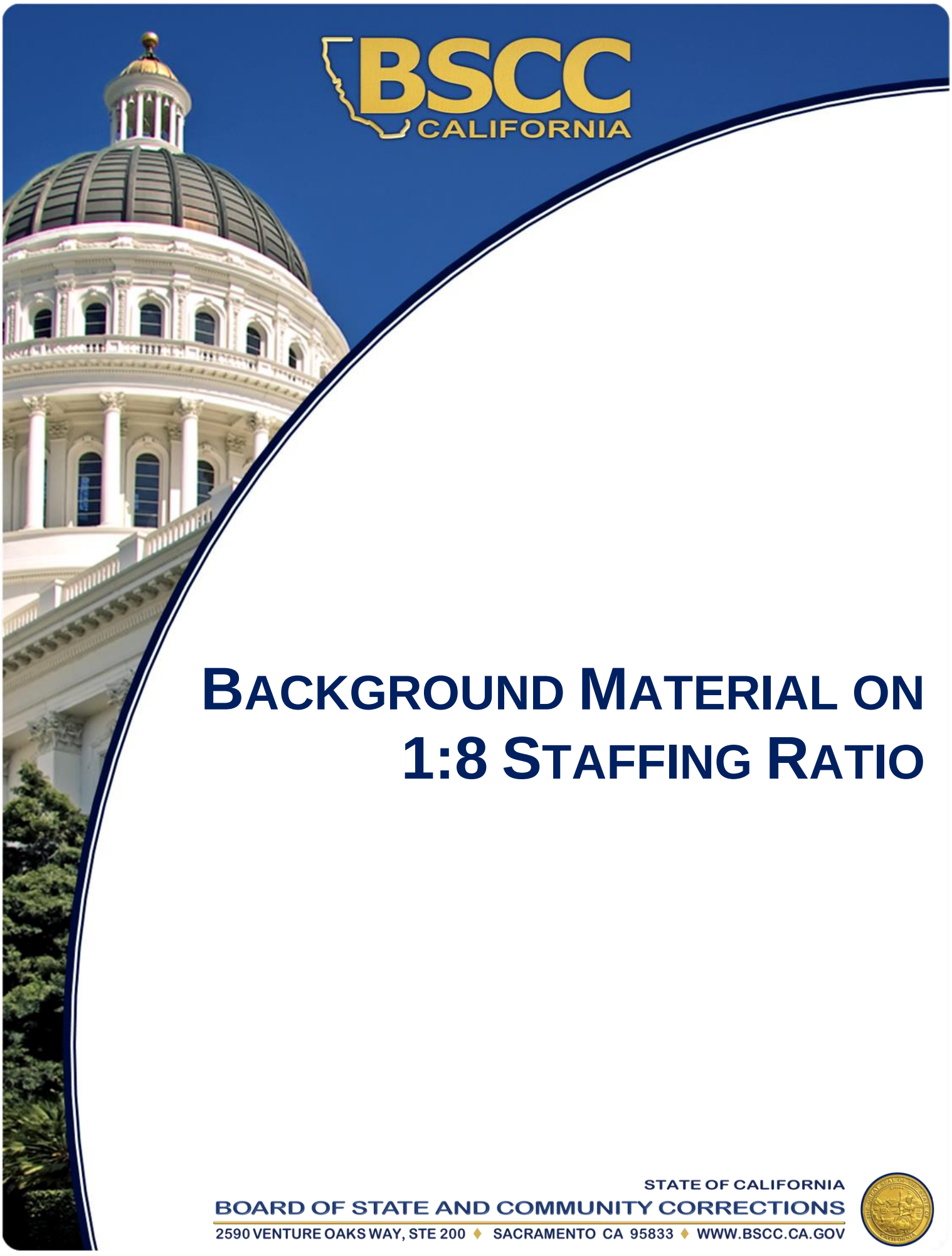

BSCC
CALIFORNIA

BACKGROUND MATERIAL ON 1:8 STAFFING RATIO

STATE OF CALIFORNIA
BOARD OF STATE AND COMMUNITY CORRECTIONS
2590 VENTURE OAKS WAY, STE 200 ♦ SACRAMENTO CA 95833 ♦ WWW.BSCC.CA.GOV

PJDC
PACIFIC JUVENILE DEFENDER CENTER

Ensuring excellence in juvenile defense and promoting justice for all children

January 19, 2018

By Electronic Mail

Allison Ganter, Deputy Director (FSO)
Board of State and Community Corrections
2590 Venture Oaks Way Suite 200
Sacramento, CA 95833

Re: Materials on Staffing Ratios for Upcoming BSCC Meeting

Dear Allison:

This is to request that you distribute to the Board for the February 8, 2018 meeting, the materials on 1:8 staffing ratios that I sent to you by email on December 13, 2017. It seems important for the Board to have this background material because a number of them may not be familiar with the basis for the standard, and the different considerations that apply in the juvenile system because of its rehabilitative purposes and the many additional duties of staff in juvenile facilities.

As you know, the staffing ratio issue was one of the issues the working groups and Executive Steering Committee were unable to resolve during this summer's Title 15 Juvenile Facilities Regulation Revision Process, and one of the Executive Steering Committees asked what the basis for 1:8 was? I subsequently furnished 17 documents that encompassed a variety of sources, including materials from the Prison Rape Elimination Act, national standards, and research:

1. Professional Standards

- National Partnership for Juvenile Services
- National Institute of Corrections
- JDAI standards

2. Research

[These are materials showing that better staffing ratios reduce harm - in reducing sexual harassment or abuse, assuring that educational services are provided, and stemming use of control measures and use of locked room time – this is just a sampling of what is available.]

- PREA Report on Sexual Victimization in Juvenile Facilities
- CJCA Blog on how staffing relates to sexual abuse issues
- Comments by advocacy groups on the need for staffing ratios
- AP article: More sex abuse at understaffed juvenile facilities

- EDJJ report on education in juvenile facilities (short reference the impact of staffing on education services)

3. Prison Rape Elimination Act (PREA)

- What the standards are and excerpts from the regulations and comments -- cost was considered, and many jurisdictions already complied (based on pre-2012 information).

- Excerpts from PREA Resource Center on applicability of PREA to county facilities -- PREA does not force compliance in local facilities, but this is only in relation to the funding enforcement sanctions (losing 5% of federal funding). The regulations do apply in local juvenile facilities.

4. Legal Cases

The PREA Final Rule excerpt (above) notes that 1:8 is the standard used by DOJ. Examples include the DOJ Los Angeles Camps Finding Letter (2008).

5. California Examples of Understaffing Reports

- LA Camps findings letter and audit finding continuing deficiencies despite DOJ involvement
- Alameda County juvenile hall - understaffing causes more use of force
- Fresno County - understaffing is stressful and harmful to staff

I am planning to be present at the February 8 meeting, so please let me know if it would be useful for me to explain the materials to the Board at that time. Thank you for your consideration.

Sincerely,

/Sue Burrell/

Sue Burrell,
Member, Executive Steering Committee,
Title 15 Regulations Revision Process 2017

Policy & Training Director
Pacific Juvenile Defender Center

PACIFIC JUVENILE DEFENDER CENTER

Why the BSCC Should Support 1:8 Staffing Ratios in the Title 15 Minimum Standards for Juvenile Facilities

1. It is the accepted professional standard nationally.

The National Partnership for Juvenile Services position paper, *Minimum Direct Care Staff Ratio in Juvenile Detention and Correctional Facilities* (October 2013), calls for "regulation, policy, procedure and practice [that] ensure a minimum ratio of one direct care staff to no more than eight (1:8) juveniles during waking hours, and a ratio of one direct care staff member to no more than sixteen (1:16) juveniles during sleeping hours, with a minimum of two direct care staff on duty at all times regardless of population."

The Council of Juvenile Correctional Administrators *Toolkit: Reducing the Use of Isolation* (October 2015), p. 8, calls for facilities to "[m]aintain staff-to-youth ratios of at least 1:8 (ideally 1:6) during waking hours, and 1:12 during sleeping hours (counting only staff engaged in continuous and direct supervision of youth).

The National Institute of Corrections *Desktop Guide to Quality Practice for Working with Youth in Confinement* provides that "[e]ach secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete circumstances, which shall be fully documented, " and also notes that "to ensure safety and security of both staff and youth while delivering specific treatment programs, a facility may need to exceed those standards."

The Juvenile Detention Alternatives Initiative standards, *Juvenile Detention Facility Assessment: 2014 Update*, call for "at least a 1:8 ratio of direct care staff to youth during the hours that youth are awake," and "at least a 1:16 ratio of direct care staff to youth during the hours that youth are asleep."

2. It will be the standard used in litigation over inadequate conditions.

Under *Youngberg v. Romeo* (1982) 457 U.S. 307, when conditions of confinement are challenged under the 14th Amendment, courts consider whether the challenged condition represents a "substantial departure from accepted professional judgment, practice, or standards." Clearly, 1:8 is the accepted standard. Department of Justice litigation has already recognized 1:8 as the standard in a number of cases, including its Los Angeles case.

BSCC should not acquiesce in a standard that does not protect juvenile facilities against liability.

3. PREA requires 1:8 staffing.

Apart from the *Youngberg* standard, the Prison Rape Elimination Act specifically calls for 1:8 staffing. The federal regulations require that:

> Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance. (United States Department of Justice Final Rule (May 17, 2012), 28 C.F.R. § 115.313(c).

A PREA Resource Center FAQ explains that "PREA standards apply equally to locally operated facilities, such as lockups, jails, juvenile detention centers, and locally operated residential community confinement facilities. The statute imposes certain financial consequences on states that do not comply with the standards. However, for local facilities or facilities not operated by the state, PREA provides no direct federal financial penalty for not complying." In other words, the staffing ratios do apply to juvenile facilities, but they are not included in the financial penalties provided for in the law. The same FAQ makes the *Youngberg* point already presented -- that "private civil litigants might assert noncompliance with PREA standards as evidence that facilities are not meeting constitutional obligations."

4. Research strongly supports staffing levels as critical in preventing harm.

Understaffing is widely recognized as a contributing factor in failing to prevent sexual abuse and harassment, as well as failure to provide access to required services such as education, outdoor recreation, and visiting.

5. Existing standards no longer reflect the responsibilities of juvenile facilities.

Title 15 staffing standards were developed in an earlier era, before the advent of many of the current responsibilities facing juvenile facilities. Today's juvenile facilities must grapple with:

- Increased post-disposition commitments to juvenile halls
- Higher level youth being retained locally since realignment
- Increased numbers of youth held for long periods pending judicial transfer hearings
- Increased requirements to provide treatment services, trauma informed care, positive behavior management
- Many more youth with mental health issues or incompetence to stand trial
- Changed standards on room confinement, treatment of suicidal youth, and other restrictions on control measures that call for greater staff monitoring and involvement

6. <u>These ratios are already met in many facilities.</u>

The PREA Resource Center reported in a February 7, 2013, that many states and localities, as a matter of law or policy, already had minimum staffing ratios in juvenile settings; and that some state and local facilities exceed the minimum staffing. Although we do not have precise data in California, there is anecdotal evidence that many counties already meet or exceed the 1:8 staffing ratios.

7. <u>Although many facilities already meet the standard, there are ongoing examples of understaffing problems in California.</u>

A quick googling of problems in juvenile facilities in the past several years reveals numerous situations in which understaffing has been a factor in increased use of force; creating stressful situations for staff forced to work overtime; and failure to prevent sexual abuse.

8. <u>Government must provide adequate resources to do Its required work.</u>

When the PREA juvenile staffing ratio provisions were adopted, there was extensive study of the potential costs to state and local systems. Ultimately, the Department of Justice determined than many facilities were already in compliance, and also that the cost of defending against allegations of harassment or abuse would offset and costs in providing the required staffing.

Beyond this, a large body of law has established that even when providing a required service may result in additional cost, governments must provide adequate resources to comply with legally mandated duties. (See *Scott v. County of Los Angeles* (1994) 27 Cal.App.4th 125, 146; and cases cited in *Morris v. Harper* (2001) 94 Cal.App.4th 52, 61.) If counties are going to run juvenile facilities, they need to provide the resources to do the job right.

<u>Proposal: BSCC should adopt the 1:8 staffing ratio option and provide an "Alternative Means of Compliance" for facilities that would experience hardship.</u>

In order to address concerns that some counties, especially small or rural counties, may be unable to meet the 1:8 staffing ratios because of fiscal restraints, or for other legitimate reasons, the Board should direct Legal Counsel, with BSCC staff assistance, to draft language providing an alternative means of compliance (placed in 15 C.C. R. §1304 or as a new stand-alone §1304.5), allowing staffing ratio adjustment under specified circumstances. The Board should set a short time frame with a process for approval so this can move forward with the other regulations.

The administrative law process that will unfold over the next year provides ample opportunity for expression of any concerns through written and oral comments. This seems preferable to postponing this decision until a future revision cycle – effectively another 3 years.

Prepared by Sue Burrell, Member of the Title 15 Revisions Process Executive Steering Committee; Member of the BSCC Juvenile Justice Standing Committee; Policy and Training Director, Pacific Juvenile Defender Center (Jan. 25, 2018)

Background Material on 1:8 Staffing Ratio
Table of Contents

JDAI Standards on Staffing 2014

Juvenile Detention Alternatives Initiative: A Project of the Annie E. Casey Foundation

Juvenile Detention Facility Assessment: STANDARDS INSTRUMENT

(2014 UPDATE)

Volume 2, Chapter III, section B, page 68 requires that:

B. STAFFING

1. There are sufficient staff at the facility to provide adequate and continuous supervision of youth. Staffing is adequate to provide for visitation, transportation to health care appointments (on-site and off-site) and access to school programming and other scheduled activities.

2. There is at least a 1:8 ratio of direct care staff to youth during the hours that youth are awake. There are sufficient available staff (on-site or on-call) beyond the 1:8 ratio to provide safe and appropriate supervision for youth with special needs or special security concerns. The ratio is calculated based on the number of direct care staff supervising the general population. Direct care staff are stationed inside living units where they can directly see, hear and speak with youth. The ratio does not include staff supervising youth from control centers or via video monitoring. Staffing in specialized care units, such as medical, mental health and special handling units that generally require more intensive staffing is not factored into these calculations. The facility does not depart from these staffing levels except in exigent circumstances, which are documented.

3. There is at least a 1:16 ratio of direct care staff to youth during the hours that youth are asleep. In addition to the required number of direct care staff, there is always at least one other staff member inside the facility who can assist in an emergency or provide relief to direct care staff. The facility does not depart from these staffing levels except in exigent circumstances, which are documented.

4. The facility uses cameras or other video technology to monitor living units and other areas of the facility. Cameras and other video technology supplement, but do not replace, direct staff supervision.

5. The facility has developed, implemented and documented a staffing plan. The facility reviews the plan at least annually. The staffing plan includes a replacement factor that accurately accounts for staff training, foreseeable vacancies, staff vacation, family and medical leave and other absences. The plan provides sufficient staff to avoid involuntary double-shifts and mandated overtime. If the facility routinely relies upon mandated overtime, administrators re-evaluate and revise the staffing plan to address the problem. (Additional detail on PREA compliance at 28 CFR §§ 115.313(a), (d).)

6. The facility complies with its staffing plan except during limited and discrete exigent circumstances and staff document any deviations from the plan during such circumstances.

7. Staff do not sleep while on duty.

8. Backup staff support is immediately available to respond to incidents or emergencies.

9. At least one female staff member is on duty in living units housing girls and at least one male staff member is always on duty in living units housing boys. Staffing levels of same-gendered staff are sufficient so that staff can avoid viewing youth of the opposite gender in a state of undress, except in exigent circumstances.

10. The facility has adequate staff to provide required direct supervision of youth during times when some staff are in other areas of the facility, such as the visitation area.

11. The facility has adequate staff with the language capacity to provide limited English proficient youth with meaningful access to programs and activities. The facility keeps accurate records of staff able to speak other languages.

PREA Report on Sexual Victimization in Juvenile Facilities 2010

Report on Sexual Victimization in Juvenile Correctional Facilities

Review Panel on Prison Rape

October 2010

Review Panel on Prison Rape

Report on Sexual Victimization in Juvenile Correctional Facilities

The Review Panel on Prison Rape's *Report on Sexual Victimization in Juvenile Correctional Facilities* is available online at http://www.ojp.usdoj.gov/reviewpanel/reviewpanel.htm. Obtaining prior permission is not necessary for copying and distributing this report. To contact the Review Panel on Prison Rape, email PREAReviewPanel@usdoj.gov or call (202) 307-0690.

Review Panel on Prison Rape, U.S. Department of Justice, Washington, DC (October 2010)

Review Panel on Prison Rape
Report on Sexual Victimization in Juvenile Correctional Facilities

Executive Summary

In accordance with the Prison Rape Elimination Act (PREA) of 2003, the Bureau of Justice Statistics (BJS) published *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09* (Jan. 2010). The report, the first of its kind that relied on data from juvenile offenders, surveyed the incidence of sexual victimization in the United States by facility.

Mindful that even one incident of sexual victimization of a youth in custody is unacceptable, the Review Panel on Prison Rape (Panel) found that BJS' report indicated that violent sexual assault in juvenile facilities was relatively rare and facility staff, for the most part, did not victimize juvenile offenders.

Also in accordance with PREA, the Panel held public hearings in Washington, DC, on June 3-4, 2010, to identify, based on the BJS' survey of juvenile facilities, the common characteristics of the following: (1) victims and perpetrators, (2) two facilities with the lowest prevalence of sexual victimization, and (3) three facilities with the highest prevalence of sexual victimization. In light of the hearing testimony and other collected data, the Panel is issuing this Report, which offers general observations, identifies common themes, and poses questions for further study.

General Observations

Given the small number and the unique characteristics of each selected facility, the Panel recognizes the limits in making generalizations. The Panel also notes that some widely recommended practices do not necessarily lead to positive results. For example, the two facilities with the lowest prevalence of sexual victimization did not have express PREA policies.

Common Themes

Culture

Institutional culture plays an important part in creating a safe environment. Facilities that foster a therapeutic model, emphasizing rehabilitation, were more likely to have less prevalence of sexual victimization than facilities that rely on a corrections model, emphasizing punishment.

Staff Training

The administrators of all of the selected facilities agreed on the need to train staff on the perils of crossing professional boundaries that lead to inappropriate relationships with youth.

Facility Size

Small facilities tend to have less prevalence of sexual victimization.

Unresolved Institutional Questions that Warrant Further Study

- What are the factors that lead female staff to become involved emotionally or sexually with male juveniles?
- What is the most effective training to encourage healthy professional boundaries?
- What are the best practices for maintaining the appropriate professional boundaries between staff and juvenile offenders?
- How can institutions better screen staff to avoid sexual misconduct?
- For youth in custody, what are the common characteristics of victims and perpetrators of sexual victimization?
- How can juvenile justice systems assist staff falsely accused of sexual misconduct?
- What are the factors that contribute to youth-on-youth sexual assault in juvenile justice facilities?
- Taking into account youth development, what are healthy, realistic expectations for youth in managing sexual expression while in custody?

The Review Panel on Prison Rape
Report on Sexual Victimization in Juvenile Correctional Facilities

In accordance with the Prison Rape Elimination Act (PREA) of 2003,[1] the Review Panel on Prison Rape (Panel) conducted public hearings and gathered relevant data based on the survey that the Bureau of Justice Statistics (BJS) published in January of 2010 on the incidence of sexual victimization in juvenile correctional facilities in the United States, *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09*.[2] The Panel presents this Report, which contains its observations and recommendations, to assist both practitioners and advocates in the juvenile justice community to eliminate sexual victimization in the nation's juvenile correctional facilities.[3]

Background

On January 1, 2010, with delegation from the Attorney General, Laurie Robinson, Assistant Attorney General for the Office of Justice Programs, appointed the current Panel members, who are Dr. Reginald Wilkinson, Panel Chairperson, President and Chief Executive Officer of Ohio College Access Network; Ms. Gwendolyn Chunn, retired Executive Director, Juvenile Justice Institute, Center for Criminal Justice Research and International Initiatives, Department of Criminal Justice, North Carolina Central University; and Ms. Sharon English, retired Deputy Director, California Youth Authority, Office of Prevention and Victim Services.

The Attorney General, through BJS, identified juvenile justice facilities as one of the prison categories under PREA meriting a survey on the incidence of sexual victimization.[4] PREA entrusted to the Panel the mission of holding annual public hearings—in this instance, on juvenile justice facilities—to assist BJS in identifying the common characteristics of (1) victims and perpetrators of sexual victimization, (2) the two correctional facilities with the lowest incidence of prison rape, and (3) the three correctional facilities with the highest incidence of prison rape.[5]

BJS Juvenile Report

In a society that values the dignity of each individual, any incident of sexual victimization of a youth in custody is unacceptable. From this perspective, the Panel reviewed the *BJS Juvenile Report* and noted that violent sexual assault in juvenile facilities is relatively rare and that facility

[1] 42 U.S.C. §§ 15601-15609 (2006) (Pub. L. No. 108-79, 117 Stat. 972).
[2] BJS, *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09* (Jan. 2010) (A. Beck et al.), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/svjfry09.pdf [hereinafter *BJS Juvenile Report*].
[3] For general information on the juvenile justice system in the United States, see Appendix A.
[4] 42 U.S.C. § 15603(c)(4).
[5] *Id.* § 15603(b)(3)(A).

staff members, for the most part, do not victimize juvenile offenders. The Panel commends juvenile justice administrators who have, as a whole, worked hard toward eliminating sexual victimization in their facilities.

The *BJS Juvenile Report* found that of the estimated 26,551 adjudicated youth held in state facilities or large non-state facilities in 2008-09, about 12.1% (3,220) reported experiencing sexual violence.[6] About 2.6% of these reported incidents involved other youths, whereas about 10.3% involved facility staff members.[7] For the reported youth-on-youth incidents, 2.0% involved nonconsensual acts;[8] for the reported staff-on-youth incidents, 4.3% involved force and 6.4% did not involve force.[9] Facilities that housed only female youth offenders had the highest rates of youth-on-youth victimization (11.0%), whereas facilities that housed only male youth offenders had the highest rates of staff sexual misconduct (11.3%).[10]

Small juvenile facilities had lower victimization rates than larger ones.[11] Facilities that held between ten and twenty-five adjudicated youth had the lowest overall rates of sexual victimization (6.3%), a result of the relatively low rate of staff sexual misconduct (2.7%), whereas facilities that held one hundred or more adjudicated youth had the highest overall rates of sexual victimization (12.9%).[12]

The more time that youth offenders spent in a juvenile facility, the more likely they were to experience sexual victimization: for youth held under five months, the victimization rate was 7.4%; for youth held between five and six months, the victimization rate was 12.7%; and for youth held between seven and twelve months, the victimization rate was 14.2%.[13]

The *BJS Juvenile Report* found that the rate of sexual victimization varied among youth depending on a variety of characteristics, including some of the following: males were more likely than females to experience sexual activity with staff; females were more likely than males to report forced sexual activity with other youth; black youth were more likely than white youth to experience sexual victimization by facility staff; youth with a sexual orientation other than heterosexual were significantly more likely to experience sexual victimization than heterosexual youth; youth who had a prior history of sexual assault were twice as likely to report sexual victimization than youth with no history of sexual assault; and among youth who reported being victims of sexual assault at another facility, two-thirds reported being sexually victimized at the

[6] *BJS Juvenile Report* 3 & tbl.1.
[7] *Id.*
[8] The *BJS Juvenile Report* excluded from its reporting of sexual victimization sexual acts between youth in which there was no report of force. *Id.*
[9] *Id.*
[10] *Id.* 10 & tbl.7.
[11] *Id.*
[12] *Id.*
[13] *Id.*

facility that currently housed them.[14] For youth reporting youth-on-youth incidents of sexual victimization, 81% reported more than one incident, and 43% reported more than one perpetrator.[15] For youth reporting staff-on-youth incidents of sexual victimization, 95% reported that the perpetrator involved a female staff member.[16] In regard to incidents of staff sexual misconduct, 92.0% involved male youth and female staff members; 1.7% involved male youth and male staff members; 2.5% involved male youth and both male and female staff members; 3.0% involved female youth and male staff members; 0.0% involved female youth and female staff members; and 0.8% involved female youth and both male and female staff members.[17] In 2008, males made up 91% of all adjudicated youth in the sampled facilities; and in facilities under state jurisdiction, females represented 42% of the staff.[18] Victims of staff sexual misconduct reported that for incidents involving physical force or other forms of coercion, 14% of the perpetrators were male, whereas for incidents that did not involve any force, 4% of the perpetrators were male.[19] Nearly all youth (95%) who reported being a victim of staff sexual misconduct reported that the incident did not result in physical injury.[20]

National Prison Rape Reduction Commission and National Standards

In addition to the Panel, PREA created the National Prison Rape Elimination Commission (NPREC or Commission)[21] and charged it with the task of conducting a comprehensive study on the impact of prison rape on communities, social institutions, and every level of government and of assessing the relationship between prison rape and prison conditions.[22] According to the scheme set forth in PREA,[23] the Commission held public hearings and then published a report of its findings with recommendations for national standards for reducing prison rape.[24] The Commission disbanded shortly after the publication of its report.

According to PREA, the Attorney General is to rely on the Commission's recommendations in issuing regulations that establish "national standards for the detection, prevention, reduction, and punishment of prison rape."[25] As of the date of the writing of this Report, the Justice Department is in the process of reviewing the Commission's recommended standards.

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[14] *Id.* 10, 11 & tbl.8.
[15] *Id.* 12 & tbl.9.
[16] *Id.* 13 & tbl.11.
[17] *Id.*
[18] *Id.* 13.
[19] *Id.*
[20] *Id.* 14 & tbl.12.
[21] 42 U.S.C. § 15606(a).
[22] *Id.* § 15606(d).
[23] *Id.* § 15606(d)(3).
[24] NATIONAL PRISON RAPE ELIMINATION COMMISSION REPORT (June 2009), *available at* http://www.cybercemetery.unt.edu/archive/nprec/20090820154816/http://nprec.us/publication/.
[25] 42 U.S.C. § 15607(a)(1).

Mindful of the Commission's thorough recommendations and the Justice Department's current posture in issuing regulatory national standards, the Panel recognizes that its mission differs from that of the Commission. Relying on the surveys of correctional institutions that BJS produces, the Panel has focused on its role in identifying the common characteristics of facilities with the highest incidence of sexual victimization and the facilities with the lowest incidence. In undertaking this task, the Panel may be able to provide insight into the results of BJS' surveys, to highlight examples of promising practices that complement the work of the Commission, and to suggest topics for further study.

Selection of Juvenile Justice Facilities for the Public Hearings

The *BJS Juvenile Report* was unable to provide an exact ranking of juvenile justice facilities in the United States based on the incidence of sexual victimization because the study relied on a sampling of youth responses at 195 juvenile facilities rather than on a complete enumeration.[26] Nonetheless, the *BJS Juvenile Report* identified eleven facilities with the lowest prevalence of sexual victimization and thirteen facilities with the highest.[27] Relying on this information as a starting point, the Panel selected the following institutions to appear at the PREA-mandated public hearings: the two facilities representing the lowest incidence of sexual victimization were (1) the Fort Bellefontaine, Missouri, Campus (Ft. Bellefontaine) and (2) the Rhode Island Training School (RITS); the three facilities representing the highest incidence of sexual victimization were (1) the Pendleton, Indiana, Juvenile Correctional Facility (Pendleton); (2) the Woodland Hills, Tennessee, Youth Development Center (Woodland Hills); and (3) the Corsicana, Texas, Residential Treatment Center (Corsicana).

The Panel chose Ft. Bellefontaine because it had a high response rate with no reported incidents of sexual abuse.[28] The Panel was also interested in learning more about Ft. Bellefontaine because the Missouri Department of Social Services (MDSS), which operates Ft. Bellefontaine, had another facility listed in the *BJS Juvenile Report* with one of the lowest reported incidence of sexual victimization.[29] The Panel chose the RITS because it had few reported incidents of sexual abuse; it housed both male and female juvenile offenders; and in comparison to other low-incidence facilities that serve both males and females, it had a relatively large number of respondents.[30] The Panel chose Pendleton because it had the highest rate of reported sexual victimization,[31] the second highest rate of reported sexual victimization by facility staff,[32] and the third highest rate of reported staff sexual misconduct with force.[33] One of the factors that

[26] *BJS Juvenile Report* 4.
[27] *Id.* 4, 5.
[28] *Id.* 5 tbl.3.
[29] *Id.* 4 tbl.2 (Ft. Bellefontaine and Montgomery City Youth Center).
[30] *Id.* 5 tbl.3.
[31] *Id.* 4 tbl.2.
[32] *Id.* 8 tbl.5.
[33] *Id.* 9 tbl.6.

contributed to the Panel's decision to select Pendleton was that the Indiana Department of Correction (IDOC), which operates Pendleton, also had another facility that the *BJS Juvenile Report* identified as having one of the highest rates of sexual victimization.[34] The Panel chose Woodland Hills because of the high rate of reported sexual victimization, the relatively large number of respondents, and the relatively high response rate in comparison to other high-incidence facilities that required juvenile offenders to obtain parental/guardian consent (PGC) to participate in BJS' survey.[35] The Panel chose Corsicana because it had the fifth highest rate of reported sexual victimization,[36] the sixth highest rate of reported sexual victimization by facility staff,[37] and the third highest rate of reported juvenile-on-juvenile sexual victimization.[38]

Hearings on Sexual Victimization in Juvenile Correctional Facilities

After selecting the facilities to appear at the hearings, the Panel sent data requests to all of the invited facilities.[39] On receiving the responses from the facilities, the Panel prepared a chart that compares the facilities' responses.[40] The Panel and its staff also conducted onsite visits to all of the facilities invited to the hearings, touring the buildings and meeting informally with administrators.

The Panel conducted two public hearings on June 3-4, 2010, at the Office of Justice Programs Building in Washington, DC.[41]

This Report presents each of the five facilities invited to the public hearings, providing a brief description of each one along with the facility's explanation for its either high or low incidence of sexual victimization. Taking these data into account, the Panel's Report offers general observations, identifies common themes, and encourages research on unresolved institutional questions that warrant further study.

