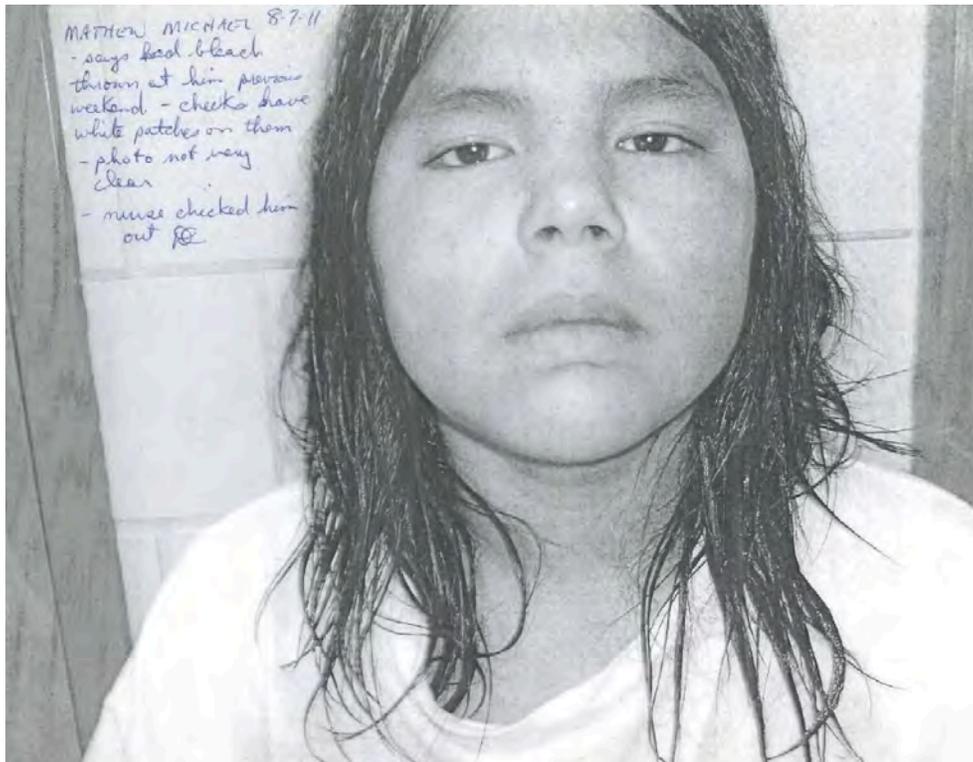
Matthew Michel's family is from Fishing Lake First Nation, where he is a band member. But he grew up in Saskatoon, 230 kilometres to the west.

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)

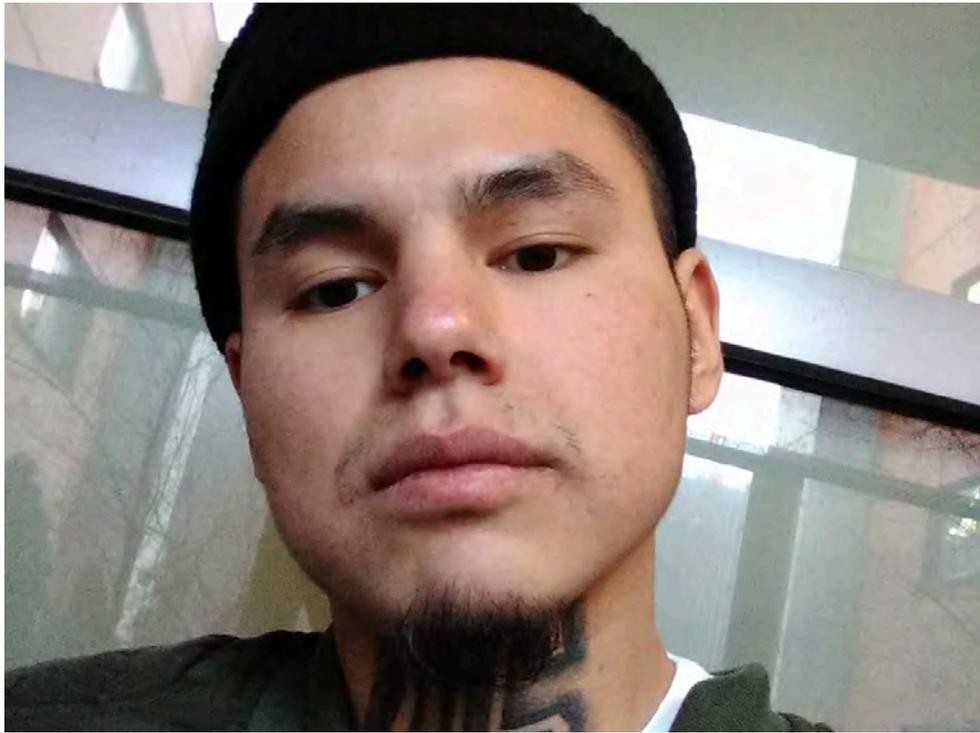
As he grew older, his life moved between the streets of Saskatoon and the walls of the province's youth correctional system.