[34] *Id.* 4 tbl.2 (Indianapolis Juvenile Correctional Facility).
[35] *Id.* In gathering information on sexual victimization from juvenile offenders, BJS distinguished between institutions that were able to provide consent for juvenile offenders to participate in the survey (i.e., *in loco parentis*) and institutions that had to obtain the prior consent of parents or guardians for juvenile offenders to participate in the survey (i.e., PGC). *Id.* 2. Woodland Hills was the only PGC facility that the Panel invited to the hearings. *Id.* 4 tbl.2, 5 tbl.3. The Panel was interested in learning whether Woodland Hills' designation as a PGC institution contributed to the reported high level of sexual victimization at the facility.
[36] *Id.* 4 tbl.2.
[37] *Id.* 8 tbl.5.
[38] *Id.*
[39] A copy of the Data Request appears in Appendix B.
[40] App. C (Side-by-Side Data Matrix of Juvenile Facility Responses to Review Panel on Prison Rape Data Requests (June 2, 2010)).
[41] For a list of the witnesses who testified at the hearings, see Appendix D.

Institutions with the Lowest Prevalence of Sexual Victimization

Ft. Bellefontaine

Facility Description

The Missouri Division of Youth Services (DYS), which is part of the MDSS, operates Ft. Bellefontaine, which is a medium-security, residential facility serving about twenty young men, located on a campus with other similar facilities in an expansive, wooded area adjacent to a state park on the west bank of the Mississippi River, north of downtown St. Louis.[42] DYS refers to Ft. Bellefontaine as a "cottage," but it is actually a large, two-storey, box-like building.[43] Ft. Bellefontaine has two sections, each with about a dozen residents.[44] The residents of each section sleep together in an open dormitory; bunk beds line the walls of the room, surrounding the desk of a staff person who monitors the sleeping arrangements throughout the night.[45] Although it may share some facilities with the other nearby cottages (e.g., computer labs and classrooms), Ft. Bellefontaine operates independently, offering programming, including counseling services, to all of its residents.[46] Ft. Bellefontaine has about twenty-four staff persons.[47] The staff-student ratio is one-to-six, which is the same for all moderate and secure care facilities in DYS.[48] DYS does require a background check for employees, which includes verifying educational background and professional licenses, fingerprinting, and reviewing disqualification lists from state agencies.[49]

Ft. Bellefontaine residents have a variety of avenues for reporting sexual abuse: filing a grievance or speaking to a personal advocate, facility manager, nurse, parent, service coordinator, volunteer, DYS staff person, or another trusted adult.[50] According to the *BJS Juvenile Report*, Ft. Bellefontaine had no reported incidents of sexual victimization during the reporting period.[51]

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[42] Transcript of Record: Panel Hearings on Sexual Victimization in Juvenile Correctional Facilities, T. Decker, 49:20-21 (June 3-4, 2010), *available at* http://www.ojp.usdoj.gov//reviewpanel/pdfs_june10/transcript_060410.pdf [hereinafter Tr.]; Interview with Timothy Decker, Director of DYS, et al. in Ft. Bellefontaine, Mo. (July 20, 2010) [hereinafter Decker Interview].
[43] *Id.*
[44] Tr., T. Decker, 50:21-51:1, 61:5-6.
[45] Decker Interview.
[46] *Id.*
[47] Tr., T. Decker, 49:22-50:2.
[48] *Id.* 61:8-9.
[49] App. C 10-11 (Ft. Bellefontaine response to Question 9(b)).
[50] *Id.* 14 (Ft. Bellefontaine response to Question 12).
[51] *BJS Juvenile Report* 5 tbl.3.

Facility's Explanation of Low Incidence of Sexual Victimization

Mr. Timothy Decker, Director of DYS, testified on June 3, 2010, that one could attribute the lack of any reported sexual victimization at Ft. Bellefontaine to DYS' philosophy, focusing on rehabilitation over punishment.[52]

Mr. Decker said that, like other states, Missouri at one time operated a large, central, residential training school for boys.[53] A federal report condemning Missouri's operation of the school led to reform, creating smaller regional facilities, like Ft. Bellefontaine, that allow residents to be as close as possible to their families.[54] Mr. Decker testified, "The punitive culture of the early days has been replaced with a safe, structured and therapeutic environment."[55] At DYS, he said, "Young people are in the constant presence of caring staff, learning firsthand what it means to have healthy relationships with peers and adults."[56]

Mr. Decker testified that each DYS facility divides the residents into groups of ten or twelve, and this group then does everything together, including chores, school activities, and group sessions.[57]

Mr. Decker said that one of the distinctive features of DYS programming is the building of group cohesion through a culture of open communication. "When a conflict or concern arises, a group circle is called by a group member or staff. Everyone stops what they are doing to share observations, feelings, discuss alternatives and help each other achieve their goals."[58] Mr. Decker stated that DYS supports this therapeutic culture with specialists and group leaders who work as a team.[59] The involvement of families and community groups with youth in DYS programs also contributes to "creating a culture of openness, engagement and transparency."[60]

Commenting on the number of juvenile justice systems that come to visit DYS facilities to learn from them, he said that he emphasizes to visitors the importance of focusing on institutional culture:

> A common message to our visitors is simple but compelling. Changing your end destination often involves starting from a fundamentally different place. To create safer institutions, leaders must often question the very philosophical foundations of their work and address the underlying organizational culture within facilities along with strengthening and changing fundamental practices. . . .

[52] Tr., T. Decker, 49:8-17, 55:17-56:8.
[53] *Id.* 48:21-49:5.
[54] *Id.* 49:12-13.
[55] *Id.* 50:11-13.
[56] *Id.* 50:17-19.
[57] *Id.* 50:21-51:2.
[58] *Id.* 51:3-6.
[59] *Id.* 51:7-12.
[60] *Id.* 51:13-15.

> Missouri DYS is very deliberate in aligning all practices with our core values. . . . The very assumptions of which many youth correctional programs are based are counter to the research and experience related to the cognitive behavioral and emotional development of adolescents. If we view young people in the system as a product of their past experiences, a work in progress, and a potential resource to others, we are compelled to weave together a safe and humane system that supports personal development and change, and to continually try to make it better.[61]

Mr. Decker contrasted DYS' therapeutic approach to the punitive approach that many other states use, noting that there are a range of services available, from placing youths back in the community to group homes, moderate care facilities, and secure facilities.[62] He said, "The emphasis is on actually rehabilitation of the youth as opposed to control of their behaviors. Positional power, autocratic approaches . . . are de-emphasized, and instead we emphasize healthy hierarchy, boundaries, and development of healthy relationships."[63]

Mr. Decker said that the terms used in a juvenile justice system tellingly reflect its culture:

> Instead of viewing the young people as inmates, we see them as young people. Instead of having majors, lieutenants and sergeants, we have leaders, managers and directors. There's a lot to be said for what you call things in these systems. We don't have correctional officer[s] or security workers or security. We have youth care workers. We have service coordinators, and we have counselors.[64]

Mr. Decker said that the youth's family plays an important part in the rehabilitation process. The family is not a problem, he observed, but a partner.[65]

Mr. Decker testified that there is a correlation between the institutional methods for treating youth in custody and sexual victimization; when coercion is the tactic for controlling youth, one should not be surprised to find youth relying on coercion as well:

> Many aspects of traditional institutional and correctional practices in juvenile justice include punitive and coercive approaches that devalue and objectify young people creating fertile ground for safety issues and sexual victimization. It should be no surprise that if the way we control the kids is through coercion that we will . . . have a growth of other coercive behavior such as sexual victimization.

[61] *Id.* 52:2-53:13.
[62] *Id.* 54:2-9.
[63] *Id.* 54:10-15.
[64] *Id.* 54:16-55:1.
[65] *Id.* 55:2-4.

> It has been our experience that in order to protect youth from being sexually victimized in our programs, we must address the issue systemically by creating physically and emotionally safe environments that protect our youth from all forms of harm, whether that be emotional, verbal, physical, sexual, et cetera.
>
> Sexual victimization in institutions cannot be effectively dealt with in isolation or as a singular issue. At the core, all forms of institutional abuse create a lack of safety for young people, staff, and eventually for the public because young people get released without having the root causes addressed.[66]

Missouri's emphasis on building a therapeutic culture in its juvenile correctional facilities, Mr. Decker testified, does not come at the expense of weakened security:

> Security is a very important aspect of all programming. . . . Missouri has found that even with the best security tools and high-tech equipment, youth are still not protected from harm, and public safety may be compromised. Safety and security is actually enhanced by creating a humane culture of care. This is ultimately what keeps young people safe, not hard work, fences or cameras.[67]

Mr. Decker stated that a safe environment in DYS facilities relies on five building blocks: (1) basic expectations, (2) basic needs, (3) engaged supervision, (4) clear boundaries in communication, and (5) unconditional positive regard.[68]

"Basic expectations are norms created for the program environment and how staff and students are expected to treat one another."[69]

Basic needs are food, clothing, and shelter. Many young people who come under the protection of juvenile facilities come from backgrounds where they did not get their basic needs met.[70] Unless juvenile facilities meet the residents' basic needs in a healthy way, residents may seek to meet them in unhealthy ways, through bartering, hoarding, or misuse of power.[71]

Engaged supervision differs from the traditional custodial-care approach in that the staff is involved in all group activities, not posting themselves on a stand or patrolling from the sidelines.[72] Mr. Decker said, "In all programs staff are required to see all youth at all times, except during hygiene, and even then staff are strategically placed and aware. . . . By keeping

[66] *Id.* 55:17-56:14.
[67] *Id.* 56:15-57:3.
[68] *Id.* 57:20-58:1.
[69] *Id.* 58:5-8.
[70] *Id.* 59:12-14.
[71] *Id.* 59:14-18.
[72] *Id.* 60:21-61:4, 61:13-15.

youth productively engaged and structuring staff member involvement, opportunities for unproductive or harmful interactions are decreased."[73]

Setting clear boundaries in communication is essential for establishing safe relationships, not only in the institution, but also when the young person returns home.[74] Because many young people come to juvenile institutions with compromised boundaries, Mr. Decker testified, it is critical that the staff has extensive training on "staff roles, ethical conduct, adolescent development . . . [and] indicators in what we call slippery slopes, and team responsibilities."[75] DYS requires all staff members to participate in professional boundary training sessions within the first three months of employment; the DYS offers more advanced training to staff members within their first three to twelve months of employment.[76] DYS also provides training to staff in providing feedback to peers, supervisors, and direct reports by offering coaching to all leaders at DYS.[77]

A program with staff members who have an unconditional positive regard for youth and their families enhances safety by cultivating an environment that does not tolerate harmful behavior.[78] According to Mr. Decker, one has to be able to see beyond the problematic behavior that brought a young person into the juvenile justice system, otherwise one cannot address the underlying core issues that led to the misconduct.[79]

Mr. Decker added five other observations. First, juvenile justice facilities need to recognize that they are responsible for insuring the safety of youth in custody and that "juveniles have rights to a safe, humane, and developmentally appropriate environment."[80] Second, juvenile justice systems should focus on changing the culture within juvenile correctional institutions.[81] Mr. Decker noted that sexual victimization is often a symptom of the compromised safety young people experience in institutional settings. "Developing action plans to proactively address the systemic problems with prevention of institutional victimization will pay greater dividends than action and efforts focused only on education, detection, investigation, and disciplinary responses to sexual abuse. In other words, culture trumps everything."[82] Third, there are drawbacks in relying too heavily on a medical model for classification and treatment.[83] Mr. Decker said that when placement decisions rely only on professional, medical, and mental-health assessments, youths may remain unnecessarily in custody.[84] Fourth, national standards need to take into

[73] *Id.* 61:9-12, 61:17-20.
[74] *Id.* 61:22-62:4.
[75] *Id.* 62:10-15.
[76] *Id.* 61:16-20.
[77] *Id.* 63:3-16.
[78] *Id.* 63:17-21.
[79] *Id.* 64:3-9.
[80] *Id.* 64:15-20.
[81] *Id.* 64:21-65:1.
[82] *Id.* 65:9-15.
[83] *Id.* 65:16-18.
[84] *Id.* 66:3-8.

account the successes of state juvenile justice systems.[85] "Overly prescriptive models for achieving standards and capacity-building risk compromising the structure and goals of effective systems."[86] Fifth, juvenile justice systems need to address the cycle of offending that leads to sexual victimization.[87] When youth who have been sexually victimized return to their communities, they not only need effective support, but those who were involved in inappropriate sexual behavior also need effective intervention programs.[88]

DYS provides training to its staff on a broad range of topics, including programs on conducting investigations and identifying child abuse and neglect.[89] Within the first two years of employment, all DYS staff must complete at least 180 hours in adolescent care with forty hours of on-the-job coaching.[90] After the initial training, each staff person receives annually forty hours of professional development training.[91]

In response to the Panel's request, DYS provided after the hearing more information on its training program for staff on maintaining professional boundaries.[92] The training program identifies what it terms "the zone of helpfulness," the optimal professional relationship staff should have with juvenile residents.[93] Staff members miss this mark when they are either under-involved or over-involved with the youth in their care.[94] From the youth's perspective, an example of a staff person being under-involved is "[s]taff doesn't know anything about my family."[95] Again, from the youth's perspective, an example of a staff person being over-involved is "[s]taff spends time with me even when not on shift."[96] The training program addresses the "gray areas" in professional boundaries, noting that when the relationship between a staff member and a resident becomes confused, the boundaries blur.[97]

The training program cautions employees that they may encounter professional boundary issues under circumstances that do not rise to the level of a legal or policy violation.[98] According to the staff training program, warning signs of inappropriate boundary-crossing may include the following actions: "isolating yourself with youth . . . confiding secrets to youth; relying on a youth for emotional support . . . telling sexual jokes or stories; giving or receiving gifts;

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[85] *Id.* 66:15-18.
[86] *Id.* 66:18-20.
[87] *Id.* 67:7-9.
[88] *Id.* 67:1-5.
[89] App. C 19-20 (Ft. Bellefontaine response to Question 17(b)).
[90] *Id.* 21 (Ft. Bellefontaine response to Question 19(a)).
[91] *Id.*
[92] Supplemental Materials (Ft. Bellefontaine) (on file with the Panel) [hereinafter Supp.].
[93] Supp. (Slide 1(b)).
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.* (Slide 1(d)).
[98] *Id.*

'defending' the youth's inappropriate behavior . . . unauthorized and personal letters, email, calls, text[s] . . . staff covering for staff in regard to inappropriate behavior."[99]

The program also identifies practices that support healthy boundaries and the practices that undermine them.[100] Examples of practices supporting healthy boundaries include hiring the right staff, having one-on-one conversations with youth in view of others, scheduling inexperienced staff to work with more experienced colleagues, and staying on the topic in team meetings.[101] Examples of practices that undermine healthy boundaries are transporting a youth alone in a staff person's personal vehicle, talking to a youth about another staff person, making inappropriate self-disclosures to a youth, and having a conversation with a youth at night when the rest of the residents are sleeping.[102]

In regard to training for supervisors and coworkers, DYS' training program notes the following areas that require watchfulness: a staff member's distress or upset, therapeutic drift, lack of counseling goals, counseling that exceeds the usual time limit, reluctance to refer a youth to another staff person for help, and becoming overly involved in a youth's life.[103] The watchfulness list also flags "unwise techniques" and "unique vulnerabilities."[104] Unwise techniques include establishing a relationship with routine hugging or excessive touching, counseling in non-traditional settings, socializing with a youth, and intervening inappropriately in a youth's life.[105] Unique vulnerabilities include being attracted to the youth, over-identifying with the youth, having similar family dynamics as the youth's, experiencing divorce or loss, or undergoing identity confusion.[106]

Rhode Island Training School

Facility Description

The RITS, located in Cranston, Rhode Island, operates under the auspices of the Rhode Island Department of Children, Youth and Families (DCYF), a unified state agency responsible for child welfare, child protection, behavior health, juvenile probation, parole, detention, and secure corrections.[107]

Since January of 2009, the RITS has undergone a major change, moving to new facilities and reorganizing the services it provides residents.[108] Prior to January 2009, the RITS had a total

[99] *Id.* (Slide 1(e)).
[100] *Id.* (Slide 1(g)).
[101] *Id.*
[102] *Id.*
[103] *Id.* (Slide 1(i)).
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] Tr., P. Martinez, 145:8-12.
[108] *Id.* 146:6-20.

capacity of 205 residents, housing both male and female residents in eight units, including a detention center, a maximum security unit, a specialized unit, a substance abuse unit, and four general population units.[109] The RITS has moved to three smaller facilities: two facilities for male residents (i.e., a youth assessment center with fifty-two beds and a youth development center with ninety-six beds), and one facility for female residents with twenty-four beds, which houses both detailed and adjudicated youth.[110] The youth development center has a specialized treatment program, which houses two distinct populations: youth with aggressive behavior and youth with a history of sex-offender behavior.[111] The development center also has a specialized treatment program for substance abuse.[112] For juvenile program workers, the staff-to-student ratio is one to eight.[113]

The RITS staff includes administrators, unit managers, clinical social workers, and juvenile program workers.[114] The RITS has a staff that provides a regular education program for residents (i.e., principal, guidance counselor, psychologist, and teachers).[115] The RITS also has five registered nurses, and a private vendor, the Life Span hospital system, provides medical and psychiatric services.[116]

In the time period of the survey that produced the *BJS Juvenile Report*, there was a single reported juvenile-on-juvenile sexual encounter at the RITS, but a thorough investigation concluded that the charge was unfounded.[117]

Facility's Explanation of Low Incidence of Sexual Victimization

Ms. Patricia Martinez, Director of DCYF, testified at the Panel hearing on June 3, 2010, that in addition to a commitment to a zero-tolerance policy regarding sexual misconduct,[118] there may be three factors that contributed to the low prevalence of sexual victimization at the RITS: (1) the training program for staff, (2) the assessment procedures for youth, and (3) transition planning.[119]

In regard to training, before DCYF hires each staff member, the applicant must complete six weeks of training, with forty hours each week.[120] The training academy covers a wide range of topics, including laws on identifying and reporting abuse, with a special emphasis on the staff of

[109] *Id.* 146:6-12.
[110] *Id.* 146:13-147:1.
[111] *Id.* 147:9-13; *id.*, K. Aucoin, 166:17-21.
[112] *Id.*, P. Martinez, 147:13-17.
[113] App. C 13 (RITS response to Question 11).
[114] Tr., P. Martinez, 148:4-9.
[115] *Id.* 148:10-14.
[116] *Id.* 148:15-19.
[117] App. C 17 (RITS response to Question 16).
[118] Tr., P. Martinez, 145:13-15.
[119] *Id.* 148:20-149:2, 150:14-16, 151:5-9.
[120] *Id.* 149:2-6.

the RITS.[121] Topics include issues related to the abuse of residents, the investigative process, and the various treatment programs available to residents.[122] In addition to this training program, DCYF partners with the Rhode Island College's School of Social Work through the Child Welfare Institute to provide in-service training for each RITS staff member.[123] Every week, staff members attend a training session offering professional development.[124]

In regard to student assessment, within forty-eight to seventy-two hours of a youth being admitted to the detention facility at the RITS, the staff conducts assessments.[125] The RITS uses the Massachusetts Youth Screening Inventory (MAYSI) to evaluate safety and risk issues for each new student.[126] Once the youth is adjudicated, the RITS makes another assessment using a global assessment instrument to determine the youth's treatment plan during the youth's tenure at the RITS.[127]

In regard to transition planning, Ms. Martinez testified that DCYF understands its mission as planning for transition from the first day that the youth comes to the RITS, which entails working with the youth's family to prepare for the success of the youth's eventual discharge.[128] Ms. Martinez said, "[I]t's our mission to do transitioning from day one, from the day that that youth comes into the Training School."[129]

Mr. Kevin Aucoin, the Acting Superintendent of the RITS, identified additional factors that contributed to the RITS' low incidence of sexual victimization. Consistent with Ms. Martinez's testimony, Mr. Aucoin emphasized the importance of transition planning.[130] Mr. Aucoin said, "Our goal is to decrease the length of time youth have to spend in institutional care, and I think that culture has very much helped us and achieved some of the results that you have before you today."[131] Mr. Aucoin said, "My feeling is the longer [a] youth stays in institutional care, the worse off the outcome is going to be for that youth, both in-house and out of the facility."[132]

In addition to transition planning, Mr. Aucoin said the RITS' success relies on the programming it provides its residents.[133] Mr. Aucoin noted that the RITS has been under a federal court consent decree since the 1970s, which is still in effect.[134] One of the key elements of the consent decree is that within thirty days of adjudication, every youth must have an individualized

[121] *Id.* 149:7-13.
[122] *Id.* 149:13-19.
[123] *Id.* 149:20-150:6.
[124] *Id.* 150:7-9.
[125] *Id.* 150:14-19.
[126] *Id.* 150:19-21.
[127] *Id.* 150:22-151:4.
[128] *Id.* 151:5-14; *id.*, K. Aucoin, 165:17-21.
[129] *Id.*, P. Martinez, 151:7-9.
[130] *Id.*, K. Aucoin, 163:9.
[131] *Id.* 163:9-13.
[132] *Id.* 168:21-169:2.
[133] *Id.* 164:11-14.
[134] *Id.* 164:15-18.

treatment plan.[135] Once a youth has a treatment plan, the RITS reviews the plan bimonthly and includes in the program transition planning.[136]

Mr. Aucoin noted that the relatively high educational level of RITS staff members contributes to its success; all have at least an associate's degree, and many have a bachelor's degree.[137]

Mr. Aucoin said that the RITS benefits from being part of DCYF; as a unified agency, DCYF is concerned about the broader project of community development—being able to provide services that involve children's health and welfare, not just juvenile justice services.[138]

Mr. Aucoin said that the RITS considers whether an alternative program would better serve a youth who is in custody, which may lead DCYF to placing the youth at home with a variety of services.[139]

In 2006 and 2007, the RITS had a population of over 200; at the time of the hearing on June 3, 2010, it had a population of 146.[140] Mr. Aucoin said that the reduction in numbers reflects the ability of the RITS to integrate juvenile offenders back into the community, shortening the length of time in the program.[141] "It [the reduced population] has communicated a culture both inside and outside the Training School that we will work together. We will work with the family. We will work with community providers to insure . . . the safety of youth both in the facility and outside the facility."[142]

According to Mr. Aucoin, youth who arrive at the RITS immediately become aware of the RITS' process for investigating complaints: they meet with the unit manager and the unit social worker and they receive the rules for the facility.[143] One of the clear rules in all units is zero tolerance for abuse and neglect, and the RITS encourages youth to meet with the unit manager or with a social worker if an issue arises that needs attention.[144] Residents are also aware of the right to call (or have administrative management call) the child-abuse hotline.[145] They also have access to nurses, doctors, clinicians, and therapists to report sexual victimization; and as Rhode Island is a mandatory reporting state, any of these professionals who has reason to believe a child has been abused has a duty to report the suspected abuse to the child-abuse hotline.[146] In Rhode Island, the Child Advocate's Office serves as an ombudsman for all youth in DCYF's care; it has

[135] *Id.* 165:6-16.
[136] *Id.*
[137] Interview with K. Aucoin, Acting Superintendent of RITS, et al., in Cranston, R.I. (July 22, 2010).
[138] Tr., K. Aucoin, 163:2-8.
[139] *Id.* 165:22-166:7.
[140] *Id.* 178:6-9.
[141] *Id.* 178:10-12.
[142] *Id.* 178:13-17.
[143] *Id.* 170:14-21.
[144] *Id.* 171:6-11.
[145] *Id.* 171:11-17.
[146] *Id.* 171:18-172:3.

unrestricted access to all youth at the RITS at any time to inspect conditions of confinement without obtaining prior permission.[147] Citing the role of the Child Advocate's Office, Mr. Aucoin noted that it promotes a culture of deterrence and safety within the facility.[148]

Included in the orientation packet for new arrivals at the RITS is the Rhode Island Children's Bill of Rights, which clearly states the civil and due process rights of children in DCYF's care, and the RITS displays posters with the same information in all living units.[149]

Child Protective Services (CPS), which is part of DCYF but separate from the RITS, provides training to RITS staff on its duty to protect children and report abuse; operates the child-abuse hotline; and investigates any allegations of child abuse, including sexual victimization at the RITS.[150]

In the RITS facilities, there is constant video surveillance in the two programs for boys.[151] Mr. Aucoin said that he thought the cameras provided "a very strong deterrent in terms of conduct, [for] both residents and . . . staff."[152]

Institutions with the Highest Prevalence of Sexual Victimization

Pendleton

Facility Description

Pendleton, located in Pendleton, Indiana, about an hour's drive northeast of Indianapolis, operates under the auspices of the Division of Youth Services (DYS) of the IDOC. Pendleton is a 360-bed maximum security facility for males between the ages of twelve and twenty-one.[153] "Pendleton typically holds Indiana's most violent youth, including all adjudicated male sex offenders. The facility's sex offender population currently accounts for approximately 37 percent of the overall population."[154] Pendleton also holds youth with special needs and mental health issues.[155]

The complex for sex offenders at Pendleton, which has ninety-six beds, has cameras in all of the rooms; the other housing units do not have cameras, except for the segregation unit.[156]

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[147] *Id.* 172:4-21.
[148] *Id.* 172:22-173:3.
[149] *Id.* 199:11-14; app. C 25 (RITS response to Question 20(a)).
[150] Tr., S. Fogli-Terry, 153:20-155:16.
[151] *Id.*, K. Aucoin, 177:5-8.
[152] *Id.* 177:17-19.
[153] *Id.*, E. Buss, 219:11-13.
[154] *Id.* 219:13-17.
[155] *Id.* 219:19-21.
[156] *Id.*, L. Commons, 264:2-5.

The Panel noted that during the onsite visit to Pendleton, it would be difficult on first impression to distinguish Pendleton from an adult facility—residents wore orange jumpsuits and the atmosphere had a heavy corrections emphasis.[157]

The *BJS Juvenile Report* found that 36.2% of the youth at Pendleton reported sexual victimization,[158] with 18.1% reporting staff sexual misconduct with force and 16.8% reporting staff sexual misconduct without force.[159] During the time period of review, Pendleton reported nineteen complaints with allegations of sexual victimization of a youth.[160]

Response to the *BJS Juvenile Report* and Corrective Actions

In preventing prison rape in IDOC facilities, and especially at Pendleton, Mr. Edwin Buss, Commissioner of IDOC, testified that IDOC has taken the following actions: (1) implementing policies and procedures to enforce zero tolerance for sexual victimization, including the issuance of an executive directive in the wake of the findings of the *BJS Juvenile Report*; (2) having a Prison Rape Oversight Group (PROG), which is responsible for working with both adult and juvenile facilities to address issues related to prison rape and to respond to incidents of sexual assault; (3) restructuring the DYS; (4) adopting a balanced and restorative justice model, moving toward a more therapeutic model in managing corrections facilities; (5) adhering to the Council of Juvenile Correctional Administrators' performance-based standards; (6) reducing the stay for youths in secure facilities; (7) working to return youth to community-based supervision; (8) reducing the population of residents; (9) maintaining staffing levels despite budget constraints; (10) moving the youngest offenders at Pendleton to a separate facility; (11) partnering with a private service provider to oversee the sex offender treatment program at Pendleton; (12) conducting sexual victimization interviews with all Pendleton residents; (13) developing a digital, web-based education training video on PREA and prevention of sexual abuse in a secure environment; (14) requiring all staff to complete the National Institute of Corrections' online course on responding to sexual abuse and providing staff with other opportunities for training; (15) creating a PREA-awareness public-service announcement, which Pendleton shows to every new resident at intake and broadcasts to residents every week over its TV-video system during school hours; (16) enhancing reporting procedures for incidents of sexual victimization; (17) requesting technical assistance from the Indiana Juvenile Justice Task Force to strengthen staff hiring and screening practices; (18) removing solid doors to coat closets, living areas, and storage rooms at Pendleton; (19) relocating and installing cameras at Pendleton to avoid blind spots in housing units, the kitchen, and the laundry; (20) creating a camera surveillance monitoring room at Pendleton, staffed eighteen hours per day, seven days per week; (21)

[157] *Id.*, R. Wilkinson, 234:15-235:2.
[158] *BJS Juvenile Report* 4 tbl.2.
[159] *Id.* 9 tbl.6.
[160] App. C 17 (Pendleton response to Question 16).

initiating a staff-to-youth mentoring program; and (22) adding correctional officer positions, especially during the evening shift.[161]

Mr. Buss noted the reduction of the average length of stay at Pendleton from 256 days in 2007 to 186 days in 2009.[162] The overall population at Pendleton has also decreased; at one time it was over 360, whereas in recent months, it has remained about 270.[163]

Ninety-four percent of the staff at Pendleton has undergone a six-hour training program on offender manipulation and sexual misconduct.[164]

The *BJS Juvenile Report* also prompted a review of every place at Pendleton a staff person could be alone with a student, which led to making as many changes as possible not only to protect the youth but also to prevent the staff from being in a vulnerable position.[165] Pendleton has also developed an employee council to listen to the concerns of staff members who were affected by the negative publicity connected to the reported high incidence of staff sexual misconduct at the facility.[166] Training and the publication of the *BJS Juvenile Report* have raised awareness among employees of the responsibility that they share to pay attention to one another and to hold each other accountable.[167]

There are different reporting mechanisms now in place at Pendleton than there were at the time of the BJS study.[168] One of the changes in the reporting process is the establishment of an anonymous tip line that residents may call by pressing #22 (pound twenty-two) on the key pad of telephones readily accessible to them.[169] Pendleton has also posted PREA posters in the facility with relevant information on preventing and reporting sexual abuse.[170]

Intake at Pendleton is a two-week process and preventing sexual victimization is one of the issues covered.[171] During the orientation for new residents, the staff discusses the PREA manual and has a lesson on preventing sexual victimization; moreover, the staff calls each new resident's home and has the same discussion with the youth's parents.[172] Every Wednesday, a multi-disciplinary committee convenes to classify residents; for new residents, one of the factors the committee considers is prevention of sexual victimization.[173] In placing residents, DYS

[161] Tr., E. Buss, 220-27.
[162] *Id.* 222:4-6.
[163] *Id.* 222:17-20.
[164] *Id.*, M. Grady, 250:20-251:3.
[165] *Id.*, L. Commons, 277:9-15.
[166] *Id.* 277:22-278:5.
[167] *Id.* 278:6-13.
[168] *Id.* 267:2-4.
[169] *Id.* 267:4-5.
[170] *Id.* 267:5-8, 10-11.
[171] *Id.*, M. Greathouse, 271:7-11.
[172] *Id.* 271:12-15.
[173] *Id.* 240:11-241:8.

separates younger students from older ones; it also separates residents by their offenses.[174] For example, in the sex offender unit, predators and victims do not share the same room.[175]

After reviewing the data on sexual incidents in the facility, Pendleton found that most of them occurred during the evening shift.[176] To address this problem, Pendleton increased the frequency of staff tours from every fifteen minutes to every five minutes.[177] Now staff members must have their eyes on offenders every five minutes.[178]

Ms. Commons, the current superintendent at Pendleton, stated that Pendleton is currently involved in a program to assess its cultural competency by having outside officials work with staff members by listening to their comments and coaching them to develop values statements for the facility.[179] Echoing the testimony from Missouri, Ms. Commons stressed the importance of institutional culture:

> [C]ulture is the issue, and if you can change that culture, if you can find the areas that are weak or wanting in your culture, you can make all of the difference in the world, and when you empower staff to be involved in that process so that it comes from the bottom up, it can be very powerful.[180]

In regard to institutional culture, Mr. Buss observed that, contrary to his own viewpoint, IDOC in the past, reflecting the national mood at the time, had a philosophy of operating juvenile facilities similar to adult facilities.[181] He said that two years ago, when he walked into his first juvenile facility at DYS, he was surprised to find a twelve-year-old boy in a segregation cell similar to one found in an adult facility.[182] Up to a few years ago, adult and juvenile policies were in the same book; and superintendents transferred back and forth from adult facilities to juvenile facilities, as there was no thought to whether a superintendent needed special skills to work with youth offenders.[183] There was also a time when the distinctions between staffing adult and juvenile facilities blurred; staff members who worked in juvenile facilities received training that allowed them to work in adult facilities.[184] IDOC has been moving away from this model, training youth service officers through a separate training academy with the focus on serving young people.[185]

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[174] *Id.*, L. Commons, 239:10-13, 19.
[175] *Id.* 239:20-240:3.
[176] *Id.* 263:15-16.
[177] *Id.* 263:16-17.
[178] *Id.* 263:18-19.
[179] *Id.* 233:4-17, 234:3-13.
[180] *Id.* 233:18-234:2.
[181] *Id.*, E. Buss, 235:15-20.
[182] *Id.* 235:21-236:6.
[183] *Id.* 284:2-3, 9-13.
[184] *Id.*, M. Dempsey, 256:10-20.
[185] *Id.*

In assessing why Pendleton had a high incidence of sexual victimization, Mr. Michael Dempsey, Executive Director of DYS, who was also previously the superintendent at Pendleton, identified a number of contributing causes.

Mr. Dempsey stated that the "number one factor" was overcrowding.[186] He testified, "When you put that many kids in one facility like that, bad things tend to happen. Regardless of your best efforts, they do."[187] Mr. Dempsey said that another contributing factor was staffing; at the time BJS interviewed residents at Pendleton, there were significant hiring delays.[188]

Mr. Dempsey said that another one of the principal failings of Pendleton was failing to train staff on dealing with adolescent development:

> I think if there is any one particular area where we're failing, it's in providing . . . training where they [staff members] can effectively manage and deal with adolescent development, particularly as it relates back to sexual growth. I think that many times they just simply don't know how to deal with those situations with those children as they're growing and developing inside a correctional facility.[189]

Reflecting on staff members who cross professional boundaries to become sexually involved with residents, Mr. Dempsey said that a traumatic event in the life of a staff person might have caused a serious lapse in judgment:

> I have seen seasoned correctional professionals who have been in the business for many, many years, who you would at first never believe to be involved in . . . a situation like that . . . at some point they grew close to that child. They developed a personal relationship and a professional one at that, and at some point in time, some sort of traumatic event took place in that person's life, a death, a divorce, something occurred, and the situation was manipulated from there.[190]

Mr. Dempsey said that staff members becoming involved in these misguided relationships is just one source of youth sexual victimization; he recognized that other sources included staff members who are predators and staff members who fail to follow proper procedures and find themselves manipulated by a resident.[191]

In thinking about why supervisors and colleagues fail to recognize the indicators that may identify a staff person becoming overly involved with a youth, Mr. Dempsey suggested that

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[186] *Id.* 260:19-21, 261:1-2.
[187] *Id.* 261:4-6.
[188] *Id.* 262:2-6.
[189] *Id.* 242:13-20.
[190] *Id.* 247:7-20.
[191] *Id.* 247:21-248:1-7.

employees may discount what they are observing because they have a relationship with the coworker and they know that the ramifications of falsely accusing a colleague are grave:

> I think that in most cases people work so closely with one another that they believe in that person, and they don't believe that that other person would get off into a situation like that or do anything that would harm a kid, and they know that those are serious allegations to raise against another fellow staff member, and if you're going to raise that type of allegation, you need to be 100 percent sure that that's what's taking place.[192]

Mr. Dempsey expressed frustration in not being able to identify reliable screening mechanisms that would identify candidates for employment who have a propensity for entering into inappropriate relationships with youth:

> I think when you're looking at the perspective of how we screen and qualify staff to work in our juvenile facilities, I have looked at . . . what the other states are doing, and I have yet to find anything that anybody is doing that we're not already doing or at least looking into. . . . So I don't think there's an easy answer and I don't believe that there's any one system that anybody has employed that helps fight this issue. It's an incredibly complex issue when you look at it from the perspective of staff sexual misconduct with youth, and it's not something that is unique to prisons.[193]

The Panel noted in response to its Data Request that Pendleton reported a high rate of attempted suicides and one suicide during the time period under review.[194] Pendleton administrators reported that there was no linkage between sexual victimization and the suicide or the attempted suicides.[195]

Woodland Hills

Facility Description

Woodland Hills, located in Nashville, Tennessee, serves 120 male youth offenders, and is one of the five secure youth development centers that the Division of Juvenile Justice (DJJ) of the Tennessee Department of Children's Services (TDCS) operates.[196] The staff-to-resident ratio is one to twelve.[197]

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[192] *Id.* 249:13-21.
[193] *Id.* 245:22-246:20.
[194] App. C 9 (Pendleton responses to Questions 8(a) and 8(b)).
[195] Tr., L. Commons, 274:14-275:9; *id.*, M. Dempsey, 275:19.
[196] *Id.*, S. Hornsby, 305:4-12.
[197] *Id.*, A. Dawson, 320:21-321:2.

According to the *BJS Juvenile Report*, the only incidents of sexual victimization at Woodland Hills involved staff and youth; there were no youth-on-youth incidents.[198] Twenty-six percent of youths reported sexual victimization by staff,[199] but the reported incidents with staff did not involve force, coercion, or pressure.[200]

Response to the *BJS Juvenile Report* and Corrective Actions

Steven C. Hornsby, Deputy Commissioner, DJJ, TDCS, testifying at the hearing on June 4, 2010, explained the organization of TDCS and summarized the TDCS response to the publication of the *BJS Juvenile Report*. Neither Mr. Hornsby nor any of the other witnesses from Tennessee provided an explanation for the high incidence of sexual victimization at Woodland Hills, as TDCS questioned the accuracy of the *BJS Juvenile Report* as it pertains to Woodland Hills.

Mr. Hornsby stated, "Tennessee has long recognized the need for a juvenile justice system that is separate and distinct from the adult correctional system and which is focused on rehabilitation, treatment and training of young offenders."[201] Mr. Hornsby explained that Tennessee was one of the leading states, beginning in the 1970s, to recognize that issues relating to juvenile justice are completely separate from adult corrections; and in 1987, the state created a separate juvenile justice department, which later merged with child welfare and mental health services for youth to become the TDCS in 1996.[202] TDCS "handles all child protection, dependency, abuse, neglect and delinquency" in Tennessee.[203] Youth in custody who are not in the development centers, such as Woodland Hills, are in a variety of other placements, "including private and state-operated group homes, therapeutic foster care and adolescent mental health facilities."[204]

As DJJ is part of a larger child welfare organization, external organizations undertake any investigations of DJJ facilities related to sexual victimization.[205] The external investigatory organizations are the Internal Affairs (IA) unit, which is under the Office of the Inspector General (OIG), and the Special Investigations Unit (SIU), which is under the Division of Child Safety.[206]

Each year, the Tennessee Commission of Children and Youth (TCCY or Commission) conducts an onsite quality service review of all of the youth development centers.[207] A component of the review is an examination of safety issues and concerns, and it includes private interviews with

[198] *Id.*, A. Beck, 339:11-14; *see also BJS Juvenile Report* 8 tbl.5.
[199] *Id.*
[200] Tr., A. Beck, 339:20-340:1.
[201] *Id.*, S. Hornsby, 303:22-304:4.
[202] *Id.* 304:12-305:1.
[203] *Id.* 305:2-4.
[204] *Id.* 305:14-16.
[205] *Id.* 305:17-19.
[206] *Id.* 305:19-306:1.
[207] *Id.* 306:5-10.

residents, families, service providers, and staff.[208] After its review, the Commission releases its findings and recommendations and works with TDCS on making improvements.[209] For the last three years, the Commission's quality service reviews gave Woodland Hills top scores on child safety.[210]

Following the publication of the *BJS Juvenile Report*, DJJ asked TCCY and SIU to conduct another review of the youth development centers in Tennessee, including in-depth interviews of residents, to determine whether they are safe from sexual victimization.[211] The survey concluded that there was no evidence of current sexual abuse.[212]

Mr. Hornsby said, "After thoroughly reviewing all of the facts, we have significant concerns that Woodland Hills was identified and labeled as having a high . . . prevalence of sexual victimization . . . ."[213] [214]

In addition to resurveying youth development centers, in response to the *BJS Juvenile Report*, the DJJ convened a PREA compliance task force, which undertook a comprehensive review of DJJ operations to identify deficiencies and to address them.[215] Consequently, the task force drafted a new PREA-specific policy.[216] The new policy includes notification forms that both residents and staff must sign, acknowledging that they are aware of their legal rights and obligations; the forms then become part of the employee's personnel file and the resident's file.[217] DJJ has also initiated a PREA-awareness campaign, with all of the superintendents of the youth development centers meeting with each staff member to review applicable policies and state laws.[218] DJJ created a frequently-asked-question sheet related to PREA and produced a hotline-reporting poster for distribution at its facilities.[219] DJJ is in the process of revising the student handbook and expanding the section on sexual abuse, noting in particular how to report violations.[220] Woodland Hills is revising its staff-training curriculum to include PREA-related materials, focusing in particular on how to identify and protect vulnerable youth.[221] The TDCS' medical

[208] *Id.* 306:10-14.
[209] *Id.* 306:14-22.
[210] *Id.* 306:22-307:2.
[211] *Id.* 312:18-313:5.
[212] *Id.*, C Aaron, 325:2-6.
[213] *Id.*, S. Hornsby, 316:7-10.
[214] Dr. Allen Beck, the principal author of the *BJS Juvenile Report*, provided testimony supporting the methodology of the BJS' findings related to Woodland Hills. He distinguished between surveys based on personal interviews, which are less reliable because they introduce into the data-collection process the elements of embarrassment and fear of retaliation, and surveys that use self-administered instruments, such as BJS' survey, which are more reliable because these elements are less present. *See id.*, A. Beck, 337:1-338:4, 338:7-343:16, 349:13-350:22.
[215] *Id.*, S. Hornsby, 309:18-310:1.
[216] *Id.* 310:3-8.
[217] *Id.* 310:9-13.
[218] *Id.* 310:13-18.
[219] *Id.* 310:19-21.
[220] *Id.* 311:6-9.
[221] *Id.* 311:9-12.

staff is also receiving enhanced PREA-specific training, and each member of the nursing staff is being trained on Sex Abuse Nurse Examiner (SANE) procedures.[222]

Mr. Albert Dawson, Superintendent of Woodland Hills, testified that in response to the *BJS Juvenile Report*, he met with the staff of Woodland Hills in small groups to provide a forum for questions, to emphasize the DJJ's zero-tolerance policy concerning sexual abuse, and to remind the staff of its responsibility under state law to report misconduct.[223] Mr. Dawson stated that his staff also reminded students at Woodland Hills of the various ways in which they can report abuse, which include filing a grievance or by notifying case managers, therapists, legal aid staff, or other staff members.[224]

In addition to serving as the superintendent at Woodland Hills, Mr. Dawson is the facility's PREA coordinator.[225]

In responding to the Panel's inquiry about what was happening at Woodland Hills during the period of the BJS survey, Mr. Dawson said that the population was manageable, noting that the facility's capacity is 144; and at the time of the survey, the population was about 120.[226] Also, during the relevant time period, Mr. Dawson said there were no staff shortages at Woodland Hills.[227] At the time BJS was interviewing youth, Mr. Dawson said that Woodland Hills was in the process of eliminating blind spots in the facility and implementing programs to encourage residents though positive incentives.[228]

Mr. Dawson said that in regard to providing training to staff on inappropriate relations with youth, staff members receive a two-hour orientation on PREA at the pre-service training academy.[229] One of the most important components of the nine-week, pre-service training academy is that newly hired staff shadow selected veteran employees who are aware of issues regarding adolescents, supervision, and reporting.[230]

According to Mr. Dawson, among the warning signals that indicate that a staff person may be crossing a professional boundary in relating to youth are the following: working with a youth in a one-on-one setting, selecting a youth for a work project, bringing things into the institution for the youth, giving the youth unusual attention, or calling the youth after hours.[231]

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[222] *Id.* 311:12-15.
[223] *Id.*, A. Dawson, 319:21-320:9.
[224] *Id.* 320:17-321:7.
[225] *Id.* 354:14.
[226] *Id.* 351:16-21.
[227] *Id.* 352:3-6.
[228] *Id.* 352:14-353:17.
[229] *Id.* 373:16-22.
[230] *Id.* 374:1-16.
[231] *Id.* 376:9-15.

When a youth comes to the DJJ, the youth undergoes two assessments, one for risk and one for clinical needs.[232] This information is available for the classification process.[233]

The staff at the medical center at Vanderbilt University conducts a psychological evaluation of a Woodland Hills resident on arrival; the staff then makes recommendations regarding the youth's care.[234] According to Mr. Dawson, most residents at Woodland Hills have mental health issues, but Mr. Dawson distinguishes between having mental health issues and suffering mental illness.[235] Woodland Hills refers residents with mental health issues to individual, group, or family therapy, which the Vanderbilt University staff provides.[236] All students have a case manager or family service worker,[237] and DJJ contracts with private vendors to provide behavior health services, including substance abuse and sex offender treatment as well as individual and group counseling.[238]

Parents or guardians participate in the initial classification meeting with their son and Woodland Hills staff, and they contribute to the decisions regarding the youth's program.[239] Woodland Hills also invites parents to participate in monthly and quarterly institutional team reviews of their son's progress, and it notifies the parents of any significant events (e.g., illness or injury) affecting their son.[240]

Residents of Woodland Hills with mental illness have access to the services of a psychologist who is available around the clock.[241] If there is a need for an outside evaluation, then Woodland Hills will refer the resident to a local hospital for screening.[242] If the hospital determines that the youth is suffering from mental illness, then Woodland Hills arranges for the youth's transfer to another facility, as Woodland Hills does not provide treatment for mental illness.[243]

The student handbook at Woodland Hills contains information on how a student should report any concerns related to sexual activity.[244] Woodland Hills, like other youth development centers in Tennessee, has a policy that designates a staff member as the responsible person to receive and deal with reports from residents alleging sexual abuse.[245]

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[232] *Id.*, S. Hornsby, 364:15-22.
[233] *Id.* 365:5-12.
[234] *Id.*, A. Dawson, 366:17-367:1.
[235] *Id.* 367:2-4.
[236] *Id.* 367:4-9.
[237] *Id.*, S. Hornsby, 364:8-12.
[238] *Id.* 307:3-6.
[239] *Id.*, A. Dawson, 385:13-21.
[240] *Id.* 385:22-386:9.
[241] *Id.* 367:10-18.
[242] *Id.* 367:19-22.
[243] *Id.* 368:3-7.
[244] *Id.*, S. Hornsby, 309:3-5.
[245] *Id.* 308:20-309:2.

In processing a complaint of alleged sexual victimization, Woodland Hills has the following protocols: the resident files a complaint alleging staff sexual misconduct, either through the grievance process or by notifying a staff member; Woodland Hills immediately reports the complaint to Child Protective Services; the complaint comes to the attention of the superintendent, who then enforces a no-contact period between the accused staff member and the youth; Woodland Hills then notifies Internal Affairs; and if there is a need, Woodland Hills secures medical attention for the resident.[246] A student can also request at any time protective custody.[247]

Although the process began in 2007, by December of 2009, the DJJ installed cameras in all of its youth development centers to improve its surveillance capacity to promote safety.[248]

Corsicana

Facility Description

Corsicana, which originally served as an orphanage in the nineteenth century, operates under the auspices of the Texas Youth Commission (TYC) and houses 145 adjudicated youth (i.e., 133 males and twelve females) who have either a serious mental illness or a delay in mental development.[249] What is unique about Corsicana is that all residents have a medical diagnosis.[250] The current staff-to-resident ratio is one to twelve.[251] Corsicana contains a special fourteen-bed unit, the Crisis Stabilization Unit, which provides hospital-level care to residents.[252] Corsicana employs 162 correctional officers, twenty caseworkers, and eight psychologists; it contracts with the University of Texas Medical Branch for psychiatric services.[253] As many as thirty-six percent of Corsicana residents have past trauma abuse.[254] The population of Corsicana poses special challenges in terms of safety and treatment,[255] as many residents have prior histories that make them particularly vulnerable to sexual assault.[256]

According to the *BJS Juvenile Report*, 32.4% of the residents of Corsicana reported sexual victimization,[257] with 13.9% reporting sexual victimization involving another youth and 23.7% reporting sexual victimization involving a staff member.[258]

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[246] *Id.*, A. Dawson, 382:2-383:22.
[247] *Id.*, S. Hornsby, 384:20-22.
[248] *Id.* 309:11-13.
[249] *Id.*, C. Townsend, 402:10-17; *id.*, L. Cazabon-Braly, 402:10-12; Interview with C. Townsend, et al., in Corsicana, Tex. (Apr. 27, 2010) [hereinafter Townsend Interview].
[250] Tr., L. Cazabon-Braly, 402:20-21.
[251] *Id.*, J. Smith, 397:15-16.
[252] *Id.*, L. Cazabon-Braly, 402:18-20.
[253] *Id.* 403:6-11.
[254] *Id.* 406:10-13.
[255] *Id.*, C. Townsend, 393:18-22.
[256] *Id.* 394:1-2.
[257] *BJS Juvenile Report* 4 tbl.2.

Response to the *BJS Juvenile Report* and Corrective Actions

In the wake of a highly publicized scandal at TYC involving, among other matters, staff sexual abuse of residents,[259] Cheryln (Cherie) Townsend, Executive Director, appointed by Texas Governor Rick Perry on October 14, 2008, testified to the Panel that the TYC has been in the process over the last few years of undertaking significant, systemwide reform.[260] Ms. Townsend said that given the TYC's recent problems (BJS' interviews with youth took place close in time to the emergence of the scandal), she was not surprised to learn that the *BJS Juvenile Report* identified TYC as having a high prevalence of sexual victimization, but she was surprised to learn that Corsicana had such a high response rate.[261]

Like the other juvenile justice administrators who testified before the Panel, Ms. Townsend highlighted the importance of institutional culture. "I think the greatest challenge that our agency faces, and certainly this is true at the Corsicana Residential Treatment Center . . . is changing our culture from one of correctional focus only to one that also emphasizes treatment as well as accountability."[262]

Ms. Townsend said that in recent years TYC has been moving away from a corrections culture to a more therapeutic model:

> I think that there was a time in Texas when the juvenile correction system was known as the youth prison system and there was an effort at that time probably to make our facilities more like the adult prison systems and less like a positive youth development culture of change for young people.
>
> And I think that what we've seen, especially in the last two years, is a major shift back to not forgetting accountability, but really focusing on youth development. As we've done that, [w]e've really, I think, tried to hire a different kind of person. We've tried to train for something different.[263]

Ms. Townsend noted that among the achievements in the recent reform efforts at TYC are the following: (1) establishing a twenty-four hour hotline, the Incident Reporting Center (IRC), (2) providing trauma-informed care and cognitive therapy to youth, (3) changing the physical

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[258] *Id.* 8 tbl.5.
[259] More than eighty news reports and official documents published in 2007-08 related to a scandal involving the mismanagement of TYC, which ultimately led both to the criminal conviction of an administrator for sexually victimizing residents and to legislative reform, are available online on the Investigative Reports page (Scandal at TYC: Abuse and Mismanagement in Texas Juvenile Corrections) at the website of *The Dallas Morning News*, which is available at http://www.dallasnews.com/investigativereports/tyc/.
[260] Tr., C. Townsend, 393:13-17 (While other witnesses appeared before the Panel in person, Ms. Townsend presented her testimony by telephone).
[261] *Id.* 423:7-13.
[262] *Id.* 394:4-9.
[263] *Id.* 443:14-444:3.

plants, (4) increasing the ratio of staff-to-youth supervision, (5) establishing a centralized Office of Inspector General (OIG) to conduct investigations, (6) creating a Special Prosecution Unit to insure consistency in enforcing TYC's zero-tolerance policy concerning sexual abuse, and (7) implementing safe-housing assessments to make appropriate residential placements.[264] TYC also retained a consultant to conduct an agency-wide and facility-specific review to identify how it can improve its approach to eliminating sexual assault through new or refined policies, procedures, or practices.[265]

Affirming Ms. Townsend's testimony, Mr. James Smith, the director of youth services at TYC, who is responsible for supervising residential facilities, noted that as a consequence of recent legislation,[266] many reforms at TYC were already underway prior to the publication of the *BJS Juvenile Report*.[267]

In addition to the reforms that Ms. Townsend mentioned, Mr. Smith said that as a result of recent Texas legislation, the TYC implemented a new treatment modality, the connections model, an evidence-based approach to promote positive youth development by "empowering our youth to self-direct their behavior and to work on their issues."[268] In programming and counseling for youth, TYC also focuses on reentry and continuity of services, providing for the needs of both the youth and the youth's family.[269]

TYC also installed over 11,000 cameras in its facilities, with almost 900 at the Corsicana facility alone.[270] All direct-care staff attended at least 300 hours of training,[271] including additional training on PREA,[272] and all employees underwent extensive background checks.[273] The Texas legislature also lowered the maximum age of residents in TYC facilities from twenty-one to nineteen.[274]

Mr. Smith explained that since January of 2009, TYC's housing policy requires staff to screen all new residents at intake to identify those who may be most vulnerable to sexual assault and then to place them in suitable housing units, often in close proximity to staff.[275]

TYC published a student handbook, which contains information on PREA standards, and it also published a parents' bill of rights, which empowers parents to exercise the rights they retain even

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[264] *Id.* 394:11-395:1.
[265] *Id.* 469:4-8; Townsend Interview; Tr., J. Smith, 401:3-7.
[266] Act of May 25, 2007, ch. 263, 2007 Tex. Gen. Laws 421 (effective June 8, 2007).
[267] Tr., J. Smith, 396:19-22.
[268] *Id.* 397:5-14.
[269] *Id.* 462:16-463:8.
[270] *Id.* 397:16-18.
[271] *Id.* 397:18-21.
[272] *Id.* 397:3-4.
[273] *Id.* 397:22-398:1.
[274] *Id.* 397:22-398:2.
[275] *Id.* 398:7-12; *id.*, L. Cazabon-Braly 405:1-9.

when their children are in state custody.[276] Mr. Smith stated that TYC tries to go beyond just providing parents with information; instead, it encourages parent involvement.[277]

Along with creating the OIG, the reform legislation created the Office of the Independent Ombudsman, which has ready access to TYC facilities to interview both staff and residents and to assess conditions of confinement.[278]

Mr. Smith testified that following the publication of the *BJS Juvenile Report*, Corsicana has been engaged in analyzing data related to incidents of sexual victimization, such as the time of day, the location, and the facility's operational practices.[279] As part of this analysis, Corsicana closed access to a restroom, installed bubbled mirrors and cameras, and plans to relocate cameras to multi-occupancy sleeping rooms.[280] Corsicana added psycho-educational groups for residents and held a brown-bag lunch for staff to discuss issues related to professional boundaries and PREA reforms.[281] Corsicana is planning to have an outside organization survey every resident to ensure that each is safe.[282]

In regard to training staff, Mr. Smith emphasized the importance of maintaining professional boundaries:

> So a lot of our information and training with our staff centers around understanding what those boundaries are, such things as terms of endearment with the staff, calling them mama this or they have some pet name that they use for the staff. And while initially to the staff it's flattering or it sends a sense that they are developing a good relationship with the kid, unfortunately for the kid, it's a door opening for them to maybe perhaps take advantage of the staff or create a situation.
>
> What we really find is making sure the staff understand[s] that there [are] traps that you need to be aware of and while it may be well-intentioned on your part, it could certainly be perceived on the youth's part as an opportunity. And so we are looking to enhance our training, especially for our female staff, because we do have some young men who are very sophisticated . . . ."[283]

TYC's training programs are not only for staff but also for supervisors.[284] Ms. Townsend testified that supervisors may not recognize a staff person's misconduct, because the staff person

[276] *Id.*, J. Smith, 398:12-16.
[277] *Id.* 398:17-18.
[278] *Id.* 399:1-8.
[279] *Id.* 399:18-400:2.
[280] *Id.* 400:2-5; *id.*, C. Townsend, 428:6-11.
[281] *Id.*, J. Smith, 400:12-17; *id.*, L. Cazabon-Braly, 404:1-7, 12-13.
[282] *Id.*, J. Smith, 400:18-401:2.
[283] *Id.* 433:18-434:12.
[284] *Id.*, C. Townsend, 438:5-6.

is capable in so many ways that it is hard to conceive that he or she may be crossing the line with residents.[285] The training for supervisors focuses on their responsibility to coach employees in respecting appropriate boundaries and to recognize the indicators when an employee may be developing an inappropriate relationship with a youth.[286]

Ms. Laura Cazabon-Braly, Superintendent of Corsicana, stated that each month Corsicana holds town hall meetings with staff, and a topic at every meeting is supervision strategies.[287] The clinical staff has also provided an eight-hour training program for casework staff to discuss signs indicating when a staff member may be crossing a professional boundary when dealing with residents.[288]

Ms. Cazabon-Braly stated that since the reform of TYC, Corsicana has expanded specialized treatment groups for residents.[289] One significant change has been moving the psychologists on staff to the dormitories in the living units so that residents have greater access to them.[290]

Mr. Cris Love, Inspector General for the TYC, reported that for the first seven months of fiscal year 2010, the IRC received about 1,100 complaints per month.[291] From those incident reports, the OIG initiated 150 investigations.[292] For Corsicana, each month the IRC receives about 190 complaints, and the OIG investigates close to forty of them.[293] The IRC refers most of the complaints to the TYC Youth Services Division; the IRC refers thirty-seven percent of the complaints to the TYC's grievance department.[294] The OIG currently employees forty-three staff; twenty are peace officers.[295]

Mr. Love noted the following recent accomplishments of the OIG: establishing and operating the IRC, establishing and operating a system for monitoring use-of-force (i.e., reviewing surveillance camera footage on a daily basis to assess whether the staff treats residents appropriately), establishing and operating three databases related to complaints and investigations (i.e., the IRC database, a criminal complaint database, and an administrative complaint database), apprehending absconded youth, reducing the response time for initiating investigations, reducing the time to complete investigations, and responding effectively to emergencies involving TYC (e.g., hurricane evacuation).[296]

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[285] *Id.* 438:11-15.
[286] *Id.* 438:15-18.
[287] *Id.*, L. Cazabon-Braly, 404:8-12.
[288] *Id.* 404:13-16.
[289] *Id.* 403:14-16.
[290] *Id.* 403:18-21.
[291] *Id.*, C. Love, 409:14-17.
[292] *Id.* 409:17-20.
[293] *Id.* 409:21-410:7.
[294] *Id.* 410:8-13.
[295] *Id.* 411:8-10.
[296] *Id.* 412:4-413:8.

The management team at Corsicana, not just the superintendent and assistant superintendent, assist the OIG in monitoring random samples of video footage of the facility, and then they evaluate what they observed.[297] By assigning monitoring of the footage to managers, TYC is encouraging them to realize that they have a stake in creating the culture of the institution, identifying good practices, and correcting inappropriate ones.[298] Reviewing video footage may also be a way for supervisors to identify the warning signs that a staff person may be crossing a professional boundary. Ms. Cazabon-Braly testified that her reviewing of surveillance video footage sometimes allows her to recognize incipient staff problems:

> [W]e want to stop things before they escalate to a serious situation. If I'm watching video footage and I see a staff member maybe touch a kid on the arm too much, proximity is maybe too close, they brought in something to the kid, they're calling the facility about the kid, that's a red flag for me, and that's somebody we're going to watch.[299]

On admission to Corsicana, a resident receives an immediate psychological screening to determine whether the staff should monitor the youth as a suicide risk; all residents receive a full psychological evaluation within fourteen days of admission.[300] If the youth needs placement in a mental health facility, TYC will make the arrangements.[301] All TYC facilities have psychologists on staff, and they are on call to respond to any needs around the clock.[302]

Residents at Corsicana can report incidents of sexual misconduct, attempted sexual misconduct, or any other harmful activity by calling the "blue phone" hotline, which is accessible to all residents in housing units.[303]

In the case of an incident, the chief local administrator or administrative duty officer would do the following: notify the superintendent of the facility; ensure, if necessary, that the youth receives medical treatment from the infirmary; and contact a mental health professional on call to respond.[304] If needed, the youth would go to the hospital for an examination by a SANE.[305] The SANE would then contact the Child Advocacy Center or a local rape crisis center.[306] Recent legislation requires TYC to track and provide services to a youth abused or injured while in TYC's custody.[307]

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[297] *Id.*, J. Smith, 439:6-13.
[298] *Id.* 439:14-22.
[299] *Id.*, L. Cazabon-Braly, 441:12-19.
[300] *Id.*, L. Robinson, 445:18-446:1.
[301] *Id.* 446:2-13.
[302] *Id.* 446:14-16.
[303] *Id.*, J. Smith, 421:7-13.
[304] *Id.*, L. Robinson, 448:5-15.
[305] *Id.* 448:16-20.
[306] *Id.* 448:22-449:2.
[307] *Id.* 449:19-22.