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)

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.

McFadyen 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



A Tradition of Stewardship
A Commitment to Service

Probation Department
Juvenile Hall

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:	<i>Mary Butler</i>
			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/combatative 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/combatative youth
- To limit violent/combatative youth from causing injury to themselves or others
- To prevent violent/combatative youth from causing property damage by kicking
- When conventional methods of restraint are not effective
- In transportation of violent/combatative youth
- To prevent suicidal youth from harming themselves
- To assist with room extraction from violent/combatative 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/combatative 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 breathe.
- 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
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Time:		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Staff:		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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**WRAP
AUTHORIZATION AND OBSERVATION RECORD**

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

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Staff: IS II Hourly Review		

MEDICAL/MENTAL HEALTH OBSERVATION: 1 HOUR OBSERVATION:

TIME/STAFF	LOCATION	OBSERVATIONS
Time:		
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**WRAP
AUTHORIZATION AND OBSERVATION RECORD**

PROBATION STAFF 15-Minute Observation Record:

Time/Staff	Location	Observations
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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: _____
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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 Sheriff'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

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 <input type="checkbox"/> Female <input type="checkbox"/> *Transgender <input type="checkbox"/> * Intersex <input type="checkbox"/>	D.O.B.:	JJCC File#:
Date:	Time:	Location of Search:
JUSTIFICATION FOR STRIP SEARCH		
Current Charges involve weapons, controlled substances or violence? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If strip search is due to the youth's current charges, officer may skip reasonable suspicion section</i>		Applicable Charges(s):
Reasonable Suspicion Mark all boxes that apply below <u>AND</u> provide justification supporting reasonable suspicion (Articulable Facts):		
<input type="checkbox"/> Unusual conduct	<input type="checkbox"/>	
<input type="checkbox"/> Excessive nervousness	<input type="checkbox"/>	
<input type="checkbox"/> Prior history of bringing contraband into the facility	<input type="checkbox"/>	
<input type="checkbox"/> Discovery of incriminating matter during pat-down search	<input type="checkbox"/>	
<input type="checkbox"/> Evasive or contradictory answers/statements	<input type="checkbox"/>	
<input type="checkbox"/> Other (Articulable Facts):		
Officer Requesting Strip Search (Print Name and title): Signature:		
Shift Supervisor Approving Strip Search (Print name and title): Strip Search <input type="checkbox"/> Transgender/Intersex Strip Search <input type="checkbox"/> *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 <input type="checkbox"/> No <input type="checkbox"/>		
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

Riverside County Probation Department

Policy Manual

Use of Physical Restraints for Movement and Transportation within the Facility

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.

Use of Physical Restraints for Movement and Transportation within the Facility

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.

Riverside County Probation Department

Policy Manual

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

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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):

- Past escape: Date of escape: _____
- Current threat to escape
- Past threat to harm self or others: Date of incident: _____
- Current threats to harm self or others

Restraint Options

Shackles
 Shackles
 Shackles, Waist Chains, Handcuffs
 Shackles, Waist Chains, Handcuffs

3.0 Qualifying Factors (AMC-YTEC):

- Current threats to escape
- Current threats to harm self or others
- Youth is being removed from the program

Restraint Options

Shackles
 Shackles, Waist Chains, Handcuffs
 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: _____

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.

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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. All Staff:
 - 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. Probation Corrections Officers (PCOs):
 - 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.

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- 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.

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- 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.

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Restraint Devices in Juvenile Detention and Assessment Centers (JDACs) and Treatment Facilities (TFs) (Title 15, Section 1358, 1358.5)

- 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.



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

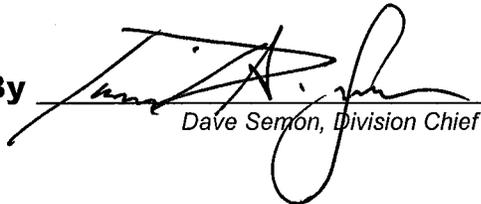
A. The use of restraints shall never be applied or used as punishment, retaliation, treatment, or for disciplinary purposes. Staff must take immediate action to stop the objectively unreasonable use of restraints from occurring. Staff will be subject to administrative discipline, up to and including 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


Dave Semon, Division Chief

Date

9/30/19