When the IRC receives a sexual misconduct complaint, it contacts the OIG staff and the executive staff, and regardless of the time, the OIG will send an investigator to the scene.[308]

General Observations

The Selected Facilities Have Distinctive Characteristics

Although the Panel's mandate is to identify common characteristics among the juvenile correctional institutions that have the lowest prevalence of sexual victimization and the juvenile correctional institutions with the highest prevalence, the Panel recognizes that the institutions that it selected for study all have unique, distinguishing characteristics. Ft. Bellefontaine, with only twenty-four beds, is a comparatively small institution. The RITS and Corsicana have undergone significant transitions since the time of the BJS survey. In the last year, the RITS has reorganized its programs and has moved to three smaller facilities, two of them recently constructed. The RITS is also unique in that unlike most states, Rhode Island does not have juvenile correctional institutions at the county level, so the juvenile justice system operates exclusively at the state level. In the last two years, in the wake of a devastating scandal, Corsicana, along with the rest of the TYC, has been implementing significant legislative reform to address many of the problems that the *BJS Juvenile Report* identified. In addition, Corsicana is the only institution among the five selected juvenile facilities that exclusively serves a mentally ill and developmentally delayed population. Pendleton is unique among the five in that it serves only maximum security residents. Woodland Hills is unique in that it is the only institution that questions the accuracy of the *BJS Juvenile Report* in finding a high prevalence of sexual victimization at the facility. Some might suggest that the populations of the five selected juvenile facilities may differ so significantly (i.e., medium security residents at Ft. Bellefontaine, maximum security residents at Pendleton, and mentally ill residents at Corsicana) that comparing these institutions may not be particularly helpful. The Panel notes these distinctions (as well as anticipated concerns) and is aware that, at least in some instances, the unique characteristics of each institution may partially explain its appearance in the *BJS Juvenile Report*.

Policies and Practices May Not Predict Outcomes

In reviewing the facilities' responses to the Panel's Data Request, the Panel discovered that some widely accepted recommended practices did not necessarily correspond with an institution's incidence of sexual victimization. For example, Ft. Bellefontaine does not have a PREA coordinator, a written PREA-specific policy, an orientation on sexual victimization for residents, or specific policies on dealing with the aftermath of sexual assault.[309] Yet, despite these lacunae,

[308] *Id.*, C. Love, 452:20-453:16.
[309] App. C 2 (Ft. Bellefontaine responses to Questions 2(a) and 3).

the *BJS Juvenile Report* identified Ft. Bellefontaine as having no incidents of sexual victimization in the time period under review.[310] [311]

In contrast, among the five selected facilities, Pendleton had one of the most thorough, documented procedures for investigating allegations of sexual abuse;[312] yet the strength of the investigative procedures did not prevent Pendleton from having, according to the *BJS Juvenile Report*, a relatively high number of reported incidents.[313]

The Selected Facilities Differ on the Causes of and Effective Prevention Methods for Sexual Victimization

The Panel heard discrepancies in the experiences of the facilities. For example, Pendleton attributed the high incidence of sexual victimization at its facility, at least in part, to overcrowding and staff shortages, whereas Woodland Hills, which also had a high prevalence of sexual victimization, was operating under capacity with an adequate number of employees. Ft. Bellefontaine, which did not rely on cameras for security, had no reported incidents of sexual victimization, whereas Corsicana, which has hundreds of cameras, reports a significant number of allegations of sexual victimization each month.

The Small Number of Reviewed Facilities Limits Reliable Generalizations

The Panel is mindful, given the small number of facilities that participated in the hearings, that its findings may not lead to reliable generalizations. Nonetheless, aware of the inherent limitations in its effort to identify common characteristics among the selected facilities, the Panel has identified common themes that emerged from the hearings that corrections administrators, practitioners, and researchers should consider exploring in eliminating sexual victimization in facilities that serve youth.

Common Themes

Culture

Every administrative leader of a juvenile correctional system who testified before the Panel stressed the importance of institutional culture. They recognized that in the world of juvenile corrections, there is a spectrum of competing models, with the therapeutic-rehabilitation model on one end and the punitive-correction model on the other. Among the institutions that the Panel selected to study, Ft. Bellefontaine presents an example of the therapeutic approach, whereas

[310] *BJS Juvenile Report* 5 tbl.3.
[311] Similar to Ft. Bellefontaine, the RITS, a facility with a low prevalence of sexual victimization, also does not have a PREA-specific policy. *See* app. C 1 (RITS response to Question 1).
[312] In the Panel's view, Pendleton had sound investigative procedures in place, and based on the documentation of the investigations that Pendleton submitted to the Panel for review, Pendleton's investigative team did a thorough, professional job. *Id.* 3, 15 (Pendleton responses to Questions 3 and 13).
[313] *BJS Juvenile Report* 7 tbl.4.

Pendleton presents, at least until the recent past, an example of the punitive approach. Regardless of how they may characterize their own institutions, all of the administrators who presented testimony to the Panel said that they valued a therapeutic culture, and they were either already committed to one or were taking steps to achieve one. All of the administrative leaders who testified also underscored the significance of differentiating juvenile correctional systems from their adult counterparts. Youth who are in custody are still in development, and institutions that serve young people well have programs and staff that take youth development into account. Another aspect of institutional culture on which all testifying officials agreed is that it is important to return youth offenders as quickly as possible to their communities and to work with families and community-based organizations to plan for successful reentry. The consensus among the leaders of juvenile correctional institutions, a consensus that the Panel supports, is that in creating safe institutions that are free of sexual abuse, juvenile correctional systems should promote a therapeutic culture, promoting programming that focuses on rehabilitation and engages families in planning for a youth offender's successful transition back to the community.

Staff Training

All of the institutions that appeared at the Panel hearings agreed on the importance of providing staff training. Many of them have already instituted training programs for their staffs on the importance of maintaining professional boundaries in youth correctional settings. The training programs often identify early indicators, called "red flags" or "slippery slopes," that should put staff members on notice that either they or one of their colleagues may be in danger of crossing a professional boundary that could lead to an inappropriate relationship with a youth. Some of the training programs include quite a long list of examples; among them are bringing presents to a youth, sharing personal information with a youth, treating a youth more favorably in comparison to others, and spending time with a youth beyond regular duty hours. Many institutions also noted that when female staff members are experiencing difficulties in their personal lives (e.g., divorce or other loss), they may be especially vulnerable to developing inappropriate relationships with male youth offenders. Again, the consensus among the juvenile corrections administrators who appeared at the Panel hearings, which the Panel also endorses, is that providing effective training to staff, especially female staff, on recognizing behavior that risks crossing a professional boundary would strengthen prevention of staff-on-juvenile sexual misconduct.

Facility Size

The Panel recognizes that some juvenile justice systems in the country may acknowledge Ft. Bellefontaine's positive record but dismiss it as a replicable model because it serves only twenty-four residents. In contrast, Pendleton has well over two hundred. Juvenile justice systems dealing with budget constraints and existing large physical plants may view emulating Ft. Bellefontaine's approach to juvenile corrections as impractical. According to Missouri DYS, the

size of Ft. Bellefontaine is a deliberate organizational decision; no facility in the Missouri system has more than fifty beds.[314] Although the Panel is aware of the financial, political, and institutional pressures that may prevent states from following Missouri's example, many of the administrators of juvenile correctional facilities who presented testimony at the Panel's hearings recognized the importance of placing youths in small facilities close to their homes.[315] Consistent with the views of the administrators who testified at the Panel hearings, the Panel encourages state juvenile correctional systems to consider adopting the strategic goal, perhaps as part of a long-term plan, of placing youth offenders in smaller facilities.

Unresolved Institutional Questions that Warrant Further Study

In reviewing carefully the testimony from the hearings and the facilities' response to the Data Request, the Panel has identified the following questions that merit further study.

What are the factors that lead female staff to become involved emotionally or sexually with male juveniles?

One of the most striking outcomes of the *BJS Juvenile Report* is its identification of the relatively high incidence of female staff having inappropriate sexual encounters with male youth offenders.[316] Without further study of this phenomenon, juvenile correction administrators speculate on the underlying dynamics that led to this result. In the absence of additional research, the Panel has heard two competing narratives that try to make sense of the data. One narrative is that sophisticated older youth manipulate young, vulnerable female staff into emotional relationships that evolve into sexual ones. The other narrative is that female staff members who are unable for a variety of reasons to build satisfying personal relationships with men gravitate, by design or by default, to juvenile facilities, where they find young men who are only too ready under the circumstances to enter into relationships with them that have a sexual component. Only additional research would show whether either of these competing narratives has any merit. Designing prevention strategies and providing effective staff training depend on solid research that sheds light on the underlying dynamics of the sexual encounters between female staff and male youth offenders.

What is the most effective training to encourage healthy professional boundaries?

Some of the administrators of the facilities that the Panel selected for study provided information on the training programs that they have developed for promoting healthy staff-youth professional boundaries. The Panel encourages research on the effectiveness of various training programs in

[314] Tr., T. Decker, 104:2-3.
[315] *See also BJS Juvenile Report* 10 tbl.7. In noting the correlation between small facility size and the low incidence of sexual victimization, the Panel recognizes that large facilities might achieve similar positive results by providing services to youth in small programmatic units.
[316] *Id.* 13 & tbl.11.

creating institutional cultures that achieve healthy staff-youth professional boundaries. The Panel encourages the development of validated training models and materials that juvenile justice facilities throughout the country could use in preventing inappropriate relationships between staff, especially female staff, and youth offenders in custody.

What are the best practices for maintaining the appropriate professional boundaries between staff and juvenile offenders?

Although training must certainly be one of the key elements in maintaining appropriate professional boundaries between staff and juvenile offenders, there is a need for research on what additional practices are effective in creating healthy staff-youth relationships. How do juvenile correctional agencies build professional communities that allow supervisors and colleagues to intervene effectively when they recognize an early indicator that a staff person risks violating a professional boundary? Are there staffing practices (e.g., periodic rotations, reassignment requests, peer support groups) that prevent inappropriate relationships while not damaging the positive relationships that staff and youth may have that promote rehabilitation? The Panel encourages research that would produce a compendium of good management practices that support healthy, professional, staff-youth relationships.

How can institutions better screen staff to avoid sexual misconduct?

Despite administering standard background tests and employing other screening procedures, Pendleton administrators were at a loss in finding a reliable way to identify prospective staff members who might have a propensity to enter into inappropriate relationships with youth offenders.[317] The Panel encourages research that identifies the most effective screening tools for identifying applicants for positions in juvenile justice facilities who may be at risk for crossing professional boundaries. If the tools already exist, then the Panel encourages validation studies that show the correlation between the testing procedures and the reduction of inappropriate staff-youth conduct. If the tools do not exist, then the Panel encourages research on developing screening protocols that would assist juvenile justice facilities in identifying applicants who may stray from their duty to keep the youth they serve safe.

For youth in custody, what are the common characteristics of victims and perpetrators of sexual victimization?

Although the Panel heard some testimony on factors that may characterize victims and perpetrators of sexual victimization in juvenile correctional facilities, the information was incomplete.[318] In reflecting on the characteristics of juvenile victims of sexual abuse, a Pendleton administrator noted that the longer young people are in the juvenile correctional

[317] *See supra* note 193.
[318] The *BJS Juvenile Report* provides some information on the characteristics of victims and perpetrators. *BJS Juvenile Report* 10-13 & tbls.8, 9, 11 & 12; *see supra* pp. 2-3.

system, the more likely they are to become victims.[319] A Corsicana administrator, conceding that there were no reliable data, nonetheless posited that there are "themes" related to victims, including that they are often younger, have a history of trauma or gender identity issues, and may be hyper-sexualized.[320] Noting also the absence of reliable data regarding perpetrators, another Texas administrator observed that when a female staff person becomes involved in an inappropriate relationship with a resident, she is often struggling with self-esteem issues, recovering from a broken relationship, or dealing with something else in her personal life.[321] Perpetrators of juvenile sexual victimization may also, of course, be male staff members (as a prior BJS survey found, using a different methodology than the *BJS Juvenile Report*)[322] or other youths in custody; but the Panel did not obtain information from the selected facilities that would allow it to draw any conclusions about the common characteristics of either of these categories of perpetrators, or any others. In the absence of reliable data from the selected facilities, the Panel encourages researchers to study further the incidents of sexual victimization in juvenile facilities so as to identify additional common characteristics of victims and perpetrators.

How can juvenile justice systems assist staff falsely accused of sexual misconduct?

On both ethical and legal bases, the Panel acknowledges that under no circumstances is a staff person ever a victim when it comes to an inappropriate relationship with a youth, no matter how vulnerable the staff person nor how seductive the youth. Still, in a juvenile justice facility, allegations of sexual misconduct against a staff person can be one of the ways that a savvy youth can retaliate against a facility employee who conscientiously enforces institutional policies. The Panel is aware that staff persons may face unfounded charges. The Panel would like to encourage further study on how to support staff persons when these unfounded charges occur and whether there are institutional practices that take allegations of sexual misconduct seriously while also protecting an innocent staff person's professional reputation.

What are the factors that contribute to youth-on-youth sexual assault in juvenile justice facilities?

In reviewing incident reports from juvenile facilities, the Panel noted that in some of the facilities with the highest prevalence of sexual victimization, there were multiple cases of youth forcing other youth into sexual activities. The Panel encourages research to develop a profile of a youth in custody who is most likely to become a sexual predator. The Panel also encourages research on institutional practices that prevent youth-on-youth sexual victimization. Some of the issues

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[319] Tr., M. Dempsey, 260:7-10.
[320] *Id.*, L. Cazabon-Braly, 458:8-14; *id.*, L. Robinson, 460:2-7.
[321] *Id.*, J. Smith, 459:6-10.
[322] BJS, *Sexual Violence Reported by Juvenile Correctional Authorities, 2005-06* (July 2008), *available at* http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1218. "[M]ost perpetrators of staff misconduct were male, age 25 to 29." *Id.* 6. This report relied on data that juvenile correctional authorities reported, whereas the *BJS Juvenile Report* relied on data that juvenile offenders reported. Tr., A. Beck, 36:22-38:2, 38:5-6, 38:8-39:12.

that researchers should consider include whether a youth's history of sex crimes significantly predisposes the youth to predatory behavior while in custody, whether a facility's classification procedures at intake can reduce sexual victimization, and whether institutional housing policies can successfully keep vulnerable youth safe.

Taking into account youth development, what are healthy, realistic expectations for youth in managing sexual expression while in custody?

In reviewing the *BJS Juvenile Report* and reading incident reports from the facilities selected for the hearings, the Panel is aware of the problem that many juvenile correctional systems have in interrupting uncoerced youth-on-youth sexual activity. Young people in custody are usually in the midst of significant psycho-sexual development while they are in an environment that does not permit any form of sexual expression. The Panel would like to encourage research from developmental psychologists and professionals in related disciplines that would address the issue of how a young person in custody deals with sexuality in a healthy way. The Panel would hope that this research would inform juvenile justice policies and lead to supportive programming for youth offenders.

Conclusion

Making sure that the youth who are entrusted to the care of the nation's juvenile justice systems are safe, free of sexual victimization, is an imperative that the Panel shares not only with the sponsors of PREA but with all the citizenry of the United States. The *BJS Juvenile Report* is an important tool for corrections administrators because it sheds light on both the prevalence and dynamics of sexual victimization in juvenile facilities. Despite the sobering data in the report, the Panel is aware that most correctional administrators are working hard to make their facilities as safe as possible. The Panel also recognizes that no single policy or practice may guarantee a low incidence of sexual victimization. The Panel issues this Report to highlight existing and evolving practices and to encourage further research that will assist juvenile justice facilities better serve youth in custody as well as their families and communities.

Addendum: While retaining the same citations, the Panel would like to amend the second and third sentences in the first full paragraph on page two of this report as follows:

About 2.6% (700) of the total youth surveyed reported experiencing incidents involving other youths, whereas about 10.3% (2,730) of the total youth surveyed reported incidents that involved facility staff members. Approximately 2.0% (530) of the total youth surveyed reported an experience that involved nonconsensual acts; for the reported staff-on-youth incidents, 4.3% (1,150) of the total youth surveyed reported an incident that involved force and 6.4% (1,710) of the total youth surveyed reported an incident that did not involve force.

Appendix A

Overview of the Juvenile Justice System in the United States

Overview of the Juvenile Justice System in the United States

The juvenile justice system in the United States is complex and varied. States treat juvenile offenders in many different ways; some feature more therapeutic rehabilitation-focused programs, while others operate juvenile facilities in much the same manner as adult correctional facilities. Despite these differences, it may be useful for placing the work of the Panel and the *BJS Juvenile Report* in context to have an understanding of the nationwide characteristics of the country's juvenile justice population.

According to the most recent available data,[1] there were 92,854 adjudicated juvenile offenders held in residential placements on any given day in 2007. There were an additional 12,105 residents in these facilities on any given day; these included individuals over the age of twenty-one and youth who have not yet been charged or adjudicated. Of the adjudicated youth in residential placements, 64,163 individuals resided in public facilities and 28,558 were held in private facilities. The juvenile population in these facilities is 85% male and 15% female. Minority youth outnumber white youth by a nearly three-to-one ratio. Most states have a greater proportion of juveniles held for person crimes than for property crimes (i.e., 34% being detained for person crimes as opposed to 25% being detained for property crimes). One third of juveniles remain in placement six months after admission; for offenders held for person crimes, this rate jumps to 45%.

Juvenile delinquency rates have changed over the past decades. For example, the percentage of youth held for person offenses has increased markedly. In 1985, only 16% of youth were held on person crimes, but by 2006, the rate had jumped to 34%. The percentage of youth held for property crimes has steadily decreased over the same time frame, falling from a high of 61% in 1985 to 24% in 2007. The total delinquency case rate increased 43% between 1985 and 1997, and then it declined 15% to the 2007 level. This means that the overall delinquency case rate was 22% higher in 2007 than in 1985. All told, in 2007, juvenile justice systems in the United States processed more than 1.6 million delinquency cases.

[1] *See* Office of Juvenile Justice and Delinquency Prevention Statistical Briefing Book, http://www.ojjdp.gov/ojstatbb/faqs.html (last visited Sept. 23, 2010); National Center for Juvenile Justice, *Juvenile Court Statistics 2006-2007* (Mar. 2010) (Charles Puzzanchera et al.), *available at* http://ww.ncjjservehttp.org/ncjjwebsite/pdf/jcsreports/jcs2007.pdf.

Appendix B

Data Request (Mar. 31, 2010)

U.S. Department of Justice

Review Panel on Prison Rape

Washington, D.C. 20531

March 31, 2010

VIA ELECTRONIC MAIL AND
FEDERAL EXPRESS

[Name]
[Title]
[Facility]
[Address]

Re: Juvenile Facility Hearings of Review Panel on Prison Rape

Dear [Name]:

As you know, the Bureau of Justice Statistics (BJS) at the United States Department of Justice recently issued the report *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09*, which identified the [facility] as having among the [highest/lowest] prevalence of sexual victimization. In response to that report, the Review Panel on Prison Rape (Panel) has selected the [facility] to participate in a hearing at [time] on [date] at the following location: Main Conference Room, Third Floor, Office of Justice Programs; 810 7th Street, N.W.; Washington, DC 20531.

In anticipation of that upcoming hearing, we have enclosed pertinent document and data requests. To prepare for the hearing, we would appreciate receiving responsive documents and information **no later than May 1, 2010**. Please submit the requested information (an original and four copies) to the following address:

Christopher P. Zubowicz, Attorney Advisor
Review Panel on Prison Rape, Office of Justice Programs
U.S. Department of Justice
810 7th Street, N.W.
Washington, DC 20531

We often experience substantial delays in the delivery of regular mail as a consequence of security precautions. Therefore, we recommend that the [facility] send its response to the Panel via a private, overnight mail delivery service. If the [facility] sends its response by an overnight courier, the zip code in the above address should be changed to 20001.

We also have enclosed a list of witnesses whom we would ask you to identify by name and make available for sworn testimony at the hearing. In connection with your oral testimony, the Panel encourages you to submit brief written testimony in response to the BJS's finding that the

[facility] has a [high/low] prevalence of sexual victimization to Mr. Zubowicz no later than May 21, 2010. The Panel also may identify additional witnesses as it reviews the facility's responsive documents and information and prepares for the hearing. The Panel will cover all reasonable costs that invited witnesses may incur in traveling to the hearing.

We will contact you again shortly to make travel and other arrangements related to the hearing.

Sincerely,

Michael L. Alston
Attorney Advisor

Enclosure

Requested Documents and Data

Pursuant to section 4(b)(3)(C) of the Prison Rape Elimination Act (PREA) of 2003, Public Law 108-79, 117 Stat. 972 (codified, as amended, at 42 U.S.C. §§ 15601-15609 (2006)), the Review Panel on Prison Rape (Panel) requests that the (name of agency) produce the information itemized below regarding the (name of institution) on or before May 1, 2010. In preparing the response to the document and data request (please submit an original and four copies), restate each numbered question in full before providing a complete, written answer or supplying the requested documentation. Please organize and label all produced documents to correspond with the numbered questions and, if applicable, their subparts. However, it is not necessary to produce more than one copy of any particular document. The request for information is an ongoing one. Until the date of your hearing before the Panel, we ask the (name of agency) to update its responses to the document and data request as appropriate.

Policy

1. Please provide copies of any relevant state or local laws, internal memoranda, general orders, policy manuals, standard operating procedures, or other documents, any of which applied to allegations of sexual abuse[1] at the (name of institution) from January 1, 2008, through April 30, 2009.

2. For the period of time from January 1, 2008, through April 30, 2009: (a) please state which staff person was responsible for coordinating administrative efforts to eliminate sexual abuse at the (name of institution) in conformity with the goals of PREA; and (b) please provide the name and title of the PREA coordinator for the (name of institution).

3. Please provide the document setting forth the (name of institution)'s standard operating procedures from January 1, 2008, through April 30, 2009, for investigating allegations of sexual abuse, noting in particular any differences in investigating SOJ, VOJ, JOJ, JOS, and JOV allegations. *See supra* note 1.

4. For the period of time from January 1, 2008, through April 30, 2009: (a) please provide the document setting forth the (name of institution)'s standard operating procedures for the use of cross-gender supervision/observation and searches; and (b) describe the extent to which the (name of institution) had any gender-based bona fide occupational qualifications for certain posts.

5. Please provide information describing your security classification and housing assignment process.

[1] For this document and data request: the term "sexual abuse" includes staff-on-juvenile (SOJ), volunteer-on-juvenile (VOJ), juvenile-on-juvenile (JOJ), juvenile-on-staff (JOS), and juvenile-on-volunteer (JOV) sexual assault; "inmate" is a youthful offender who is incarcerated in a juvenile detention facility or a state training school.

Operations

6. Please provide the average age of offenders at the (name of institution) and the age range of offenders at the (name of institution).

7. Please describe your facility's relationship with external organizations related to responding to allegations of sexual assault or inappropriate conduct and provide copies of any formal Memoranda of Understanding (MOUs) that (a) were in place from January 1, 2008, through April 30, 2009, and (b) are currently in place (e.g., with hospitals, medical centers, mental health services, training organizations, and victims services).

8. For the period of time from January 1, 2008, through April 30, 2009, how many juveniles, while housed at the (name of institution), (a) committed suicide, (b) attempted suicide, (c) were homicide victims, (d) were victims of attempted homicide, (e) were diagnosed as mentally ill, (f) were alcohol and other drug abusers, and (g) were sexually abused prior to being institutionalized (if known)?

Human Resources

9. (a) What are the minimum qualifications for custody staff (e.g., age, education, and prior criminal record)? (b) Describe the background screening process for applicants and employees in custody staff positions. (c) What is the turnover rate for custody and program staff?

10. For the period of time from January 1, 2008, through April 30, 2009, (a) how many of the custody staff and program staff were terminated from employment for sexually-related inappropriate conduct or sexually-related criminal behavior?; (b) how many custody staff and program staff were allowed to resign for similar conduct or behavior?; and (c) if available, how many custody staff and program staff were reprimanded or warned about similar conduct or behavior?

11. Please state the overall, average daily ratio of sworn staff to juveniles at (name of institution) from January 1, 2008, through April 30, 2009 (provide one average daily ratio in response to this request; do not provide separate daily ratio figures for each day during the designated time period).

Investigations

12. For the period of time from January 1, 2008, through April 30, 2009, please describe all of the ways that a youthful offender could report an allegation of sexual abuse at (name of institution).

13. Please provide a complete copy of the investigative record involving all allegations of sexual abuse at the (name of institution) that occurred from January 1, 2008, through April 30, 2009, including the identity of the alleged victim and alleged perpetrator(s).

14. Please provide copies of all incident reports that refer to alleged sexual abuse (SOJ, VOJ, JOJ, JOS, and JOV) at the (name of institution) from January 1, 2008, through April 30, 2009 (the Panel solely seeks documents that have not been produced in response to another request).

15. Please provide copies of any disciplinary records showing actions taken against staff, volunteers, or youthful offenders at the (name of institution) from January 1, 2008, through April 30, 2009, involving allegations of sexual abuse or sexually-related inappropriate behaviors (the Panel solely seeks documents that have not been produced in response to another request). Please separate into categories of SOJ, VOJ, JOJ, JOS, and JOV.

16. (a) Please provide copies of complaints filed by juveniles or on behalf of juveniles from January 1, 2008, through April 30, 2009, whether formal or informal, alleging sexual abuse at the (name of institution); and include the disposition or resolution (the Panel solely seeks documents that have not been produced in response to another request).

17. (a) Please describe the qualifications and experience that staff members must have to investigate allegations of sexual abuse at the (name of institution). (b) What is the selection process at the (name of institution) for these staff and how are they trained? (c) What is the investigator's relationship with external resources such as law enforcement, medical facilities, and prosecutors?

18. (a) Has there been any litigation brought against the (name of institution) involving sexual abuse during the last five years? (b) If so, please provide a brief description of the litigation and any settlement/court actions.

Orientation and Training

19. Please describe (a) the staff training process from orientation through in-service sessions, (b) any specific training related to inappropriate relationships or behaviors, (c) any specific training on how to deal with youthful offenders who solicit inappropriate relationships, (d) the training received about reporting sexual misbehavior and any abuse reporting requirements, (e) training on investigative procedures, (f) training for the (name of institution)'s medical staff on intervention and treatment, (g) training of counseling and/or other program staff on sexual abuse/inappropriate relationships related to treatment and casework planning, and (h) any training related to "red flags" for supervisors or managers in all phases of the operation (e.g., custody area; education area; work experience areas; and volunteer, contract, and mentoring activities).

20. (a) For the period of time from January 1, 2008, through April 30, 2009, please detail the processes of how the (name of institution) informed youthful offenders about the potential danger of sexual abuse and sexual misconduct, the procedures for reporting threats of sexual abuse, and the procedures for reporting allegations of sexual abuse. (b) Please detail how the (name of institution) presently informs youthful offenders about the potential danger of sexual abuse and sexual misconduct, the procedures for reporting

threats of sexual abuse, and the procedures for reporting allegations of sexual abuse.
(c) Please provide samples of instructional materials that the (name of institution) (i) used from January 1, 2008, through April 30, 2009, and (ii) uses presently to inform juveniles about how they could prevent or report sexual abuse.

Requested Witnesses

The Panel requests that the (name of agency) make available for sworn testimony the following individuals:

1. (name of agency) Director _____;
2. (name of institution) Superintendent _____;
3. (name of institution) PREA Coordinator;
4. (name of institution) Internal Affairs Manager who heads investigations; and
5. Others who the Director and/or Superintendent recommend and who are approved to attend by the Panel.

The Panel may also request the appearance of individuals referenced in the documents requested above.

Future Actions

The Panel is very interested in knowing what actions the Department and/or Institution have taken to address deficiencies or to build on the strengths identified in the report *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09* (Study).

1. Please provide a list of actions taken since the Study results were released to eliminate sexual assault, sexual abuse, or sexually-related inappropriate relationships between juvenile offenders, between juvenile offenders and staff, or between staff and juvenile offenders. Please provide copies of any newly developed materials or training information that could be used as guidance on this subject.
2. Please provide the Panel with any recommendations for other program operators either to avoid future sexual assault, sexual abuse, or inappropriate relationships in juvenile facilities or to implement successful approaches.

Appendix C

Side-by-Side Matrix of Juvenile Facility Responses to Review Panel on Prison Rape Data Requests (June 2, 2010)

Side-By-Side Data Matrix of Juvenile Facility Responses to Review Panel on Prison Rape Data Requests

(matrix created by Creative Corrections, LLC)

	Missouri	**Rhode Island**	**Indiana**	**Tennessee**	**Texas**
Policy	Missouri Division of Youth Services (DYS) **Fort Bellefontaine Campus**	Rhode Island Department of Children, Youth and Families (DCYF) **Rhode Island Training School (RITS)**	Indiana Department of Correction, Division of Youth Services (DYS) **Pendleton Juvenile Correctional Facility (PJCF)**	Department of Children's Services, Division of Juvenile Justice (DJJ) **Woodland Hills Youth Development Center**	Texas Youth Commission (TYC) **Corsicana Residential Treatment Center (CRTC)**
1) Provide relevant state or local laws, internal memoranda, general orders, policy manuals, standard operating procedures, or other documents, any of which applied to allegations of sexual abuse from January 1, 2008 through April 30, 2009.	State statutes were provided relative to reporting and investigating child abuse and neglect, but laws for juvenile correctional facilities were vague. No local PREA policies were provided. Respondent states no allegations of sexual abuse during this period, and further states policy requests should be considered "non-applicable."	State statutes were provided relative to reporting and investigating child abuse and neglect. Sexual abuse of a "child by another child" is specifically referenced as a "criteria for Child Protective Services (CPS) investigation." No specific references to PREA policy or policy specific to RITS were provided. Some confusion was evident as RITS was	State statute and DYS policies clearly outline procedures regarding sexual assault or violence prevention and reporting, including specific PREA policies. See Policy and Administrative Procedures, July 1, 2005 and October 1, 2009. See policy entitled the Operation of the Office of Internal Affairs for DOC for specific	State statute and DJJ policies and procedures are comprehensive and clear regarding reporting and investigating child abuse and neglect. No PREA policies were provided.	Comprehensive list of Texas state statutes were provided where sexual conduct applies to: Criminal Proceedings; SANE Nurse Program; Family Code; Government Code; Human Resources Code; Penal Code. Also provided were: Institutional Policy Manual; Intake Screening Instruments (including identifiers for potential victims or predators); *Safe Housing* Assessments; and *Texas Commission Reform*

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		excluded from some abuse reporting procedures (DCYF policy Statute 500.0060) without documentation of how RITS cases would be specifically reported.	information.		*Plan.* Other Manuals: *Incident Reporting; Complaint Resolution; Alleged Abuse, Neglect and Exploitation;* and *Alleged Sexual Abuse*
2 (a) Staff person(s) responsible for coordinating administrative efforts to eliminate sexual abuse in conformance with the goals of PREA from January 1, 2008 through April 30, 2009.	None locally. PREA coordination is provided from Central Office and 5 geographic regions.	Superintendent, Deputy Superintendents, School Principal, Clinical Director.	Executive Director of Research and Planning.	Superintendent Albert Dawson.	TYC PREA Coordinator (centralized), CRTC Facility Superintendent.
2 (b) Name(s) and title(s) of PREA Coordinator	No response	Charles Golembeske Jr., Ph.D.	Amanda Copeland; Christine Blessinger (Jan. 2008 – April 2008); and Timothy Greathouse (April 2008 – April 2009)	Superintendent Albert Dawson	TYC - James D. Smith; CRTC Superintendent Laura Cazabon-Braly. Rebecca Thomas Cox and Ron Stewart were previous superintendents for reporting period requested.

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3) Documentation and procedures for investigating allegations of sexual abuse with differences noted in investigating SOJ, VOJ, JOJ, JOS, and JOV allegations from January 1, 2008 through April 30, 2009.	All allegations investigated by internal agencies, governed by policies. (A sexual assault is considered a critical incident for reporting within 24 hours to Regional Office). Law Enforcement officials are notified, with option to investigate. No PREA investigation guidelines or policy was provided.	Allegations are investigated, including employee rights, but reporting requirements confusing as to how RITS alleged abuse cases are to be reported. (Although CPS is a separate division of DCYF, it is responsible for investigating abuse complaints). No specific reference to JOS or JOV incidents of abuse was given. SOJ, VOJ, and JOJ incidents are generically referenced in statute and policy.	All allegations are guided by strong and clear policy and investigated by the Office of Internal Affairs which coordinates all efforts with local and state authorities. No direct references to PREA investigation guidelines were provided but current policies are comprehensive and coordinated.	All procedures for investigating allegations are clearly written; allegations are investigated by either the Office of Internal Affairs or Child Protective Services (CPS), Special Investigations Unit (SIU).	Office of Inspector General (OIG) (established w/in past 3 years) has oversight. Often first reports of allegations, complaints, or incidents are fielded in the Incident Reporting Center. All medical, dental and psychiatric services provided by University of Texas Medical Branch/Correctional Managed Care. Full-time facility nursing coverage. OIG authorized to order SANE exam from local contracted hospital.
4 (a) Provide operating procedures for cross-gender supervision, observation, searches from January 1, 2008	Respondent states awareness supervision reduces necessity for body searches. If required, pat	Procedures provide for posting at least 1 staff person of the same gender of the residents in each unit on each shift.	Documentation on searches and shakedowns was thorough. It stated at least one person of same gender as	Documentation of searches was thorough, including references to parallel American Correctional	See General Administrative Policy Manual PRS.01.05. "Staff assigned who are willing and able to supervise youth of either

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through April 30, 2009.	searches only are conducted by at least 2 employees, preferably one of same gender.		resident conducts searches. Facility also provided a staff development training module on the "Making a Change Academy."	Association Standards. See Policy and Procedures Manual, Search procedures, 27.19, page 7, f.2, g.2.a.	sex. No assignment based on gender, except when both males and females are housed in same unit, in which case at least one male and one female staff will be on duty at all times."
4 (b) Extent of gender-based bona fide occupational qualifications for certain posts	There was no response to question regarding cross-gender supervision ratios or BFOQ's.	Gender-based bona fide occupational qualifications for certain posts are not specified.	The facility stated that it "does not have any gender-based bona fide occupational qualifications for certain posts…" It "makes every effort to assign male staff to certain posts such as shower or restroom areas."	Response was "there were not State of Tennessee, Department of Human Resources interpretations regarding gender-based job descriptions."	All employees are subject to work any shift or post as assigned. There was no reference to BFOQ's.
5) Description of security classification	According to policy, Fort Bellefontaine Campus is considered "moderately secure." A number of	Youth are screened and assessed for mental health by the Massachusetts Youth Screening Instrument (MAYSI II), and	Security classification policies and procedures are comprehensive and clear. The use of	Security classification policies and procedures were comprehensive and clear. Review	For the reporting period requested, two different methods of classification were used. Panel members should review statement from facility

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	assessment forms are completed at intake to determine placement among various facilities. Bed assignment is unclear.	individual needs by Global Appraisal of Individual Needs (GAIN). Specialized Treatment Unit staff classifies youth separately for aggression and sexual offending for assignment to the Specialized Treatment Unit.	assessment instruments is a helpful objective tool in this secure correctional facility to allow classification of all, including high-risk and PREA predator, offenders.	found no assessment instruments used to classify offenders for security reasons.	superintendent for detailed explanation of previous and current classification systems.
Housing assignment process	Placement per institution is based upon intake documents. No documentation was provided regarding housing assignment process other than by facility criteria.	Housing assignments are based on structured decision making instruments allowing for secure or non-secure placement and male detainees step down to the Transition Program. Transition for females was not referenced.	Policy and Procedure Manual lists extensive housing assignments and options, including "PREA considerations."	A psychosexual evaluation is completed on all youth with sexual offender charges.	Thorough written *Safe Housing* screening procedures and assessment and placement are made with emphasis on predictors for sexual victimization or predatory behavior.

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6) Average age of offenders from January 1, 2008 through April 30, 2009. Age range	15.4 years 13-17 years	Boys-17.3 years Girls-17.0 years 13-20 years	16 years 12-19 years	16 years 14-18 years	16.4 years 12-20 years
7) Relationship with external organizations for responding to allegations of sexual assault or inappropriate conduct.	Respondent reports it is fully integrated into state and local services and with the State Technical Assistance Team.	The CPS unit of DCYF is responsible for conducting investigations at RITS but reporting requirements are confusing. Reporting requirements are clear for all other child care circumstances.	Facility has extensive list of partner agencies with whom it interacts, such as the National Alliance on Mental Health and the private, non-profit Indiana Juvenile Justice Task Force, Inc.	Facility reports close relationship with Vanderbilt University for responding to assessment and treatment of allegations of sexual assault and inappropriate behavior.	CRTC "worked in correspondence with Child Advocates of Navarro County in Corsicana, TX…" with regard to 8 cases for reporting period.

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Copies of Memoranda of Understanding (MOUs) **during** reporting period	Health care services are provided through Medicaid-reimbursed services.	There were no copies of MOUs available to review. However, Lifespan, a statewide health organization and hospital, provides services for RITS residents. Lifespan is experienced in treating sexual abuse victims and convenes Multi-discipline Child Protection Teams to discuss RITS incidents of sexual abuse.	There were no MOUs available to review.	Health care and some mental health services are provided by Vanderbilt University through a contract for services. MOUs were in place during period with the Disability and Law Advocacy, Inc.; and Metropolitan Hospital for comprehensive health and mental health services as a result of allegations of sexual abuse, sexual assault, or inappropriate behavior.	SANE nurse services are contracted with local hospital via University of Texas Medical Branch.

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MOUs **currently** in place (e.g., with hospitals, medical centers, mental health services, training organizations, and victims services).	There were no MOUs with other agencies regarding allegations of sexual assault or inappropriate conduct.	There were no copies of MOUs available to review.	There were no MOUs available to review.	These services are currently in place.	For MOUs, see Superintendent Statement. Another MOU is provided between Special Prosecution Unit and OIG regarding "limiting investigations and prosecution of youth committing misdemeanor offenses to those type offenses sexual in nature or youth on youth assaults where the victim's injuries are considered more than first aid, but still fall short of felony definition of Serious Bodily Injury."

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8 (a) Number of suicides while housed	0	0	1	0	0
8 (b) Attempted suicide	0	1	32	3	16
8 (c) Homicide victims	0	Rhode Island does not track this data.	0	0	0
8 (d) Victims of Attempted Homicide	0	Rhode Island does not track this data.	0	0	0
8 (e) Diagnosed as Mentally Ill	32.1%	Medications: 15.5% males; 30% females Diagnosed with anxiety or mood disorders: 30% males; 32% females	111-118 (Criteria used were psychosis or depression).	138	90% of population diagnosed as mentally ill
8 (f) Previously abused drugs and alcohol	45.3%	76.4% males; 69.2% females	226 (Criteria used were weekly use of drugs and/or alcohol).	65	63%
8 (g) Previous sexual abuse	Unknown	5.5% males 23.1% females	60	Unknown	36%
9 (a) Minimum qualifications (custody staff)	Entry level Specialist 60 college hours w/ 6 hours in discipline or high school diploma	Associates Degree in Behavioral Science or Social Work	Three years' work experience, high school diploma or G.E.D. A.A. degree	Education and experience equivalent to high school degree	Under Texas Administrative Code: Texas Commission on Law Enforcement

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	or GED, and experience in direct care interaction with youth.	and/or relevant experience in clinical/correctional environment.	may substitute for work experience only, 21 years of age, background investigation, completion of Correctional Training Institute.		Officer, Jailer Licensing: High school diploma or GED or 12 college hours; U.S. citizen, licensed driver; not prohibited from possessing firearms; meets minimum training standards and pass Commission licensing exam for each license sought.
9 (b) Background screening process for applicants and employees (custody staff)	Employment history; professional certifications and education; fingerprint checks; child care and foster parent licensing records; Department of Mental Health Employee Disqualification Registry; Department of Health and Senior Services Disqualification list;	Background screening and criminal record checks are conducted under DCYF Policy 900.0040 and Federal Law. Also, DCYF Policy 700.0105 is followed for Clearance of Agency Activity required by Adam	Employees must have criminal history check, fingerprint check, sex offender registry, CPS screening, and drug screen.	Employees must have a criminal history and CPS records check. They must undergo health and substance abuse registry clearance, felony and sexual offender registry clearance.	Title 37: Public Safety and Corrections Employment history; criminal background check, arrest record interview, physical examination, no trace of drug dependency or illegal drug use after physical examination, psychological examination, no military discharge for less than honorable conditions.

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	Family Care Safety Registry; Registry for Adult Neglect/Exploitation; Claims Accounting Restitution System for debts owed to the State; Driver's license status.	Walsh Federal Act to check abuse/neglect registry prior to employment.			
9 (c) Turnover rate: Custody Staff Program Staff	21.9% for all job title classes	Turnover was under 5% for all custody staff, which is mostly related to promotion. Program staff turnover not recorded separately.	Custody Staff – 46% Program Staff – 19%	Custody and treatment staff – 27% Program staff – 18.5%	Approximately 26% for Correctional Officers Approximately 25% for Case Managers
10 (a) Employment terminations during reporting period for inappropriate conduct or sexually-related criminal behavior:					

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Custody Staff	0	0	3	0	0
Program Staff	0	0	1	0	0
10 (b) Allowed resignations for same conduct:					
Custody Staff	0	0	1	2	0
Program Staff	0	0	0	0	0
10 (c) Reprimanded or warned for similar conduct or behavior:					
Custody Staff	0	One incident of custody staff sexual harassment of another employee was handled through counseling.	1	One staff failed to report allegation. He investigated it himself and found it unproven. Upon learning about this incident, facility	0 (One offender complaint notes staff member was counseled.)
Program Staff	0	0	0	administrator investigated allegation and also found it to be	0

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				unproven. However, the employee was reprimanded for not following proper reporting procedure.	
11) Staff to juvenile ratio for reporting period-average daily sworn staff to juvenile ratio	8:00 a.m. – Midnight: 1:6; Midnight – 8:00 a.m.: 1:8; Additional staff present during regular business hours.	Juvenile Program Workers: 1:8; Unit Managers: 1:24; Clinical Social Workers: 1:24; Educational Staff: 35; Nurses: 3 employed and on duty from 7:00 a.m. to 11:00 p.m. Ratio of employees by category on per-shift basis was not reported.	1:3 There was no delineation between the three shifts.	1:5	1:6.6 for each shift

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12) For reporting period, methods by which a youthful offender could report allegation of sexual abuse	Grievance; Personal Advocate; Group Leader; Facility Manager; Nurse; Teacher; Trusted Adult including Parents; Service Coordinator; Volunteers; All DYS staff.	There is immediate access to telephone to report abuse. Family Service Unit Worker and Probation Counselor visit facility. Office of the Child Advocate office is located at RITS. There is a Master for the Federal Court and attorney for the plaintiffs. See Rhode Island case entitled *Inmates of the Boys Training School v. Patricia Martinez,* C.A. no. 4529. Unit Managers, Administrators, Nurses at sick call, Private clinical, vocational and educational providers and parents/guardians can be accessed to report allegation.	The "Pound 22 System" exists at this facility. This system allows juveniles to use any telephone and dial #22 to report sexual abuse, misconduct or threats. A grievance process is in place at every facility for juveniles not comfortable in using the "Pound 22 System." Juveniles who cannot talk with staff can tell parents or guardians who can report allegations to the facility on behalf of the youth.	Youthful offenders could report allegations to case manager, medical staff, Family Service worker, contract therapist, family, any staff member, or the attorney on site. An offender can report through the grievance procedure form, upon which CPS is notified. When CPS begins its investigation, that official contacts the Security Manager and Superintendent to ensure there is no contact between those involved in the allegation.	There is "blue" telephone access to Incident Reporting Center (previously known as "investigation hotline"). Allegations can also be made by e-mail, U.S. Mail, Grievance System, or Request for Conference.

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13) Complete copy of Investigative Record involving all allegations of sexual abuse for reporting period to include identities of alleged victim and alleged perpetrator(s)	No allegations were reported	One report of child-on-child sexual abuse (oral sex by fear or intimidation) was reported and complete report was reviewed and appears comprehensive.	Copies of Investigative Records were reviewed and all were clear, comprehensive and contained allegations, dispositions, and names of perpetrators and victims.	Copies of Investigative Records were reviewed and all were clear, comprehensive and contained allegations, dispositions, and names of perpetrators and victims.	Records were provided.
14) Copies of related Incident Reports for the reporting period	None	None except as noted in 13 above.	Copies of related incident reports were submitted and reviewed.	Copies of related incident reports were submitted and reviewed.	TYC/Corsicana produced approximately 590 CCF-225 incident reports and over 200 LS-051 reports of alleged abuse, neglect, or exploitation (although the LS-051 reports extended beyond the timeframe of the data requests and included information from post-April 2009, as well as 2010).

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15) Copies of disciplinary records showing actions taken against staff, volunteers or youthful offenders for reporting period involving allegations of sexual abuse or sexually-related inappropriate behaviors:	None	None	Disciplinary records were provided of incidences of inappropriate sexual activity in the following manner:	Disciplinary records were provided of incidences of inappropriate sexual activity in the following manner:	None. Investigations resulted in case dispositions where no further action was taken, for case numbers assigned.
Staff on Juvenile	0	0	0	6	0
Volunteer on Juvenile	0	0	0	0	0
Juvenile on Juvenile	0	In 13 above, complaint was unfounded due to lack of preponderance of evidence.	6	1	0
Juvenile on Staff	0	0	0	0	0

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Juvenile on Volunteer	0	0	0	0	0
16) Copies of complaints filed by juveniles or on behalf of juveniles for the reporting period	None	One report of child on child sexual abuse (oral sex by fear or intimidation) was reported and complete report was reviewed and appears comprehensive. This complaint was unfounded due to lack of preponderance of evidence.	19 complaints were received and reviewed. All were investigated initially by a facility administrator. 8 complaints were denied, 2 were resolved at an initial hearing, and 9 were referred to Internal Affairs for further investigation.	There were 7 allegations during this period. Internal Affairs and CPS staff investigated these allegations. 2 cases were unfounded and 3 were not sustained. One employee was terminated, another employee resigned as the case was investigated.	19 complaints with copies were provided by Civil Rights office. All were read and reviewed. There were a broad range of allegations. Offenders were able to suggest resolution. There was a formal disposition in all 19 complaints. No action counted as disposition.
Formal	0		9	7	19
Informal	0		10	0	0
Disposition or Resolution	0		19	7	19

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17 (a) Qualifications and experience for staff authorized to investigate allegations of sexual abuse	The Children's Division conducts an investigation. A Child Service Worker must possess a bachelor's degree or higher in the discipline or in Human Services-related fields.	Associates or Bachelors Degree in Criminal Justice. Experience in Law Enforcement or Social Science gained through full-time employment involving investigations or investigating experience related to law enforcement in areas primarily related to juveniles or related activities.	The DYS employs Internal Affairs staff to investigate allegations of sexual abuse. They must possess five years' experience, two as an investigator, a bachelor's degree and accredited graduate training.	A Special Investigator with Internal Affairs investigates allegations of sexual abuse. This investigator must have an undergraduate degree with at least one year of experience as a Special Investigator. Investigators are provided formal training on interviewing and interrogation evidence gathering and other training such as forensic interviewing, CPS training, and Wicklund-Zulawski Child Abuse Interview training	Criminal Investigator I. (Senior Level) Bachelor's degree with emphasis in Criminal Justice or combination of college education and law enforcement experience totaling 4 years (15 semester hours equals 6 months); Peace Officer License; Valid Commercial Driver's License; Acceptable driving record and criminal record check; pre-employment drug testing. 45-minute response time. Administrative Investigator: same as above plus additional education and work experience, with an emphasis on juveniles, correctional environments, treatment,

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				with the TN Bureau of Investigation.	abuse or neglect; 1 year experience in investigations case management or report writing. Minimum response time was not applicable.
17 (b) Selection process	Vacancies are filled using a competitive hiring process, postings, merit-based examination and certification, interview, performance test, and rating system to include background and reference checks.	Vacancies are filled based on civil service requirements and posted job descriptions by Chief of CPS Unit of DCYF.	The successful candidate is selected by a panel including the facility administrator or designee, DOC administrator, a current Internal Affairs investigator, and a Human Resources representative.	Vacancies are filled based on civil service requirements and posted job descriptions by Department of Human Resources, State of TN.	Vacancies are filled per state of Texas personnel system from job announcements noting qualifications, ability to perform essential job functions, background and criminal records check, etc.
Training Process	Training provided through Dep't of Social Services, covering a broad range of topics including: *Legal*	See staff training process in 19 below. Chief of CPS Unit also provides several weeks of mentoring and supervision related to	Training process includes graduation from the training academy with specialized training in the *Reid*	Training includes CPS training, forensic interviewing, Internal Affairs curriculum, regional	For sworn and non-sworn staff, OIG office provides comprehensive training for performing essential job functions, in-service training and

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	Aspects for Investigators, Child, Abuse/Neglect Investigation, Identification and Treatment of Child Abuse and Neglect	RITS abuse investigations.	*Technique of Interviewing and Interrogation.* Sample training certificates were included in the appendices.	training with a multidisciplinary team of district attorney, law enforcement, medical professionals.	outside agency training. All commissioned peace officers must maintain a Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) certification.
17 (c) Investigator's relationship with external resources such as: law enforcement, medical facilities, and prosecutors	Other agencies with which this investigator interacts include: Legal Services, Office of Civil Rights, DYS.	DCYF collaborates with law enforcement agencies, Attorney General's Office and Lifespan health services organization described in question 7 above.	The investigator must work closely with entities such as the State Police, local prosecutors, hospital, and social service officials, as well as parents, juvenile offenders, and facility staff.	The relationship of the investigator with external resources between law enforcement officials, District Attorney, Child Advocacy Center staff, and the juvenile courts is defined by statute.	See description from facility Superintendent. OIG authorizes referral to local contract hospital for SANE services.
18 (a) Litigation involving sexual abuse during previous five years	None	None	None	None	None
18 (b) Description and court action	None	None	None	None	None

Orientation and Training	Missouri Division of Youth Services (DYS) **Fort Bellefontaine Campus**	Rhode Island Department of Children, Youth and Families (DCYF) **Rhode Island Training School (RITS)**	Indiana Department of Correction, Division of Youth Services (DYS) **Pendleton Juvenile Correctional Facility (PJCF)**	Department of Children's Services, Division of Juvenile Justice (DJJ) **Woodland Hills Youth Development Center**	Texas Youth Commission (TYC) **Corsicana Residential Treatment Center(CRTC)**
19 (a) Staff training process from orientation through in-service sessions	Within first two years of employment, all DYS staff must complete at least 180 hours in Adolescent Care Treatment and 40 hours of on-the- job coaching. Forty hours of continuing professional development yearly thereafter is required.	Core Training is provided new DCYF employees prior to and during employment, which includes signs of abuse and specifically sexual abuse. Reporting and investigative protocols are also presented. CPS workers receive cross training with staff from other divisions. All Juvenile Program Workers participate in the six-week Training Academy. Issues related to abuse are covered in two 4-hour modules, one of which is presented by CPS staff. The other Module is presented by the Unit Manager	All staff members begin their employment in a four-week training program, followed by a one-week training session in the *Making A Change* curriculum, followed by a two-week on-the-job training period. Veteran staff receives forty hours of training per year.	All staff members receive 40 hours of orientation before attending the TN Correction Academy for a six-week training program. All staff is required to complete 40 hours of in-service training annually at the Academy or at the facility.	Since 2007, all Juvenile Correctional Officers (JCO) must complete 300 training hours prior to supervision of TYC youth. In addition, staff receives and signs a copy of *Notice of Improper Sexual Activity with Person in Custody* per Texas Penal Code.

Orientation and Training	Missouri Division of Youth Services (DYS) **Fort Bellefontaine Campus**	Rhode Island Department of Children, Youth and Families (DCYF) **Rhode Island Training School (RITS)**	Indiana Department of Correction, Division of Youth Services (DYS) **Pendleton Juvenile Correctional Facility (PJCF)**	Department of Children's Services, Division of Juvenile Justice (DJJ) **Woodland Hills Youth Development Center**	Texas Youth Commission (TYC) **Corsicana Residential Treatment Center(CRTC)**
		of Specialized Treatment Unit, which provides sex offender treatment. The Child Welfare Institute provides follow-up training in sexual abuse and related topics.			
19 (b) Specific training related to inappropriate relationships or behaviors	*Communication, Professional Boundaries, Facilitating for Change* are required training.	Topics are covered in six-week Training Academy and by follow-up training through Child Welfare Institute. Specific courses were not referenced but material includes victimization, grooming behaviors, danger signs of abuse, appropriate styles of interaction, problematic behaviors and therapeutic responses.	Specific related training includes *Understanding and Working with Adolescent Sex Offenders, Supervising High Risk Juvenile Offenders, Making a Change Academy* and PREA training (see Exhibit 19 2).	Specific training includes sexual misconduct, workplace professionalism, workplace harassment, student assaults in facilities, PREA: Responding to Student Sexual Assault, the role of Internal Affairs, Ethical Anchors, and Professional Communication.	All staff trained in CoNEXTions© model; eight-hour *PREA Training* as well as applicable Texas law/policy review including sexual victimization and vulnerable youth.
19 (c) Specific training on how to	Adolescent Care Treatment Workshops	Training on these topics is covered by	Specific training modules include	Specific training includes managing	Specific training included Interventions, *Perceived*

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deal with youthful offenders who solicit inappropriate relationships	are provided.	Core Training, Training Academy and Child Welfare Institute.	sexual misconduct in an institution.	the manipulative student, student misconduct, and student assaults in facilities.	*Consent,* Age-appropriate roles and conduct, *Juvenile Health and Development*, *Understanding TYC Youth.*
19 (d) Training received-reporting sexual misbehavior and any abuse reporting requirements	All employees read and sign policies on abuse.	This training was provided in Core Training.	Specific training modules include sexual misconduct, misbehavior, and abuse reporting requirements in an institution.	Specific training includes mandatory reporting laws, workplace harassment, the role of Internal Affairs, and sexual abuse and assault reporting.	Training included Texas Penal Code and TYC policies; when and how to report verbally and in writing suspected abuse, neglect or exploitation; *PREA and Preventing Sexual Misconduct* and other policy training.
19 (e) Training on investigative procedures	This training is provided through Department of Social Services on a range of topics including: *Legal Aspects for Investigators, Child Abuse/Neglect Investigation,*	Investigative procedures were provided by CPS workers in training academy module.	Basic training is provided all staff in general investigative procedures. However, specific sexual victimization complaints are investigated by the Office of Internal	Investigations are conducted by Internal Affairs. They receive training on interviewing and interrogation techniques and evidence gathering.	OIG investigators are certified and have received extensive training in conducting investigations per Texas State Statute and DYC policy.

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	Identification and Treatment of Child Abuse and Neglect.		Affairs.		
19 (f) Training for facility medical staff on intervention and treatment	None was identified.	Facility medical staff received training in a-d above. No specific training for facility medical staff on intervention and treatment was noted.	No specific training for facility medical staff on intervention and treatment was noted.	Training for medical staff provided for review was extensive, comprehensive, and specific "in the event of a sexual assault" at the facility.	Extensive training specific to managing and treating the youthful population was documented. SANE protocols are established.
19 (g) Training of counseling and/or other program staff on sexual abuse and inappropriate relationships related to treatment and casework planning	No specific response was given.	See a-d above.	Specific training materials in these areas were provided and reviewed.	Specific training courses are presented for program staff that includes Sexual Abuse: Building Trusting Relationships with Families and Conducting Family Centered Assessments.	Counseling and other program staff members receive the same, four-week training as correctional officers.
19 (h) "Red Flag" training for supervisors or managers in all	None was identified.	See a-d above. Supervisors and managers received and trained program staff	Specific training was outlined in the *Understanding and Working with*	There is no specific training in this area. This area will be included in the	Excellent "Red Flags" section included in *PREA and Preventing Sexual Misconduct* to include:

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phases of facility operations (custody, education, work areas, volunteers, contract and mentoring)		in detecting signs of sexual abuse.	*Adolescent Sexual Offenders* module.	current course development. A PREA course has been taught at the Academy since August 2007.	Signs of Favoritism; Confrontation; Sexual and Personal Banter; Further training was provided in changes in behavior or appearance, rumors, sharing food or other items between offenders, sexualized conversations between staff and youth, etc.
20 (a) For the reporting period, process for informing youthful offenders about: (1) Potential danger of sexual abuse and sexual misconduct, (2) Procedures for reporting threats of sexual abuse, and (3) Procedures for reporting	Youthful offenders were provided information about basic rights and grievance procedures. Facility reports always attempting to create a climate of safety.	Children's Bill of Rights for Rhode Island is posted in all living units pursuant to RI General Law 42-72-15. Risk Assessment also reviews safety and resources for reporting with residents during orientation. Daily contact with Clinical Staff and Unit Managers. Youth are encouraged to report all inappropriate	Youthful offenders were provided information about basic rights and grievance procedures, PREA considerations and guidelines and signed a sheet following instruction. Specific training for youthful offenders on reporting incidences, threats,	Four staff are designated to complete the intake process for newly admitted youth. During the intake process, each new resident receives a copy of the student handbook. Page 17 has a Sexual Abuse/Assault Reporting section which the resident can use in the event of abuse or assault.	According to statement provided by James D. Smith, Director of Youth Services, Sexual Abuse Education is included as a part of the orientation process for TYC youth, to include potential of sexual abuse, sexual misconduct, and procedures for reporting. Information is reinforced using posters, written materials and personal instruction for grievances and reporting hotline.

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allegations of sexual abuse		behavior by staff or residents.	and allegations of sexual abuse were noted.	This material is explained and read aloud to the resident. The resident is advised that by law all allegations of sexual or physical abuse to CPS will begin a formal investigation.	Zero Tolerance policy is emphasized.
20 (b) At the present time, process for informing youthful offenders about: (1) Potential danger of sexual abuse and sexual misconduct; (2) Procedures for reporting threats of sexual abuse; and (3) Procedures for reporting allegations of	Facility acknowledges need to become more deliberate in establishing procedures to address these issues.	This information is provided during GAIN Assessment tool administration at orientation.	Youthful offenders receive training on the units of potential danger of sexual abuse and misconduct. Youthful offenders also receive training on the units and at Intake on reporting threats of sexual abuse. The facility staff emphasizes zero tolerance for any sexual abuse or misconduct.	Same as 20(a) above.	Facility Superintendent reports offenders are provided extensive orientation materials with information about how to contact the Incident Reporting Center. Complaints reflect offenders' awareness of process as well.

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sexual abuse.					
20 (c) **For the reporting period,** samples of instructional materials used to inform juveniles about how they could prevent or report sexual abuse	None was provided.	None was provided.	Excellent materials are provided in Exhibit 20 1 (1).	None was provided.	None was provided.
For the present time, sample instructional materials used to inform juveniles about how they can prevent or report sexual abuse	None was provided.	None was provided.	Excellent materials are provided in Exhibit 20 1(1).	Excellent materials are provided in Exhibit 21, Book 2 of the Manual provided for review.	None was provided.
Please provide a list of actions taken since the Study results were released to	*See* written testimony of Tim Decker and Future Actions Summary.	*See* written testimony of Patricia Martinez.	*See* written testimony of Edwin Buss and Future Actions Summary.	*See* written testimony of Steven Hornsby and related Future Actions Summary.	*See* written testimony of Cheryln Townsend, statement of James Smith, and Action Plan.

Orientation and Training	Missouri Division of Youth Services (DYS) **Fort Bellefontaine Campus**	Rhode Island Department of Children, Youth and Families (DCYF) **Rhode Island Training School (RITS)**	Indiana Department of Correction, Division of Youth Services (DYS) **Pendleton Juvenile Correctional Facility (PJCF)**	Department of Children's Services, Division of Juvenile Justice (DJJ) **Woodland Hills Youth Development Center**	Texas Youth Commission (TYC) **Corsicana Residential Treatment Center(CRTC)**
eliminate sexual assault, sexual abuse, or sexually-related inappropriate relationships between juvenile offenders, between juvenile offenders and staff, or between staff and juvenile offenders. Please provide copies of any newly developed materials or training information that could be used as guidance on this subject.					
Please provide the Panel with any recommendations	*See* written testimony of Tim Decker and Future Actions Summary.	*See* written testimony of Patricia Martinez.	*See* written testimony of Edwin Buss and Future Actions Summary.	*See* written testimony of Steven Hornsby and related Future Actions	*See* written testimony of Cheryln Townsend, statement of James Smith, and Action Plan.

Orientation and Training	Missouri Division of Youth Services (DYS) **Fort Bellefontaine Campus**	Rhode Island Department of Children, Youth and Families (DCYF) **Rhode Island Training School (RITS)**	Indiana Department of Correction, Division of Youth Services (DYS) **Pendleton Juvenile Correctional Facility (PJCF)**	Department of Children's Services, Division of Juvenile Justice (DJJ) **Woodland Hills Youth Development Center**	Texas Youth Commission (TYC) **Corsicana Residential Treatment Center(CRTC)**
for other program operators either to avoid future sexual assault, sexual abuse, or inappropriate relationships in juvenile facilities or to implement successful approaches.				Summary.	

Appendix D

Witness List for Review Panel on Prison Rape Hearings on
Sexual Victimization in Juvenile Correctional Facilities (June 3-4, 2010)

Review Panel on Prison Rape
Hearings on Sexual Victimization in Juvenile Correctional Facilities

Witness List

June 3, 2010

Dr. Allen J. Beck, Bureau of Justice Statistics

For the **Fort Bellefontaine Campus**, Missouri Division of Youth Services:

Timothy Decker, Director, Division of Youth Services
Donald Pokorny, Jr., St. Louis Regional Administrator, Division of Youth Services
Phyllis Becker, Deputy Director, Leadership Development and Quality Improvement, Division of Youth Services

For the **Rhode Island Training School**, Rhode Island Department of Children, Youth and Families:

Patricia Martinez, Director, Department of Children, Youth and Families
Kevin Aucoin, Superintendent (Acting), Rhode Island Training School
Stephenie Fogli-Terry, Associate Director of Child Protection/Child Welfare, Department of Children, Youth and Families

For the **Pendleton Juvenile Correctional Facility**, Division of Youth Services, Indiana Department of Correction:

Edwin Buss, Commissioner, Indiana Department of Correction
Michael Dempsey, Executive Director, Division of Youth Services, Indiana Department of Correction
Dr. Amanda Copeland, Director of Research and Planning, Indiana Department of Correction
Linda Commons, Superintendent, Pendleton Juvenile Correctional Facility
Tim Greathouse, PREA Coordinator, Pendleton Juvenile Correctional Facility
Chris Blessinger, Former PREA Coordinator, Pendleton Juvenile Correctional Facility
Mavis Grady, Internal Affairs, Pendleton Juvenile Correctional Facility

June 4, 2010

Dr. Allen J. Beck, Bureau of Justice Statistics

For the **Woodland Hills Youth Development Center**, Division of Juvenile Justice, Tennessee Department of Children's Services:

Steven C. Hornsby, Deputy Commissioner, Division of Juvenile Justice, Tennessee Department of Children's Services
Albert Dawson, Superintendent, Woodland Hills Youth Development Center
Carla Aaron, Executive Director, Division of Child Safety, Tennessee Department of Children's Services
Patricia C. Wade, Lead Reviewer of Quality Service Review Teams, Tennessee Commission on Children and Youth

For the **Corsicana Residential Treatment Center**, Texas Youth Commission:

Cheryln K. Towsend (via telephone), Executive Director, Texas Youth Commission
Laura Cazabon-Braly, Superintendent, Corsicana Residential Treatment Center
Cris W. Love, Sr., Inspector General, Texas Youth Commission
Lori Robinson, Director, Specialized Treatment Services, Texas Youth Commission
James D. Smith, Director of Youth Services/PREA Coordinator, Texas Youth Commission

Enhancing our Understanding of Sexual Assault in Youth Facilities – CJCA

Enhancing our Understanding of Sexual Assault in Youth Facilities: Individual and Facility Level Correlates

CJCA Blog – Council of Juvenile Correctional Administrators

Posted by Darlene Conroy
March 08, 2017
More from this author |

Written by Allen J. Beck, Ph.D., Senior Statistical Advisor, Bureau of Justice Statistics and Jessica Stroop, Statistician, Bureau of Justice Statistics.

In 2003, when Congress passed the Prison Rape Elimination Act (PREA), it required the Bureau of Justice Statistics (BJS) to "carry out, for each calendar year, a comprehensive statistical report and analysis of the incidence and effects of prison rape" from a sample "not less than 10 percent of all federal, State and county prisons" (P.L. 108- 79).

To meet this requirement, BJS worked with juvenile justice, prison, and jail administrators and other stakeholders throughout the nation. While much has been learned about rape and sexual assault in the nation's juvenile correctional facilities since 2003, the Act requires BJS to continue its data collection efforts.

The National Survey of Youth in Custody (NSYC-3) is the third collection of these data, and will begin in juvenile facilities in late fall of 2017. In previous surveys, a large number of juveniles have been interviewed, including more than 9,000 in 2008-09, and 8,700 in 2012. Findings from these surveys show that juveniles have high rates of sexual victimization when compared to incarcerated adults in prisons and jails. In 2012, about 9.5% of juveniles reported some type of sexual victimization that was perpetrated either by another youth (2.5%) or staff (7.7%). BJS has published these findings and others in detailed reports available on its website: https://www.bjs.gov/
A key requirement of the Act is for BJS through youth self-reports to provide a listing of facilities ranked according to the prevalence of sexual victimization. In response, BJS developed procedures in which data are collected directly from youth in a private setting using audio computer-assisted self-interview (ACASI) technology with a touchscreen laptop and an audio feed to maximize confidentiality and minimize literacy issues. The NSYC-2 was conducted in 2012 in a random sample of 273 state-owned or –operated juvenile facilities and 53 local or privately operated facilities that held adjudicated youth under state contract. In addition to facility-level estimates, the NSYC-2 provided state-level estimates. State-level rates were particularly valuable in states comprised of small facilities that were too small to provide reliable estimates. Since 2012 the number of youth held in juvenile facilities has dropped sharply. To meet the requirements of the Act, BJS has modified the sampling procedures and reporting criteria to better provide estimates for the largest facilities and for facilities state-wide.

The purpose of the NSYC has always been to measure the prevalence and incidence of sexual victimization; however, the Act has also challenged us to better understand sexual victimization. In July 2016, BJS published additional analyses of that looked at facility- and individual-level correlates of sexual victimization. Findings from that analyses showed that facilities with higher rates of sexual assault do not have enough staff to monitor what takes place in the facility, have higher levels of gang fights and tend to house youth in multiple living units. The full report is available on the BJS website.

These analyses, along with a stakeholder workshop held in Washington, DC in April 2016 and other outreach efforts, have provided the basis for development of new questions for the NSYC-3. The intention of the new items is to help us better understand youth-on-youth victimization and staff sexual misconduct, including more detail on the circumstances surrounding the reported incidents. NYSC-3 will include a

detailed incident report that asks youth about their most recent experience. It will also include a more detailed facility survey, which will separately identify additional characteristics of facilities that have higher or lower rates of sexual victimization.

When administered later this year, it will be the first time the NSYC will be conducted since the release of the PREA standards. NSYC-3 will determine the impact the standards have had on the prevalence of sexual victimization, the type of incidents, the reporting behaviors of victims, and the response by correctional staff when incidents occur. As a consequence, in addition to ranking facilities, a focus of the next NSYC will be to measure the impact of these standards and other efforts, to see if the incidence of sexual assault has changed.

A pilot test of the NSYC-3 is being completed in spring 2017, and will be followed by a test of the Spanish language version in early summer. National data collection in facilities is scheduled to occur in late 2017, once the survey has been approved by the Office of Management and Budget. The first report from NSYC-3 is expected in late 2018 or early 2019.

Written by Darlene Conroy

CJCA Toolkit Reducing the Use of Isolation

COUNCIL OF JUVENILE CORRECTIONAL ADMINISTRATORS TOOLKIT: REDUCING THE USE OF ISOLATION

March 2015

…."Although room confinement remains a staple in most juvenile facilities, it is a sanction that can have deadly consequences…. more than 50 percent of all youths' suicides in juvenile facilities occurred while young people were isolated alone in their rooms and that more than 60 percent of young people who committed suicide in custody had a history of being held in isolation."

Lindsay M. Hayes,
Juvenile Suicide in Confinement:
A National Study. 2004

CJCA Council of Juvenile Correctional Administrators

CCAS
Center for Coordinated Assistance to States

Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation

Council of Juvenile Correctional Administrators

March 2015

This Toolkit was prepared by the Council of Juvenile Correctional Administrators (CJCA) with support from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) through the Center for Coordinated Assistance to the States.

The Center for Coordinated Assistance to the States is a Cooperative Agreement between the U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention and the American Institutes for Research (AIR). CJCA partners with AIR and the Center for Juvenile Justice Reform at Georgetown University to assess the need for and coordinate the delivery of high quality research driven training and technical assistance to improve juvenile justice policy and practice.

Copies of this Toolkit can be downloaded at www.cjca.net

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A CJCA Toolkit: Reducing the Use of Isolation

CJCA Board of Directors

Suggested citation:
Council of Juvenile Correctional Administrators. (2015). Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation [Toolkit] Retrieved from http://www.cjca.net

Acknowledgements

CJCA is grateful to the many individuals who assisted in developing this Toolkit and willingly shared their talents. We extend our gratitude to the moderator and CJCA administrator panelists who participated on the panel on "Culture Change and Reducing the Use of Isolation" during the CJCA Second Annual Leadership Institute, Oct. 1-3, 2014: Robert L. Listenbee, OJJDP Administrator, Mike Dempsey (IN), Peter Forbes (MA), Candice Jones (IL), Fariborz Pakseresht (OR) and the many directors who participated in the Leadership Institute.

We thank Laurie Garduque, Director, Justice Reform at the John D. and Catherine T. MacArthur Foundation whose generous grant to CJCA supported the Leadership Institute, a component of the CJCA Resource Network.

The Toolkit was prepared by Karen Chinn, President, of Chinn Planning, Inc. Kim Godfrey, Executive Director, PbS Learning Institute provided invaluable assistance editing the document and reviewers included: Phil Harris, Michael Umpierre, Sharon Harrigfeld (ID), Stephanie Bond (WV), and Candice Jones (IL).

TABLE OF CONTENTS

APPENDICES

INTRODUCTION

The Council of Juvenile Correctional Administrators (CJCA) membership is comprised of juvenile justice system administrators and directors from across the United States who meet annually to discuss common issues, share experiences, review emerging trends, and attend workshops and seminars that promote best practice in delivery of juvenile justice services.

One of the critical issues discussed by members over the past few years is the use of isolation at correctional and detention facilities. A response to behavioral problems in many facilities has been reliance on isolation for acting out youths who are mentally challenged, chronically violent, or gang involved. Instead of being used as a last resort to protect youths from self-harm, hurting others or causing significant property damage that is terminated as soon as a youth regains control, isolation too often becomes the behavior management system by default.

Research has made clear that isolating youths for long periods of time or as a consequence for negative behavior undermines the rehabilitative goals of youth corrections. Agencies and facilities across the country are looking for help to change practices to align with the research and promote positive youth development. Many agencies have made sustainable reforms eliminating and reducing the use of isolation; at least 10 states have banned punitive solitary confinement. However others see increasing use of isolation and face significant barriers and resistance to changing the practice.

At the CJCA October 2014 Leadership Institute a panel of four state agency directors and the administrator of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) led the approximately 50 leaders in an open discussion of the need to address the use of isolation, the barriers to changing facility culture and practices, and strategies and tools that the directors used to reduce the use isolation in their facilities. The group of juvenile correctional leaders spoke frankly also about the need to develop alternative approaches to managing behavior and the difficulties they face changing staff beliefs and attitudes that isolation is a necessary management tool despite research showing it is counterproductive and harmful.

At the conclusion of the October 2014 CJCA Leadership Institute, members requested that a Toolkit be developed for states to use as a guide to reduce the use of isolation in youth correctional and detention facilities. CJCA presents this toolkit to help its members and the field reduce the use of isolation and ultimately better help youths in juvenile facilities become successful members of the community.

The CJCA Toolkit provides:

- An overview of the issue of isolation and how it is defined;
- A summary of the research substantiating the negative impacts of isolation;
- Five steps to reducing the use of isolation:
    1. Adopt a mission statement and philosophy that reflects rehabilitative goals.
    2. Develop policies and procedures for use and monitoring of isolation.
    3. Identify data to manage, monitor and be accountable for use of isolation.
    4. Develop alternative behavior management options and responses.
    5. Train and develop staff in agency mission, values, standards, goals, policies and procedures.
- Action steps for CJCA directors; and,
- Case studies from four state agencies that significantly reduced the use of isolation.

OVERVIEW OF THE ISSUE OF ISOLATION AND HOW IT IS DEFINED

Department of Justice data indicates that roughly 70,000 young people are held daily in state, county, private and federal juvenile residential facilities across the United States and that the use of isolation, including solitary confinement, in these facilities is widespread.

One of the first obstacles to changing the practice of placing youths in isolation is that there is no nationally agreed on definition of isolation and no national publication of standardized, uniform and comparable isolation data. The one program that does have standardized, uniform and comparable data, Performance-based Standards (PbS), is voluntary and not adopted in every state[1].

For the purposes of this Toolkit, isolation means: Any time a youth is physically and/or socially isolated for punishment or for administrative purposes. (This intentionally excludes protective and medical isolation.)

[1] PbS was launched by OJJDP in 1995 to address the dangerous and ineffective conditions of confinement in juvenile facilities. CJCA was selected by OJJDP to develop national performance standards and performance outcome measures to manage facilities according to research and best practices.

Isolation has many names and many variations of location and duration:

- Solitary confinement, the most extreme form of isolation, is physical and social isolation in a cell for 22 to 24 hours per day;
- Time out, a short cooling off period in a room or other location away from the general population and/or activities;
- Room confinement, placing youths in their rooms and not allowing them to leave, whether as a punishment or administrative purpose (i.e., staff shortage);
- Seclusion;
- Special management housing units where youths are placed for disciplinary purposes that removes them from the general population. Limited programming such as education may be provided, but there is very limited out of room activity.

> ***"Our feeling was, why ever deprive yourself of a tool? Corrections is about tradeoffs, and one of the tradeoffs is if you don't use a tool like this, you disrupt the program for everybody else. If you have somebody who is messing things up so other wards who are trying to participate and deal with their issues can't do it, then what you've done is you've said "Well, we're not going to isolate this ward. In exchange we're going to let him mess up the program for 10 or 15 other guys. It's necessary for programming, it's necessary for staff safety, it's for the safety of the other wards—at times."***
>
> ***Source: Craig Brown, Chief Lobbyist for the California Correctional Peace Officers Association. "Juvenile Solitary***

The opposition to reducing the use of isolation comes most vocally from staff and unions. They argue that restricting or eliminating the practice puts staff in danger and facility security at risk; it would remove a tool from their tool belt of sanctions and the youths would run the facilities. There is no research showing any of those reasons to be true.

A SUMMARY OF THE RESEARCH SUBSTANTIATING THE NEGATIVE IMPACTS OF ISOLATION

Academic research continues to show that placing incarcerated youths in isolation has negative public safety consequences, does not reduce violence and likely increases recidivism. Subjecting developing adolescents to isolation can cause permanent psychological damage and multiple studies suggest it is highly correlated with suicide. Additionally, youths who are placed in isolation can be subjected to revocation of privileges such as reduced family visitation or limited access to educational programming and classes – two practices research has shown positively impacts youths.

Research also has shown that isolation can cause serious psychological, physical, and developmental harm, resulting in persistent mental health problems, or worse, suicide. Lengthy periods of isolation can be equally traumatizing and the result is the same

serious risk to health. These risks are magnified for youths with disabilities or histories of trauma and abuse. Experts agree that adolescents are particularly vulnerable to psychological harm caused by isolation because their brains are still developing. Solitary confinement is the most harmful and extreme form of isolation and has damaging impacts (See the sidebar story: "Solitary Confinement Harms Children" for more information).

The overwhelming research that isolation, and particularly prolonged solitary confinement, can cause serious mental health-trauma, re-traumatization, depression, anxiety, psychosis, suicide, self-harm, violence and negatively impacts education, rehabilitation, physical health, family involvement and social development prompted the American Academy of Child and Adolescent Psychiatry (AACAP) to develop a policy statement opposing the use of prolonged isolation (see Appendix C for a copy of the statement). There is no research showing the benefits of using isolation to manage youths' behavior.

SOLITARY CONFINEMENT HARMS CHILDREN

Solitary confinement is well known to harm previously healthy adults, placing any prisoner at risk of grave psychological damage. Children, who have special developmental needs, are even more vulnerable to the harms of prolonged isolation.

- **Psychological Damage:** Mental health experts agree that long-term solitary confinement is psychologically harmful for adults—especially those with pre-existing mental illness and the effects on children are even greater due to their unique developmental needs.
- **Increased Suicide Rates:** A tragic consequence of the solitary confinement of youth is the increased risk of suicide and self-harm, including cutting and other acts of self-mutilation. According to research published by the Department of Justice, more than 50% of all youth suicides in juvenile facilities occurred while young people were isolated alone in their rooms, and that more than 60% of young people who committed suicide in custody had a history of being held in isolation.
- **Denial of Education and Rehabilitation:** Access to regular meaningful exercise, to reading and writing materials, and to adequate mental health care—the very activities that could help troubled youth grow into healthy and productive citizens—is hampered when youth are confined in isolation. Failure to provide appropriate programming for youth including access to legal services hampers their ability to grow and develop normally and to contribute to society upon their release.
- **Stunted Development:** Young people's brains and bodies are developing, placing youth at risk of physical and psychological harm when healthy development is impeded. Children have a special need for social stimulation and since many children in the juvenile justice system have disabilities or histories of trauma and abuse, solitary confinement can be all the more harmful to the child's future ability to lead a productive life. Youth also need exercise and activity to support growing muscles and bones.

Source: ACLU STOP SOLITARY "Ending the Solitary Confinement of Youth in Juvenile Detention and Correctional Facilities,"2015.

Conversely, research has shown that the facilities that minimally use isolation are more safe – fewer injuries to youths and staff, less suicidal behavior and overall violence – and healthier staff-youth relationships that lead to less recidivism. Research done using Performance-based Standards (PbS) data multiple times between 2007 and 2011 showed healthy staff-youth relationships and four specific practices, including placing youths in isolation, were consistent predictors of youths' odds of victimization while at the facility. The PbS findings were supported by the Pathways to Desistance Study that showed youths' positive experiences in facilities impacts their likelihood of re-offending.

"You literally are locking a child down with nothing to do, with no interaction, for 22, 23, 24 hours a day. In some ways, it's common sense to look at the denial of education, the denial of drug treatment, the denial of adequate mental health care that exists in solitary confinement, and think to yourself 'Well, what's going to be the result for that kid? How could anything positive ever come from such treatment?' And the answer is, it doesn't."
Bart Lubow, Annie E. Casey Foundation

Source: "Juvenile Solitary Confinement: Modern-Day 'Torture' in the US", by Gary Gately, March 5, 2014.

CJCA POSITION ON THE USE OF ISOLATION

The Council of Juvenile Correctional Administrators believes that isolating or confining a youth in his/her room should be used only to protect the youth from harming him/herself or others and if used, should be for a short period and supervised.

CJCA believes that all jurisdictions should have a written policy that limits the use of isolation to situations involving a serious threat by a youth to harm oneself or others, the authority that must approve its use, for what duration of time, appropriate and adequate staff to monitor the youth with appropriate follow up and review. CJCA supports the following guidelines for the use of isolation:

1. The use of isolation should be a last resort only after verbal de-escalation techniques are employed to defuse a situation;

2. All staff should be trained in use of Isolation policy;

3. Isolation may not be used as punishment;

4. Staff must request permission to use room confinement from higher managers in a facility;

5. Residents on 'suicide watch' may never be placed in isolation;

6. Any use of isolation beyond 15-minutes must be recorded in incident reports;

7. Duration of isolation must be recorded;

8. Medical and Mental Health staff should be included in the intervention; and

9. Use of isolation report should be completed and reviewed at program and higher administrative levels.

FIVE STEPS TO REDUCE THE USE OF ISOLATION

The following five steps to reduce the use of isolation were compiled based on the national body of research that supports positive youth development and the harms of using isolation, best practices used by four states that have reduced the use of isolation (see Appendix B State Examples) and the national discussion held at the 2014 CJCA Leadership Institute.

1. Adopt a mission statement and philosophy that reflects rehabilitative goals;
2. Develop policies and procedures for use and monitoring of isolation;
3. Identify data to manage, monitor and be accountable for use of isolation;
4. Develop alternative behavior management options and responses; and,
5. Train and develop staff in agency mission, values, standards, goals, policies and procedures.

Reducing the use of isolation successfully and sustainably requires a holistic approach to agency reform and culture change, starting with the leadership.

Step 1: Adopt a Mission Statement and Philosophy that Reflects Rehabilitative Goals

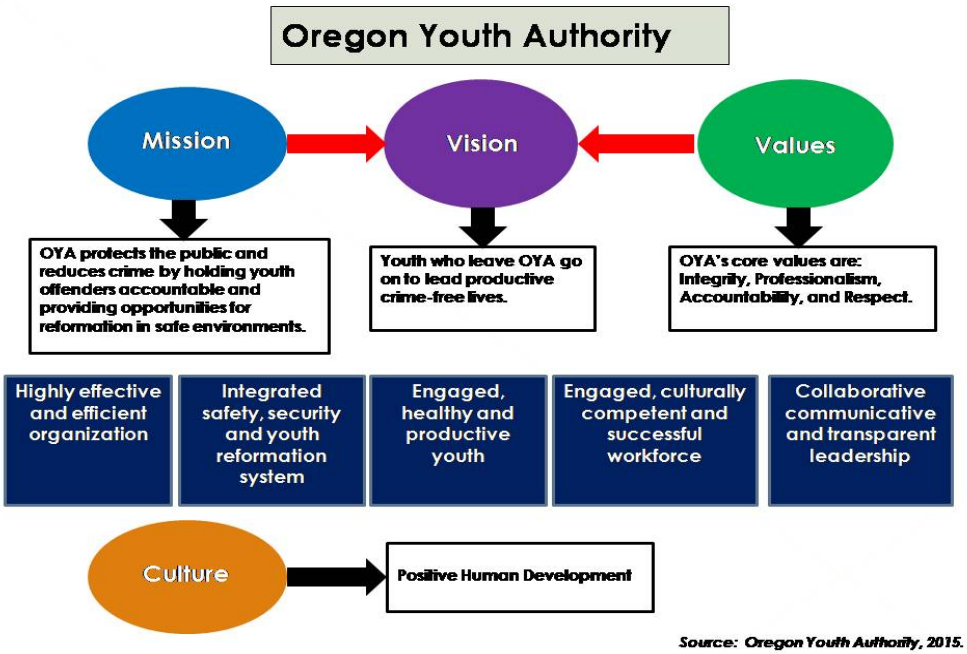
Agency chief executive officers must lead the change in agency and facility culture. The first step is to examine the agency's overall vision, mission, goals and values for delivery of services to youth. These statements should reflect the philosophy of the jurisdiction, and the philosophy should be reflected in all operations throughout the facility. Policies and procedures associated with the use of isolation have to tie back into the overall vision and mission of the system and facility. States that have adopted a mission and philosophy of therapeutic rehabilitation of youth do not rely on isolation because isolating youth does not support the mission and philosophy of rehabilitation.

GUIDELINES TO REDUCE ISOLATION

- Develop immediate correction actions.
- Develop graduated sanction grid.
- Conversion to trauma – informed care – calming rooms (60% reduction of room confinement).
- Make facilities more home like.
- Policy and procedures clearly articulated.
- Alternatives for staff when serious incidents take place.
- Collaborative problem solving
- Explosive child – what are the pre-cursors? triggers?
- Clinical interventions based on scientific and behavioral research.
- Utilize various levels of treatment based on development levels.
- Relapse prevention programming.
- Staff, Youth and Family Input
- Research and implement "Best Practices".
- Educate leadership, stake holders and staff.
- Stakeholder support.
- Continuous improvement and measurement.

Source: CJCA Leadership Institute. October 2014.

The Oregon Youth Authority (OYA) adopted a model of Positive Human Development, which is reflected in all aspects of operations and service delivery. The use of isolation, particularly punitive isolation, is not consistent with the mission, vision and values outlined by OYA.



Source: Oregon Youth Authority, 2015.

States that provide "evidence-based" therapeutic treatment programming use youth-centered therapeutic treatment models that do not support the use of isolation, particularly as a punitive measure. Typical practices of youth-centered therapeutic treatment facilities include:

- Maintain staff-to-youth ratios of at least 1:8 (ideally 1:6) during waking hours, and 1:12 during sleeping hours (counting only staff engaged in continuous and direct supervision of youth).
- Provide staff with specialized training and ongoing coaching in age-appropriate, positive behavior-management techniques, particularly de-escalation techniques designed for youth.
- Incorporate positive, rewards-based management practices that do not primarily rely on punitive discipline to manage youth behavior.
- Provide age-appropriate education, programming, recreational activities, and other services that take up a significant proportion of the youth's waking hours, seven days a week, available to all youth at all times (even when they are separated from the general population).
- Provide access to dental, medical, and mental health services from qualified professionals with specialized training in caring for children and adolescents; these services should be available to all youth at all times (even when they are separated from the general population).
- Ban the use of mechanical and chemical restraints, corporal punishment, or other such punitive measures.
- Conduct classification and evaluations on youth to identify educational, programming, mental health and other needs and diagnoses.

If an agency's mission is therapeutic rehabilitation of youths, use of isolation will be greatly reduced or eliminated based on the overwhelming evidence that isolation is harmful to youths and does not support therapeutic treatment goals.

Step 2: Develop Policies and Procedures for Use and Monitoring of Isolation

It is important to have clearly stated policies and procedures related to any use of isolation. Policies and procedures should define when isolation can be used; the duration; review process and protocols; programming and services; staff communications; alternatives; and reporting procedures.

Once policies and procedures have been adopted, staff training—initial and ongoing—will be required to uniformly implement the policies. Facility directors must monitor and enforce compliance with policies and procedures related to the use of isolation. Facility directors can't assume or take for granted that all staff are complying with

policies and procedures. Staff must be held accountable for consistently implementing policies and procedures, and monitoring of the use of isolation and outcomes is critical.

The Indiana Department of Correction, Division of Youth Services (DYS) revised its Use of Isolation Policy to limit its use and duration. Any youth held in isolation is assessed hourly with a goal of returning the youth to program as soon as he or she is ready to return. Indiana DYS, which reduced the use of isolation with positive outcomes as a result, points to the importance of getting staff input when revising policies and procedures related to the use of isolation.

The Massachusetts Department of Youth Services (DYS) has developed a model policy for the use of isolation (see Appendix B State Examples). The policy was developed in response to suicides at agency facilities while youths were confined in their rooms. It took DYS several years working with the officers' union, providing training and sharing data that demonstrated the facilities were not any more dangerous but in fact more safe. Critical steps for implementation were:

1. Identify data to manage, monitor and be accountable for use of isolation;
2. Develop alternative behavior management options and sanctions; and,
3. Train staff and monitor compliance.

Step 3: Identify Data to Manage, Monitor and be Accountable for Use of Isolation

Once policies are established data must be identified that measures how the policies are implemented. The data selected should accurately reflect the intention and direction of the policies and be collected, analyzed and used to monitor how well the policies are being implemented and the changes in use and duration of isolation. Data provides the picture of what is happening in facilities and allows directors and leaders to take a look at what the quality of life is in facilities and determine if it meets their expectations and goals. Often simply collecting data and sharing the results starts to shift practices.

MEASURING AND MONTIORING THE USE OF ISOLATION

- When used and when not used
  - Low level interventions, high level interventions and behavioral characteristics
- Day of week
  - Time of day; staff on duty
- Location of Incident
- Use of Alternatives
  - Verbal de-escalation, calming rooms, other alternatives
- Assaults
- Workers Compensations
- Youth on staff assaults
- Average daily population

The only standardized national data on use of isolation was developed by CJCA as part of the Performance-based Standards (PbS) program. PbS is a data-driven improvement model that collects and reports both quantitative administrative record data and qualitative survey data from youths, staff and families to provide a holistic and comprehensive picture of the conditions of confinement and quality of life in secure facilities for young offenders. PbS' primary purpose is to provide facility and agency leaders and staff with national standards to guide operations, implement best practices that best serve youth, staff and families and to continuously monitor daily activities and culture within facilities using performance outcome measures. As of October 2014, 159 facilities in 32 states participated in PbS: 96 correction, 48 detention and 15 assessment[2].

PbS facilities collect information about the use of isolation and room confinement by reviewing all incident reports during two data collection months per year. PbS' advisors established a comprehensive definition of isolation that includes any instance a youth is confined alone for cause or punishment for 15 minutes or more in his or her sleeping room or another room or separation unit. Exceptions are made for protective isolation, medical isolation or when requested by a youth. The time measured begins when the youth is placed in the room and continues until he or she leaves, including sleeping time when extending overnight. PbS' growth model reports isolation data twice a year for continuous measuring and improving.

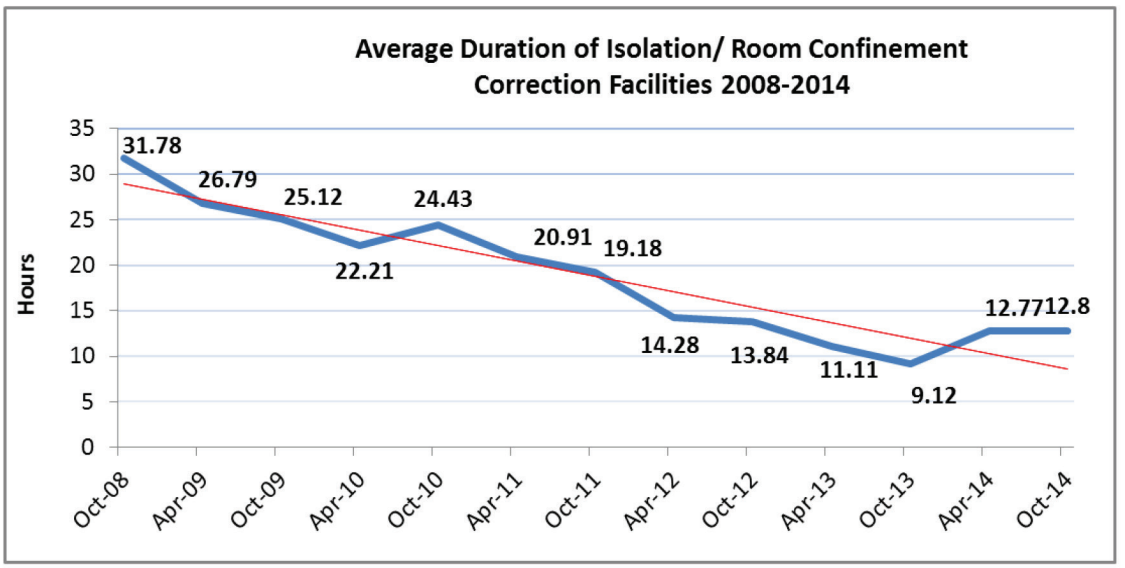
PbS facilities monitor four outcome measures of isolation and confinement:

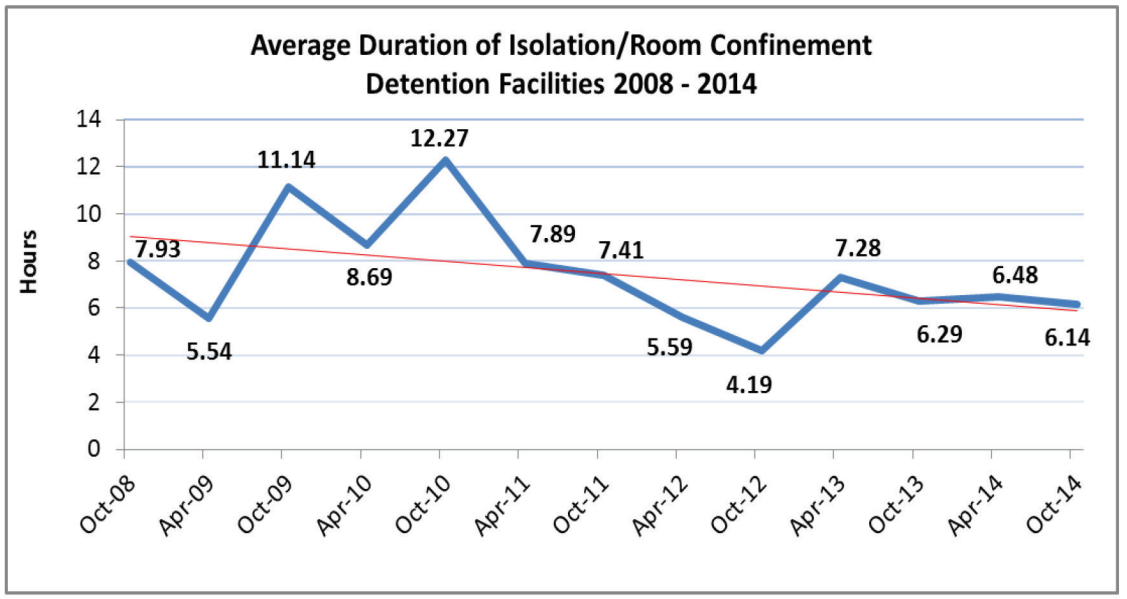
- Number of cases of isolation, room confinement and segregation/special management unit is used;
- Average duration of uses of isolation, room confinement and segregation/special management unit;
- Percent of cases terminated in four hours or less; and,
- Percent of cases terminated in eight hours or less.

Over time, PbS participants have shown marked decrease in use of isolation, especially the length of time youths are isolated. In 2008, the average time a youth was in isolation in a correction facility was about 32 hours; in 2014, the average time was almost one-third of that about 12 hours. A similar reduction was shown by the PbS detention centers; the all-time high of 12 hours average time a youth spent isolated was cut in half to 6 hours in 2013 and held steady since. As the case studies in Appendix B show, PbS data is a key tool to create culture change, manage safe facilities and achieve positive outcomes in the use of isolation.

[2] PbS Perspective January 2015.

Greater transparency and data reporting are definitely key components of implementing change and reducing the use of isolation. PbS provides a tool for comprehensively measuring and monitoring the use of isolation. States should collect and analyze data on the current use of isolation in order to inform a comprehensive plan to reduce or eliminate the use of isolation. Once a plan is in place, data and trends should be continually monitored to determine if goals are being achieved.





Step 4: Develop Alternative Behavior Management Options and Responses

At the CJCA 2014 Leadership Institute, members identified and discussed core components and approaches necessary to develop alternative behavior management options to using isolation:

- Strength-based assessments
- Positive reinforcement
- Pro-social skills development
- Individual goal setting
- Research and evidenced-based interventions
- Youth voice
- Staff voice
- Staff training
- Staff buy-in
- Transparency and communication
- Clear and consistent policies and procedures
- Family engagement
- Measuring and monitoring results

The group also identified five proven interventions used by agencies that have successfully reduced or eliminated the use of isolation:

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Effective Practices in Community Supervision (EPICS)
- Collaborative Problem Solving (CPS)
- Trauma-Informed Care (TIC)
- Motivational Interviewing (MI)

Additional effective strategies to respond to difficult and escalating behavior discussed included developing interventions along a continuum of responses to de-escalate behavior in a way that supports rehabilitative goals, is developmentally appropriate and results in better outcomes and keeping youths busy and engaged in programming.

Isolation also can be reduced by behavior management strategies that prevent the misbehavior from happening using a system of rewards and incentives. Research shows punishment, including isolation, is not effective in changing behavior and that youths learn best when given opportunities to do the right thing and behave appropriately.

Rewards and incentives that provide those opportunities are used widely across the country in various ways. For example, points, levels and phase systems that recognize when youths do something well. The key to successful reward and incentive systems are clear and clearly communicated expectations and rules and the consistent application of the rewards or incentives.

See box "Rewards and Incentives" for creative ideas shared at the 2014 CJCA Leadership Institute.

REWARDS AND INCENTIVES

- **Special personal hygiene items**
- **Lunch with staff**
- **Day with superintendent**
- **Mentoring**
- **Extra gym time**
- **More visitation, allow friends**
- **Wear own clothes**
- **Late nights**
- **More library time/multipurpose affinity time**
- **Coupons – trade for points**
- **Weekly activity posted so kids know what they are working for**
- **Random events – i.e., ice cream cart, pizza, movies.**

Step 5: Train and Develop Staff in Agency Mission, Values, Standards, Goals, Policies and Procedures

Safe and healthy facility cultures are established and sustained by positive and nurturing staff-youth relationships. Placing a youth in isolation creates many reasons for youths and staff not to engage: mistrust, anger, power and unfairness. Creating positive and nurturing relationships with youths in custody requires staff who can respond appropriately to the needs of youths. Staff who are not adequately trained and supervised to manage a population of young offenders tend to rely on isolation and punitive responses that worsen the facility conditions and culture. Research has shown that in facilities where most staff feel adequately trained and supervised, there are fewer incidences of negative behavior, incidents and punishment.

Training staff has played a major role in transforming systems from the adult correctional model to the developmentally-appropriate, rehabilitative model. Some training suggested at the 2014 CJCA Leadership Institute was:

1. Cross training of treatment and direct care staff to bridge the gaps often between staff in different areas (direct care, clinical, recreation for example)

2. Trauma Informed Care and Conflict Resolution to better address the majority of youths in facilities who have experienced trauma and traumatic stress that can be exacerbated by inappropriate treatment

3. Communication interventions, not physical interventions

4. Adolescent brain development

5. Individual characteristics and treatment needs of youths

In Alaska, which has greatly reduced the use of isolation, staff are trained in the following areas:

- How traumatic childhood experiences impact the youth's developing brain;
- How trauma impacts the youth's behavior and response to stress;
- How to enhance the youth's ability to regulate his / her own emotions and improve coping skills; and
- The importance of healthy relationships with healthy adults in healthy environments.

Supervision practices successful in reducing the use of isolation focused on evaluating and de briefing with staff when an incident occurs.

CONCLUSION AND ACTION STEPS FOR AGENCY ADMINISTRATORS

Agency leaders who have reduced or even eliminated the use of isolation advice that change can't be implemented overnight—real change will take time. Changing the way systems respond to youths' acting out and misbehavior demands a holistic approach. Agency administrators need to analyze the system starting with the overarching mission and vision, ensuring consistency by aligning the policies governing isolation practices and holding staff accountable for implementing the policies as intended by measuring what is actually happening in the facilities. The negative impact of isolation should drive the resolve to create culture change and evidence that reducing and eliminating isolation leads to decreases in violence, staff and youth incidents, aggression and other negative outcomes should persuade staff.

The agency administrators must lead the change by:

- Making a compelling case for change,
- Engaging staff in the process of culture change,
- Providing tools and training to develop the skill set staff need to make the change,
- Utilizing outcome data to measure the impact of policy change; and,
- Sustaining the culture change.

The following action steps for leaders in youth correctional agencies are recommended to guide reform and reduce and/or eliminate the use of isolation:

- Align policy and procedures with rehabilitative vision, mission and goals of the agency;
- Screen and assess youths upon intake with a validated risk and needs assessment instrument (s) to determine housing and specific treatment needs;
- Analyze intake data to track and understand the changing demographics of the adolescent offender population entering youth corrections;
- Develop treatment programs based on the treatment profile of youths in the facility;
- Create separate, specialized units for youths with serious mental health problems, youths with substance use issues and juvenile sex offenders;
- Ensure that the staffing for these specialized units meets the clinical level of need for the youths;
- Employ evidence-based programs to treat youths along the continuum of programs they experience;
- Develop staff training programs that adequately prepare staff to manage and treat high risk/high needs offenders;
- Develop multidisciplinary staff teams whose members work closely together and support one another;
- Constantly monitor facility culture and make adjustments to keep facilities safe;
- Regularly survey staff to determine if they feel adequately equipped to work effectively with the existing youth population;
- Involve families in treatment planning and implementation for their children;
- Incorporate positive youth development principles and practices in facilities;
- Utilize volunteers to normalize facility culture and enrich programming;
- Adequately prepare youths for reentry so they can return to the community ready to succeed as adults;
- Concurrently prepare communities for the reentry of youths, especially those with ongoing behavioral needs; and
- Adopt a performance management system such as Performance-based Standards (PbS) that collects and analyzes outcome data from programs and uses the data to lead and manage change.

See Appendix A for two states (Oregon and Indiana) that have worked to change the culture of youth corrections and provide insight into how they were able to bring about culture change, enhance the philosophy of youth rehabilitation, and as a result reduce the use of isolation.

APPENDIX A - TIPS FROM AGENCY DIRECTORS THAT HAVE REDUCED THE USE OF ISOLATION

OREGON YOUTH AUTHORITY
REDUCING ISOLATION AND CREATING CULTURE CHANGE

Why Culture Change and What is the Role of Leadership in Shifting Culture?

Culture: *is the set of values, guiding beliefs, understanding, and ways of thinking that is shared by members of an organization. The purpose of culture is to provide members with a sense of organizational identity and values.*

As new research evolves, we need to align our practices with our desired outcomes. As our understanding of the system and our role in creating better outcomes changes, our culture also needs to change in order to align with best practices and minimize the probability of potential harm to the development of youth we serve.

Five specific roles of leaders:

1. Make a compelling case for change on two levels.
   - Moral case – the trauma of isolation itself; the potential for future victims of crime and an increase of recidivism that might result
   - Business case – cost of maintaining status quo of isolation use: more injuries to youths and staff and longer lengths of stay for youths.

2. Engage staff in the process of culture change. Helping staff see that change is the right thing to do, not that they just have to follow a new policy directive. Does this change create a safer work environment? Develop an action plan and involve staff so they can own the plan and take pride in improvements that follow

3. Provide tools, training and skills that staff need to make the change. Staff need to be involved in the change process from conceptualization through implementation. Realize and share with staff that there will be setbacks along the way. Persistence and patience are essential.

4. Use outcome data to measure the impact of a policy change. Provide data on the use of isolation before new policy directive is implemented; measure use of isolation regularly after new policy is put into place to demonstrate to staff and others the impact of isolating fewer youths. Show return on investment and celebrate success.

5. Sustain the culture change. The agency's leadership team must be fully involved in the implementation process. Build relationships with the staff; listen to their fears and concerns; speak with them frequently and provide guidance in carrying out new policies. Leaders must model the change and walk the talk.

Source: "Why Culture Change and What is the Role of Leadership in Shifting Culture?" Fariborz Pakseresht, Director, Oregon Youth Authority. October 2014.

INDIANA DIVISION OF YOUTH SERVICES (DYS)
REDUCING ISOLATION AND CREATING CULTURE CHANGE

What are the components of culture change?

We can't reduce the use of isolation without changing the culture. The biggest obstacle to overcome is staff fear for safety. Staff feel safe when they use isolation; they are conditioned to respond through the use of isolation. Leadership must change their philosophy and entrenched mindset. Staff must believe in what the leader is undertaking and, most importantly, believe that the changes will result in positive outcomes and a safer environment for both staff and youth.

Steps to take in changing the culture of an organization:

1. Review hiring practices. What type of staff is the agency hiring to work directly with youths? Aim to hire staff who desire to make a difference in the lives of youths.
2. Invest in staff training and education. Training that is rooted in the theory of adolescent development will better prepare staff to work effectively with youths who are experiencing physical, sexual and emotional changes in their lives. Staff must be trained in adolescent development in order to work effectively with this population.
3. Treat youths fairly; reward positive behavior and ensure due process when holding youths accountable for negative behavior. Staff must fully understand the behavior modification program.
4. Staff must understand and commit to carrying out the mission of the agency
5. Share data on the impact of policies and procedures with staff, especially regarding the use of force, restraints and isolation. Staff must understand the reasons behind the changes taking place, without a full understanding, they will always resist the change.
   a. Research has shown that excessive use of isolation creates an unsafe environment; and
   b. The use of less isolation creates safer environments with fewer injuries to youth and staff. (IN PbS data)
6. Leaders need to spend time building relationships with staff. Learn who is on board with culture change, who is opposed and who is on the fence. Leaders should influence those on the fence.
7. Leadership team must be entirely committed to culture change, any one lone dissenter can seriously impede the progress.
8. Staff must understand why the organization is changing the culture and envision the impact of change, viz., creation of a safer facility for youths, staff and visitors.

<u>Three turning points that helped Indiana DYS facilitate change</u>:

1. PbS gave us tools to engage staff in culture change by sharing the biannual site report that contained four outcome measures on the use of isolation and by involving them in developing Facility Improvement Plans for outcomes that needed improvement.

2. Introducing and training staff in Trauma Informed Care and Motivational Interviewing helped staff see youths they were caring for in a new light as victims of neglect and abuse when they were children.

INDIANA DIVISION OF YOUTH SERVICES (DYS)
REDUCING ISOLATION AND CREATING CULTURE CHANGE
(continued)

Three turning points that helped Indiana DYS facilitate change:

3. Family engagement – historically DYS has shied away from involving family members in their children's rehabilitation.
   a. Bring families in, get them involved, they need to be as invested as we are; they begin to trust staff and build relationships with staff – then the kids start to see staff differently;
   b. Utilize family members, staff and volunteers in conflict resolution strategies;
   c. Less isolation and more family engagement leads to less restraint and isolation; which leads to less injuries to youth and staff; which leads to increased staff morale, dependability, and increased staff to youth ratio; which leads to improved atmosphere and climate, which ultimately leads to sustained culture change. Not just culture of the facility, but the culture of state government as well.

Source: CJCA Leadership Institute, October 2014.
Mike Dempsey, Executive Director, Indiana Division of Youth Services

APPENDIX B - EXAMPLES FROM STATES THAT HAVE REDUCED THE USE OF ISOLATION

MASSACHUSETTS

Reducing the Use of Isolation
Massachusetts Department of Youth Services

Background/Issues:
The Massachusetts Department of Youth Services (DYS) drew on the findings of "Juvenile Suicide in Confinement: A National Survey" by Lindsay M. Hayes, a report commissioned by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) published in 2009 to change its policy and practices using room confinement and/or isolation of youths.

DYS participates in the Performance-based Standards (PbS) program, a continuous improvement system launched by OJJDP specifically to address safety, health and quality of life issues in youth facilities identified as problematic in the 1994 Conditions of Confinement Study.

Standards:

PbS standards are clear: isolating or confining a youth to his/her room should be used only to protect the youth from harming himself or others and if used, should be brief and supervised. Any time a youth is alone for 15 minutes or more it is a reportable PbS event and is documented. PbS reports isolation, room confinement and segregation/special management unit data together to draw attention to practices that are inappropriate, ineffective and can have deadly consequences, as cited in Hayes' study.

Process and Changes:

Below is the list of specific changes introduced by DYS to reduce isolation. Changes were made in four areas:

- Policy
- Training
- Practice
- Programming

Policy

- Room confinement policy was revised in the context of not being used as punishment and in relation to suicide prevention;
- Room confinement may be used for the following reasons only:
  - To calm a youth who is exhibiting seriously disruptive or dangerous behavior;
  - For population management;
  - For the safety and security of a youth; and
  - For investigation of an incident.
- Room confinement may not be used for:
  - As a consequence for non-compliance;
  - Punishment;
  - Harassment; or
  - In retaliation for any youth conduct.
- Staff must request permission to use room confinement from higher managers in facility;
- Residents on "suicide watch" are never allowed to be placed in isolation regardless of circumstances;
- Extension of room confinement beyond three hours must be approved by regional administrator or designee;
- Room confinement report must be completed daily and forward to regional administration;
- Use of room confinement is reviewed at the program and regional levels.

Training

- All staff are trained in the "Use of Isolation" policy;
- All staff are trained in Juvenile Suicide Prevention, which has a use of confinement risk for actively suicidal youth component.

Practice

- Developed an "Exit Strategy" to facilitate timely removal of youth from room confinement:
  - Staff apply DYS de-escalation, behavior management and conflict resolution techniques to help a resident process disruptive and dangerous behaviors and out of room confinement.
  - Youth in room confinement are engaged at least once every 30 minutes of confinement;
  - Each engagement of youth must be by a direct care staff not involved earlier and a clinical staff member.

Programming

- "Learning Exercises" – a strategy for interventions over a period of time that promotes a better understanding of one's behavior and reduces reoccurrence of the specific actions/reasons that resulted in the room confinement and include:
  - Focused sessions with a youth's advocate and/or clinician;
  - A parent or guardian in on-site sessions and/or visits;
  - Behavioral Contracts that are tailored to the youth (s) that identifies problematic behavior and tracks his/her progress over time.
  - Progress reviews with the youth daily and weekly.

Results:

According to the last three years of PbS data, DYS' use and duration of isolation is well below the field average of the other 159 PbS facilities. (PbS reports on all uses of isolation during the months of April and October and provides field averages of all like participants as a comparison point). DYS rarely uses isolation and since April 2011, all of the cases when a youth was placed in isolation were terminated in less than four hours.

DYS uses the PbS' continuous improvement technology to collect data, identify issues such as high use and/or duration of isolation that need to be addressed, to design and implement structured improvement plans setting targets for desired outcome measure changes and to monitor performance over time.

MAINE

Reducing the Use of Isolation
Maine Division of Juvenile Services

Background/Issues:
Several years ago, the Maine Division of Juvenile Services (DJS) relied excessively on the use of isolation to manage youths in its two facilities. Youths were routinely confined to a Special Management Unit (SMU) for a variety of acting out behaviors. Staff repeatedly resisted all efforts to limit the use of isolation. They responded to all attempts to limit use of the SMU with: "You can't take our 'tools' away from us and expect us to do our jobs."

Maine's campaign to reduce the use of isolation extends back to 2008 when it began to develop Facility Improvement Plans (FIP) as part of its participation in the Performance-based Standards (PbS) continuous improvement process. Two of the FIP Action Steps written in April 2008 were:

1. "To review and revise time-out forms while implementing a supervisory review of all time-outs designed to identify issues that will decrease the number of incidents of use, as well as the duration of time-outs."

2. "Define, review and track all incidents (time-outs & disciplinary board hearings) to determine needed areas for improvement and provide training in the use of less restrictive alternatives."

Standards:
PbS standards are clear: isolating or confining a youth to his/her room should be used only to protect the youth from harming himself or others and if used, should be brief and supervised. Any time a youth is alone for 15 minutes or more is a reportable PbS event and is documented. PbS reports isolation, room confinement and segregation/special management unit data together to draw attention to practices that are inappropriate, ineffective and can have deadly consequence, as cited in Hayes' study.

Process and Changes:
Below is the list of specific changes introduced by DJS to reduce isolation. Changes were made in four areas:

- Policy
- Training
- Practice
- Programming

Policy

- Behavior Management System revised – Phase System created opportunities for residents to demonstrate the capacity to function with increasing independence.

Training

- Staff receive training in Behavior Management System and Motivational Interviewing;
- Staff and youths receive training in Collaborative Problem Solving and Trauma Affect Regulation Guide to Education and Treatment (TARGET) –staff and youths receive training by teams in each facility; and
- Agency leadership participates in training in the "teamwork model."

Practice

- Prevailing philosophy in two youth development centers: "There are not many benefits to keeping a resident behind a closed door. As soon as all threats are believed to be gone, the resident is returned to programming;"
- Use of isolation operates in the context of the 'unit team' – cannot move the youth away from the staff he has a relationship with. If a resident must be isolated, his unit manager follows the youth to the isolation unit to understand the events that precipitated the isolation and work with the youth to solve the problem;
- Unit team works with resident to return him to program as soon as possible, collaborative problem solving and motivational interviewing techniques that staff and youth have been trained on are employed;
- Upon release from the isolation unit, a new program plan is developed by the team and the resident that is different from the previous plan;
- Facility administration is committed to keeping the high-risk offender in as normalized an environment as possible; and
- DJS uses PbS outcome measures to monitor change over time.

Programs

- Introduced Creative Problem Solving Curriculum developed by Ross Greene, Ph.D. in 2006.
- Introduced Trauma Affect Regulation Guide to Education and Treatment (TARGET) in 20011.
- Aggression Replacement Therapy
- Motivational Interviewing

Results:

According to three years of PbS data, DJS is well below the use and duration of isolation compared to other PbS facilities. (PbS reports on all uses of isolation during the months of April and October and provides field averages of all like participants as a comparison point). Maine uses isolation infrequently and only for short periods of time. DJS uses the PbS' continuous improvement technology to collect data, identify issues such as high use and/or duration of isolation that need to be addressed, to design and

implement structured improvement plans setting targets for desired outcome measure changes and to monitor performance over time.

INDIANA

Reducing the Use of Isolation
Indiana Division of Youth Services

Background/Issues:
The Indiana Department of Correction, Division of Youth Services (DYS) had serious problems in its facilities. Crowded and dangerous, staff relied on overuse of isolation. The Executive Director of DYS decided to change the adult corrections culture staff had become accustomed to. The first facility selected for improvement through culture change was the Pendleton Juvenile Correctional Facility, a program that had come under Department of Justice oversight after a Civil Rights of Institutionalized Persons (CRIPA) lawsuit over conditions of confinement.

Standards:
DYS participates in the Performance-based Standards (PbS) initiative.

Process and Changes:
Below is the story of specific changes made in DYS to reduce the use of isolation by changing facility culture. Changes were made in four areas:

- Policy
- Training
- Practice
- Programming

Policy

- Use of Force Policy was revised;
- Use of Isolation Policy was revised to limit its use and to reduce its duration;
- Superintendent and staff conduct an "hourly assessment" and "daily review" of any youth held in isolation with a goal of returning him to the program as soon as he is ready to return;
- Student's Code of Conduct was revised; and
- Behavior Management System for residents was adopted- based on token economy (rewards outnumber the sanctions).

Training

- Trained and educated staff to treat youth in the facility as young offenders who needed help with their problems, not as adult inmates;

- Established and trained teams of staff to work together in each unit;
- All staff are trained in Trauma Informed Care (7.5 hour training);
- All staff are trained in Conflict Resolution/ staff mediation;
- Superintendent speaks with new staff members during orientation training.

Practice

- Population of the facility (Pendleton) was reduced from 370 youths to 200;
- Developed living units no larger than 12-14 youths;
- Assessed youths in order to place them in the appropriate treatment program;
- After going a full year without using its Special Management Unit (segregation), the unit was converted into a transitional living unit;
- Created a Crisis Awareness Response Efforts (CARE) Team made up of experienced staff who were not involved in an assaultive incident to intervene and try to use "conflict resolution" practices to resolve the issue without using isolation - 95 percent of the time, the CARE Team has successfully calmed the situation without resorting to a security response;
- Increased family involvement at the facility;
  - As a Performance-based Standards (PBS) participant, the facility volunteered to pilot implementation of new set of Family Engagement and Social Support Standards. One of the standards encourages family visitation. After receiving the PbS site report that showed low visitation rates, staff created a Facility Improvement Plan (PbS component) that opened visitation to just about any time a family member could get to the facility. The plan resulted in an increase in visits and improved behavior by youths.
  - Created a Family Council called PIES to improve communication between staff and parents;
  - If a youth is placed in isolation, the staff conducts a conference call with the parent (s) and youth to speak about the events that resulted in the youth's isolation. Staff noted that this involvement of the parent has been very helpful in ending the isolation event;
  - Held daily incident monitoring meetings at the beginning of each day to discuss the issues a youth in isolation might be experiencing, e.g., not taking medication. Staff are kept abreast of developments. This practice has increased communication among all staff so they can address current issues within the facility;
  - Introduced "Staff Shadowing Program". In lieu of using isolation, a single staff member is selected to "shadow" or follow the youth during his program activities during the day;
  - Reviewed film footage of use of isolation to determine if isolation was the appropriate response to the youth's behavior;
  - Established a Student Council in order to hear the 'youth voice' about life in the facility – youth involvement has been a factor in reducing use of isolation.

Programming

- Introduced trauma informed care perspective into the facility;
- Introduced use of motivational Interviewing that has facilitated the decrease the use of isolation;
- Introduced Conflict Resolution (mediation) – staff and youth use alternative approaches to address the active issue rather than resorting to isolation.

Results:

According to three years of PbS data, Indiana DYS' use of isolation has trended downward in its facilities and is lower than other PbS facilities around the country. The average duration of isolation has dropped significantly. For example, the Logansport facility reported 42 incidents of isolation with an average duration of 37 hours in the October 2010 data collection. In the April data collection, Logansport had only one isolation event, which lasted 17 minutes.

Indiana DYS uses the "continuous cycle of improvement" (i.e., data collection, facility site report analysis and Facility Improvement Plan) to improve the conditions of confinement.

ALASKA

Reducing the Use of Isolation
Alaska's Juvenile Justice Facilities – DJJ Trauma Informed Care Initiative

Background/Issues:

- Initiative launched in 2009 as a pilot project at the state's largest facility.
- Now expanded to all DJJ facilities and probation offices.

Standards:

- Performance-based Standards (PbS):
  - Data for 8 facilities;
  - Trend analysis and progress reported by facility and by state and compared to national average; and,
  - Track data in room confinement, isolation, and segregation.
- Alaska Incident Tracker:
  - Database used to report incidents in all DJJ facilities and probation offices. Trends are analyzed to inform practice, policy, and training.

Process and Changes:

- Training staff in the following areas:
  - How traumatic childhood experiences impact the youth's developing brain;
  - How trauma impacts youths' behavior and response to stress;
  - How to enhance youths' ability to regulate their own emotions and improve coping skills; and
  - The importance of healthy relationships with healthy adults in healthy environments.

Results:

- Results include a reduction in resident restraint, assault incidents and reduced room confinement.

APPENDIX C – STATEMENT FROM THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY (AACAP)

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis[1]. Due to their development vulnerability, juvenile offenders are at particular risk of such adverse reactions[2]. Furthermore, the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.

Solitary confinement should be distinguished from brief interventions such as "time out," which may be used as a component of a behavioral treatment program in facilities serving children and/or adolescents, or seclusion, which is a short term emergency procedure, the use of which is governed by federal, state and local laws and subject to regulations developed by the Joint Commission, CARF and supported by the National Commission of Correctional Healthcare (NCHHC), the American Correctional Association (ACA) and other accrediting entities.

The Joint Commission states that seclusion should only be used for the least amount of time possible for the immediate physical protection of an individual, in situations where less restrictive interventions have proven ineffective. The Joint Commission specifically prohibits the use of seclusion "as a means of coercion, discipline, convenience or staff retaliation." A lack of resources should never be a rationale for solitary confinement.

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty establish minimum standards for the protection of juveniles in correctional facilities.

The UN resolution was approved by the General Assembly in December 1990, and supported by the US. They specifically prohibit the solitary confinement of juvenile offenders. Section 67 of the Rules states:

"All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned." In this situation, cruel and unusual punishment would be considered an 8th Amendment violation of our constitution[3].

Measurements to avoid confinement, including appropriate behavioral plans and other interventions should be implemented[4].

The American Academy of Child and Adolescent Psychiatry concurs with the UN position and opposes the use of solitary confinement in correctional facilities for juveniles. In addition, any youth that is confined for more than 24 hours must be evaluated by a mental health professional, such as a child and adolescent psychiatrist when one is available.

References:

1. Grassian, Stuart. "Psychiatric Effects of Solitary Confinement." Journal of Law and Policy. (2006): 325-383.
2. Mitchell, Jeff, M.D. & Variety, Christopher, M.D. "Isolation and Restraint in Juvenile Correctional Facilities." J.Am. Acad. Child Adolesc. Psychiatry, 29:2, March 1990.
3. Vasiliades, Elizabeth. "Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards." American University International Law Review 21, no.1 (2005): 71-99.
4. Sedlak, Andrea, McPherson, Carla, Conditions of Confinement, OJJDP, May 2010.

Source: American Academy of Child & Adolescent Psychiatry Policy Statements: Solitary Confinement of Juvenile Offenders (April 2012).

Comment-Staffing-Ratios-in Secure-Juvenile-Facilities-Final

A housing area at the Connelly Transition Unit in Roslindale, MA © Richard Ross

The Prison Rape Elimination Act Standards

Comments from youth advocates on minimum staffing ratios in juvenile facilities

Docket No. OAG-131

August 20, 2012

TABLE OF CONTENTS

INTRODUCTORY LETTER

Dear Attorney General Holder,

Thank you for the opportunity to comment on the Prison Rape Elimination Act (PREA)'s staffing ratio standard for secure juvenile facilities. Our organizations previously submitted joint comments in response to the Department's advanced notice of proposed rulemaking and notice of proposed rulemaking on the proposed PREA standards in May 2010 and April 2011, respectively. We are pleased that the Department has issued standards that reflect a practical approach to the widespread problem of sexual victimization in facilities that house youth.

Staffing ratios represent one crucial component of this approach. They ensure that facilities maintain a level of direct supervision that is necessary to protect youth from victimization. When used alongside rigorous implementation of the PREA standards' other tools to combat sexual misconduct such as staff training, youth education, supervision of staff, and reporting mechanisms, minimum staff-to-youth ratios represent a key component in protecting youth from sexual misconduct in juvenile facilities.

Although we strongly support the Department's inclusion of a minimum staffing ratio requirement, we recommend revisions that are necessary to fulfill PREA's mandate. Our submission outlines the importance of staffing levels to sexual misconduct prevention, details specific revisions we believe are appropriate, and answers the individual questions posed by the Department. Where we propose textual changes to the staffing ratio standard, we mark deletions of text as ~~struck through~~ and additions of text in **bold**. In each section, we only include deletions and additions of text that pertain to the suggestions addressed in that section, even when we recommend other changes to the same sentence elsewhere in our comments.

In the last round of public comments, some submissions opposed the inclusion of minimum staffing ratios in the PREA standards. Commenters stated a desire to determine staffing levels based on differences in treatment goals and the needs of the youth in their care. The inclusion of minimum staffing ratios is consistent with this desire. While there are many differences among juvenile facilities, and many circumstances under which youth may need more supervision than others, the risk of sexual victimization is a reality in all settings that house youth. The staffing ratio requirement simply sets a floor below which facilities may not go in order to achieve PREA's mandate, but allows agencies to analyze their particular facility structures, youth populations, youth with special needs, and other factors to determine staffing levels above the mandated floor.

Our research and experience – and the Department's own experience investigating sexual misconduct in juvenile facilities – demonstrates that insufficient staff supervision bears a clear

link to the sexual victimization of youth. Although we prefer the standard's minimum staffing levels to no minimum at all, we urge you to consider and accept our recommended modifications.

Thank you for your consideration.

Sincerely,

Dana Shoenberg, Center for Children's Law and Policy
Jason Szanyi, Center for Children's Law and Policy
Liz Ryan, Campaign for Youth Justice
Shannon Price Minter, The Equity Project
Jessica Feierman, Juvenile Law Center
Sarah Bergen, National Juvenile Defender Center
Sue Burrell, Youth Law Center
Amy Fettig, American Civil Liberties Union, National Prison Project
Catherine Beane, Children's Defense Fund

ORGANIZATION DESCRIPTIONS AND CONTACT INFORMATION

Our organizations are committed to policy reforms that remove youth from adult facilities, improve the conditions of confinement for youth held in juvenile and adult facilities, and ensure that youth under community supervision are kept safe. Many of our organizations have extensive experience working to improve the conditions of confinement for youth held in juvenile and adult facilities. Please feel free to contact us if you have questions about our recommendations or other concerns regarding children and youth.

- The **Campaign for Youth Justice** (CFYJ) is dedicated to ending the practice of prosecuting, sentencing, and incarcerating youth under the age of 18 in the adult criminal justice system. CFYJ advocates for reforms to the justice system by serving as a clearinghouse of information on youth prosecuted as adults; conducting original research; providing support to federal, state, and local elected officials, policymakers, and advocates; coordinating outreach to parents, youth, and families; and leading national coalition efforts to reauthorize the Juvenile Justice and Delinquency Prevention Act.
  Staff Contact: Liz Ryan, President and Chief Executive Officer, (202) 558-3580 ext. 11, lryan@cfyj.org.

- The **Center for Children's Law and Policy** (CCLP) is a public interest law and policy organization focused on reform of juvenile justice and other systems that affect troubled and at-risk children, and protection of the rights of children in those systems. The Center's work covers a range of activities including research, writing, public education, media advocacy, training, technical assistance, administrative and legislative advocacy, and litigation. CCLP has a central role in major foundation-funded juvenile justice initiatives in the United States including the John D. and Catherine T. MacArthur Foundation's Models for Change initiative and the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI). CCLP staff provide training and technical assistance nationwide on assessing conditions of confinement in juvenile facilities, investigate potentially abusive conditions for youth in locked juvenile and adult facilities, and advocate for needed changes to the Prison Litigation Reform Act.
  Staff Contact: Dana Shoenberg, Deputy Director, (202) 637-0377 ext. 107, dshoenberg@cclp.org.

- **The Equity Project** is an initiative to ensure that lesbian, gay, bisexual, transgender and intersex (LGBTI) youth in juvenile delinquency courts are treated with dignity, respect, and fairness. The Equity Project examines issues that impact LGBTI youth during the

entire delinquency process, ranging from arrest through post-disposition. Core activities of The Equity Project include: gathering information from stakeholders about LGBTI youth in juvenile delinquency courts, identifying obstacles to fair treatment, reporting findings, and crafting recommendations for juvenile justice professionals. Partners of The Equity Project include Legal Services for Children, National Center for Lesbian Rights, and the National Juvenile Defender Center.
Staff Contact: Shannon Price Minter, Legal Director, National Center for Lesbian Rights, 415.392.6257 x310, sminter@nclrights.org.

- The **National Juvenile Defender Center** (NJDC) was created in 1999 to respond to the critical need to build the capacity of the juvenile defense bar and to improve access to counsel and quality of representation for children in the justice system. In 2005, NJDC separated from the American Bar Association to become an independent organization. NJDC's mission is to ensure excellence in juvenile defense and promote justice for all children. NJDC gives juvenile defense attorneys a more permanent capacity to address practice issues, improve advocacy skills, build partnerships, exchange information, and participate in the national debate over juvenile crime. NJDC provides support to public defenders, appointed counsel, law school clinical programs and non-profit law centers to ensure quality representation in urban, suburban, rural and tribal areas. NJDC offers a wide range of integrated services to juvenile defenders, including training, technical assistance, advocacy, networking, collaboration, capacity building, and coordination.
  Staff Contact: Sarah Bergen, Staff Attorney, (202) 452-0010, SBergen@njdc.info.

- **Juvenile Law Center** (JLC) is one of the oldest multi-issue public interest law firms for children in the United States. JLC maintains a national litigation practice that includes appellate and amicus work. JLC promotes juvenile justice and child welfare reform in Pennsylvania and nationwide through policy initiatives and public education forums. JLC uses the law to protect and promote children's rights and interests in the child welfare and juvenile justice systems, with a particular emphasis on ensuring that public systems do not harm children and youth in their care. JLC works to ensure that the juvenile justice and child welfare systems, which were created to help vulnerable children and youth, provide them with access to education, housing, physical and behavioral health care, employment opportunities and other services that will enable them to become productive adults.
  Staff Contact: Jessica Feierman, Supervising Attorney, (215) 625-0551, jfeierman@jlc.org.

- The **Youth Law Center** (YLC) is a public interest law firm that works to protect children in the nation's foster care and juvenile justice systems from abuse and neglect, and to ensure that they receive the necessary support and services to become healthy and productive adults. Since 1978, its lawyers have worked across the United States to reduce the use of out-of-home care and incarceration, to ensure safe and humane conditions in out-of home placements, to keep children out of adult jails, and to secure equitable treatment for children in both systems. Its efforts have focused on strengthening families and on advocating for education, medical and mental health, legal support, and transition services needed to assure children's success in care and in the community. YLC advocates for increased accountability of the juvenile justice and child welfare systems, and champions professional and public education.
  Staff Contact: Sue Burrell, Staff Attorney, (415) 543-3379 ext. 3911, sburrell@ylc.org.

- The **American Civil Liberties Union** is a nationwide, nonprofit, non-partisan organization with more than a half million members, countless additional activists and supporters, and 53 affiliates nationwide dedicated to the principles of liberty and equality embodied in our Constitution and our civil rights laws. The ACLU and many of our legal projects, such as the National Prison Project (NPP) and the Lesbian, Gay, Bisexual and Transgender Project, have long worked to protect and promote the civil and constitutional rights of prisoners. Our years of experience in the American criminal justice system have made us acutely aware of the problem of sexual violence in our prisons, jails and youth detention centers. As a result, we advocate for greater oversight and institutional accountability to help eradicate this pervasive problem.
  Staff Contact: Amy Fettig, Senior Staff Counsel, National Prison Project of the ACLU, (202) 548-6608, afettig@npp-aclu.org.

- The **Children's Defense Fund** (CDF) is a non-profit child advocacy organization that has worked relentlessly for more than 35 years to ensure a level playing field for all children, with special attention to the needs of poor and minority children and those with disabilities. CDF champions policies and programs that lift children out of poverty, protect them from abuse and neglect, and ensure their access to quality health and mental health care and early childhood and education experiences. CDF's *Cradle to Prison Pipeline®* Crusade seeks to achieve a fundamental paradigm shift in policy and practice away from punishment and incarceration and toward prevention and early intervention and sustained child investment.
  Staff Contact: Catherine V. Beane, Director of Policy, (202) 662- 3615, cbeane@childrensdefense.org.

GENERAL STATEMENT ON THE MINIMUM STAFFING RATIO REQUIREMENT

We strongly support the Department's inclusion of minimum staff-to-youth ratios in the Prison Rape Elimination Act (PREA) juvenile facility standards. Requiring minimum staffing ratios reflects what we now know about the best ways of preventing and detecting sexual misconduct, as well as the many tragic examples of what can happen when facilities fail to adequately supervise youth in their care.

The proposed standard reflects a practical approach to the widespread problem of sexual victimization in facilities that house youth. By establishing a minimum level of direct supervision, agencies and facilities will be better equipped to prevent and detect the red flags associated with victimization. When implemented alongside other tools to combat sexual misconduct such as staff training, youth education, supervision of staff, and reporting mechanisms, the minimum staff-to-youth ratios will present the best opportunity to protect youth from sexual misconduct.

Although we strongly support the Department's inclusion of a minimum staffing ratio requirement, we recommend revisions to ensure that the standard fulfills PREA's mandate. These include:

- **Modifying the current standards to require staff-to-youth ratios of 1:6 during waking hours and 1:12 during sleeping hours**. Many jurisdictions mandate staffing ratios that provide for greater levels of supervision than the ratio currently included in the PREA regulations. Although we prefer the standard's minimum staffing levels to no minimum at all, we encourage the Department to look to best practices when determining the levels of direct supervision that will reduce sexual victimization in secure facilities.

- **Revising the definition of "exigent circumstances" that allow for a departure from minimum staffing requirements.** As written, the Department's definition leaves open the potential for abuse, as facilities may claim that a wide range of unforeseen but foreseeable events justify departures from the standard. We encourage the adoption of a strengthened definition that limits exceptions to situations that present a serious threat to the safety of an institution and that requires agencies to plan ahead for foreseeable occurrences.

- **Ensuring that facilities only include staff who directly supervise and interact with youth when computing staffing ratios.** The inclusion of the staffing ratio requirement reflects the value of direct supervision in preventing and detecting misconduct. We

encourage the Department to clarify that only those staff who interact with youth in person should be included in the minimum staffing ratios.

- **Requiring that all juvenile facilities have at least two direct care staff on duty at all times when youth are present**. Sexual victimization is a risk in any setting that houses youth. However, almost all of the research on the relationship between staffing levels and safety has been limited to secure facilities. Although we do not recommend a particular staffing ratio for non-secure settings for this reason, we strongly encourage the Department to lead the effort in gathering information on the connection between staffing ratios and safety in non-secure settings. We also recommend that the standard require that *all* juvenile facilities – not just secure juvenile facilities – have at least two direct care staff on duty at all times when youth are present. This is a basic protection that many jurisdictions already take to ensure the safety of both youth and staff.

- **Requiring immediate steps to comply with the standard.** Facilities can and should begin planning now to meet the required staffing ratios. We do not believe that setting August 20, 2017, as the deadline for compliance with the staffing ratio standard is appropriate, as it allows for a lengthy delay that will perpetuate ongoing victimization. We do recognize that agencies may need to request appropriations to implement the standard, and we know that some state legislatures operate on a two-year legislative cycle. Accordingly, we recommend that the Department require compliance by August 20, 2014, which will give jurisdictions a full two years to meet the standard.

We expect that the Department will receive comments opposing the inclusion of minimum staffing ratios because of a desire to set staffing levels based on differences in treatment goals and the characteristics of youth. The inclusion of minimum staffing ratios is not inconsistent with this desire. While there are indeed many differences among juvenile facilities, the risk of sexual victimization and the value of direct supervision are principles common to all settings. The standard does not dictate particular staffing patterns. It simply sets a floor for supervision, allowing agencies to analyze their particular facility structures, youth populations, youth with special needs, and other factors to determine staffing rates above the mandated floor. As the Department noted in its comments accompanying the PREA standards, a majority of states already mandate staffing ratios in their facilities. They have done so because they, too, see the value in setting a floor for minimum levels of direct supervision.

As the National Prison Rape Elimination Commission noted in its 2009 report, "[d]irect supervision is the most effective mode of supervision for preventing sexual abuse." Our research and experience – and the Department's own experience investigating sexual

misconduct in juvenile facilities – demonstrates that insufficient staff supervision bears a clear link to the sexual victimization of youth. For these reasons, we urge the Department to retain and strengthen its proposed standard on minimum staffing ratios.

RESPONSES TO THE DEPARTMENT'S QUESTIONS

(1) Whether the provision, as written, is appropriate.

We applaud the Department's inclusion of a minimum staffing ratio for secure juvenile facilities in the PREA standards. However, in this response and the responses to the other questions posed by the Department, we recommend a number of modifications to ensure that the standard provides for the level of in-person supervision necessary to prevent and detect sexual victimization.

First, the standard should clarify that staff-to-youth ratios should be computed with respect to individual housing units and other defined areas, not on a facility-wide basis. A facility-wide ratio that simply divides the number of youth by the number of staff on duty at any one time will not ensure that youth receive the level of direct supervision envisioned by the standard because staff may not be deployed in a way that maintains the same level of supervision throughout the institution. We propose language to clarify the way that facilities should assess staffing levels.

Our second concern relates to the reference to "security staff" in the standard. The term is problematic because it will not ensure that facilities provide the type of in-person supervision that will curb abuse. For one, the term "security staff" does not reflect the intent of the staffing ratio standard, which is to ensure a baseline level of direct supervision. For example, in some facilities, there are staff members who stay in a central location and respond to security threats. Such personnel should not be included in the staffing ratios, but would be considered "security staff" under the definition in the PREA regulations. Also, "security staff" is a more adult facility-oriented term. "Direct care staff" is a term more frequently used to describe the kind of personnel we think that the Department intended to include in this ratio: those staff routinely spending time with youth in their units and during activities. Because the use of the term "security staff" is appropriate in other parts of the PREA standards, we propose that the department use a different term such as "direct care staff" here, which will convey the particular importance of in-person interactions in juvenile facilities.

The definition of "security staff" is also overinclusive for the purposes of computing a minimum ratio of staff to youth. As written, the definition includes staff responsible for the "*supervision and control* of . . . residents in housing units, recreational areas, dining areas, and other program areas of the facility." Under this definition, facilities could include a wide range of staff who are not directly supervising youth in their staffing ratio calculations. For example, facilities may include staff who work in a control center because control center staff monitor video cameras and open doors to permit movement throughout the facility. However, control center staff must split their attention across a range of competing demands and cannot engage in the

type of in-person interactions that help uncover red flags associated with sexual misconduct. Thus, the standard's reference to "security staff" is too broad to achieve the goals of the staffing ratio standard.

Given these concerns, we propose two possible approaches to modifications. First, we propose that the department include a new term in the PREA standards' general definitions – "direct care staff"— that reflects the goal of direct, in-person supervision. The staffing ratio standard should reference this term in lieu of the current reference to "security staff."

Alternatively, the Department could modify the standard to include only those individuals providing "direct staff supervision," a term also defined in the regulations. This change would help ensure that facilities only include staff who are physically present and interacting with youth in their staffing ratio calculations.

Proposed revision #1:

§ 115.5 General definitions.

For purposes of this part, the term—

. . .

Direct care staff **means staff who are responsible for providing in-person supervision of and interacting with residents in housing units, recreational areas, dining areas, and other program areas of the facility.**

. . .

§ 115.313 Supervision and monitoring.

. . .

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only ~~security staff~~ **direct care staff** shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

. . . .

Proposed revision #2:

§ 115.313 Supervision and monitoring.

. . .

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only ~~security staff~~ **individuals who provide direct staff supervision** shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

. . . .

(2) Whether the specific ratios enumerated in the provision are the appropriate minimum ratios, or whether the ratios should be higher or lower.

Although we support the Department's inclusion of a minimum staffing ratio requirement, we propose two modifications to the current supervisions levels. First, we encourage the department to revise its staff-to-youth ratios to 1:6 for waking hours and 1:12 for sleeping hours. These staffing levels best permit the type of eyes-on supervision and quality interactions that are effective at preventing and detecting victimization.

In the Bureau of Justice Statistics Study of Sexual Victimization in Youth Facilities, only one state has more than one facility on the list of institutions with the lowest victimization rates: Missouri. The state agency responsible for those facilities generally maintains a staff-to-youth ratio of 1:5 or 1:6.[1] Missouri is not alone. The following jurisdictions also establish standards for supervision in secure facilities that are more stringent than the Department's proposed ratios:

- **Alabama**
  - Detention: 1:6 (does not distinguish between waking and sleeping hours).[2]
- **District of Columbia**
  - Detention: 1:5.5, plus one floater staff member for 2 units during waking hours; 1.5:11 during sleeping hours.[3]
  - Post-adjudication: 1:5.5 during waking hours; 1:11 during sleeping hours.[4]

[1] Email from Scott Odum, Assistant Deputy Director, Treatment Section, Missouri Department of Youth Services, to Vivian Murphy, Director, Missouri Juvenile Justice Association (June 25, 2012).
[2] Ala. Admin. Code § 950-1-13-.03.
[3] Interview with Jeff McInnis, Department of Youth Rehabilitation Services (June 27, 2012).

- **Kansas**
  - Detention: 1:7 during waking hours; 1:11 during sleeping hours.[5]
  - Post-adjudication secure care centers: 1:7 during waking hours; 1:11 during sleeping hours.[6]
- **Maryland**
  - Detention (Baltimore City Juvenile Justice Center): 1:6 during waking hours; 1:12 during sleeping hours.[7]
- **Oklahoma**
  - Detention: 1:7 during waking hours; 1:16 during sleeping hours.[8]
- **Pennsylvania**
  - Detention and post-adjudication: 1:6 during waking hours; 1:12 during sleeping hours.[9]
- **Texas**
  - Post-adjudication (Corsicana Residential Treatment Center): 1:4 during evening and weekend awake shifts.[10]

National standards also support a higher level of supervision than that proposed by the Department. For example, the Institute for Judicial Administration and American Bar Association's Juvenile Justice Standards provide for a staff ratio of 1:4 during waking hours and 1:12 during sleeping hours in post-adjudication facilities.[11]

Second, the standard should require that all juvenile facilities – not just secure juvenile facilities – have at least two direct care staff on duty at all times when youth are present. Many jurisdictions already include such a provision in the rules, regulations, and statutes governing

[4] Department of Youth Rehabilitation Services, Post Analysis, March 19, 2007.
[5] Kan. Admin. R. § 28-4-353(e)(2)(B).
[6] *Id.*
[7] Kelly Dedel & Peter Leone, Fourth Monitor's Report for the Baltimore City Juvenile Justice Center (BCJJC) (June 2009), *available at* http://www.djs.state.md.us/pdf/fourth-bcjjc-monitors-report.pdf. The report notes that while the Department of Juvenile Services generally maintains a staff-to-youth ratio of 1:8 during waking hours and 1:16 during sleeping hours, there is increased staff supervision at BCJJC because of its two-tiered housing unit structure.
[8] Okla. Admin. Code § 377:3-13-44(4).
[9] 55 Pa. Code §§ 3800.274(5), (6).
[10] Sexual Victimization in Juvenile Correctional Facilities: Hearing Before the Review Panel on Prison Rape, U.S. Department of Juvenile Justice (2010) (written testimony of Cheryln K. Townsend, Executive Director, Texas Youth Commission). The agency responsible for overseeing the Corsicana facility increased staffing at the facility in the wake of findings from the Bureau of Justice Statistics report, *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09*.
[11] Institute for Judicial Administration and American Bar Association, Juvenile Justice Standards § 7.11(F) (1996). The standard contemplates small secure residential facilities of no more than 24 youth.

staffing.[12] The reasons to do so are obvious. Any event that requires one staff member to devote his or her attention to one area of a facility will leave another area unsupervised. This may leave youth vulnerable to victimization by other youth. It is also dangerous for staff, as sexually aggressive or otherwise violent youth can more easily victimize staff members who do not have adequate backup. Accordingly, we recommend adding the proposed subsection (d) to the standard.

Although we prefer the standard's minimum staffing levels to no minimum at all, we encourage the Department to incorporate best practices when establishing a minimum staffing ratio in the PREA standards.

Proposed revisions:

§ 115.313 Supervision and monitoring.

. . .

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of ~~1:8~~ **1:6** during resident waking hours and ~~1:16~~ **1:12** during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

(d) All juvenile facilities shall have a minimum of two direct care staff on duty at all times to directly supervise residents.

~~(d)~~ **(e)** Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:

(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

[12] *See, e.g.*, Arkansas Juvenile Detention Facility Review Commission, Juvenile Detention Standards § 6-100; Il. Admin. Code Tit. 20 §§ 702.30, 702.130; Kan. Admin. R. §§ 28-4-353, 505; Ky. Admin. R. 2:060; Mo. Supreme Court Rule 129, Section 11.2; Okla. Admin. Code § 377:3-13-44(4); Utah Department of Juvenile Justice Services Policy No. 05-08.

~~(e)~~ **(f)** Each secure facility shall implement a policy and practice of having intermediate-level or higher level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

(3) Whether the provision appropriately allows an exception from the minimum ratios during "limited and discrete exigent circumstances" (as "exigent circumstances" is defined in § 115.5), or whether that exception should be broadened, limited, or otherwise revised.

The staffing ratio requirement appropriately allows for an exception from the minimum ratios. We recognize that facilities may encounter a limited number of situations that necessitate a brief departure from what the standards require. However, the current definition of "exigent circumstances" is problematic, and raises three issues.

The first issue relates to the use of the term "unforeseen," which is too broad to provide an adequate limit on the exigent circumstances exception. For example, facility administrators know that altercations among youth are common in secure settings. Facility administrators may not be able to predict exactly when and where fights may break out, or which youth will be involved, so each incident is arguably unforeseen, but such incidents are certainly foreseeable. The same analysis could apply for the purposes of staff who are unavailable because of illness. An administrator might argue that the individual staff member's illness was unforeseen. However, a facility should not be able to depart from minimum staffing ratios and several other provisions allowing departure for exigent circumstances just because an employee calls in sick. We are concerned that agencies may characterize routine events such as these as "unforeseen" for the purpose of evading the staffing ratio requirement and other requirements in the PREA standards. Accordingly, we recommend that the Department use the term "unforeseeable" instead of the term "unforeseen." The proposed change will ensure that predictable occurrences do not expand the limits of the exigent circumstances exception to unreasonable points.

The second issue relates to the definition's references to circumstances that present "a threat to the security or institutional order of a facility." This provision, like the term "unforeseen," is too broad to place reasonable limits on the exigent circumstances exception. In our experience, facilities may categorize a wide range of events as threats to security or institutional order – events ranging from a riot to a youth's refusal to leave his or her room to attend school to a

youth who talks back to a staff member. While a riot requires a response that may justifiably draw staff away from assigned positions, other less serious situations should not suspend the obligation to provide adequate direct, in-person supervision of youth. Accordingly, we recommend that the Department modify its definition to limit exigent circumstances to situations that require "an immediate action in order to combat a serious threat to the security of a facility."

The final issue relates to the fact that the exigent circumstances exception applies to multiple requirements in the PREA standards. Of the requirements that apply specifically to youth, these include:

- the bar on cross-gender pat down searches of youth in juvenile facilities;
- the bar on cross-gender viewing of youth in juvenile facilities when showering, performing bodily functions, or changing clothing;
- the bar on cross-gender strip searches or visual body cavity searches of youth in juvenile facilities by staff other than medical professionals;
- the requirement to afford youth in adult facilities who are isolated the opportunity for large muscle exercise and legally required special education services;
- the requirement to comply with the staffing plan in juvenile facilities; and
- the requirement to maintain minimum staff-to-youth ratios during the hours when youth are awake and when they are asleep.

We believe that our proposed limits on the definition of exigent circumstances should apply to each of these situations for the reasons described above. Thus, we recommend that the Department modify the definition of exigent circumstances contained in section § 115.5 to reflect our proposed edits. We strongly recommend this fix to the regulations. If, however, the Department determines that a narrower definition of exigent circumstances should only apply to the staffing ratio standard, we propose that the Department develop a new term such as "emergency situations" to reflect that narrower definition.

Proposed revision #1 (strongly preferred):

> **§ 115.5 General definitions.**
>
> For purposes of this part, the term—
> . . .
> *Exigent circumstances* means any set of temporary and ~~unforeseen~~ **unforeseeable** circumstances that require immediate action in order to combat a **serious** threat to the security ~~or institutional order~~ of a facility.
> . . . .

Proposed revision #2:

§ 115.5 General definitions.

For purposes of this part, the term—

. . .

Emergency situations **means any set of temporary and unforeseeable circumstances that require immediate action in order to combat a serious threat to the security of a facility.**

. . .

§ 115.313 Supervision and monitoring.

. . .

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete **emergency situations** ~~exigent circumstances~~, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

. . . .

(4) Whether certain categories of secure juvenile facilities should be exempt from the minimum ratio requirement or, conversely, whether certain categories of non-secure juvenile facilities should also be included in the minimum ratio requirement.

We strongly oppose any exemption for certain categories of secure juvenile facilities from the minimum staffing ratio requirement. The crucial role of direct supervision in preventing and detecting sexual misconduct does not change based on the programming offered by a facility or whether the facility serves pre- or post-adjudicated youth.

Although sexual victimization is a risk in any setting that houses youth, almost all of the research on the relationship between staffing levels and safety has been limited to secure facilities. Unfortunately, the same type of efforts to understand the links between staffing levels and safety have not taken place in non-secure settings, which are generally less regulated and more varied in terms of program design, facility layout, and population served.

Because of the limited information available on the relationship between staffing levels and victimization in non-secure settings, we do not recommend a particular minimum staffing ratio at this time for these facilities.[13] However, we strongly encourage the Department to lead the effort in gathering information that will help the field understand how staffing levels relate to sexual misconduct in non-secure facilities, as non-secure facilities house a large number of youth in out-of-home placements. For example, the most recent Juvenile Residential Facility Census conducted by the Department revealed that a 27 percent of facilities surveyed were group homes.[14]

Although we do not propose a particular staffing ratio for non-secure facilities, we do recommend that the standard require that *all* juvenile facilities – not just secure juvenile facilities – have at least two direct care staff on duty at all times when youth are present. As described in our response to question two, this is a basic protection that many jurisdictions already take to ensure the safety of both youth and staff, and it should extend to all custodial settings.

Proposed revisions:

§ 115.313 Supervision and monitoring.

. . .

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this

[13] Although we do not propose a particular staffing ratio, our research reveals that many jurisdictions already require staffing levels at the same level or a higher level in their group homes and shelters than what the Department has proposed for secure juvenile facilities. *See, e.g.*, 29 DCMR §§ 6219(10)-(11) (District of Columbia group homes and shelter houses serving delinquent youth must maintain staff-to-youth ratios of 1:5 during waking hours and 1:10 during sleeping hours); Iowa Admin. Code 441 – 105.5(c) (requiring minimum staff ratio of 1:5 during "prime programming time" in juvenile shelter care homes and juvenile detention homes); Kentucky Department of Juvenile Justice Policy #319 (requiring minimum of two staff members present and on duty during waking hours in Kentucky group homes housing more than eight youth); Mich. Admin. Code R. § 400.10123(2) (requiring minimum staff ratio of 1 direct care worker or supervisory staff for 8 youth at all times during waking hours); New York City Administration for Children's Services, Close to Home: Plan for Non-Secure Placement 119 (June 8, 2012) (non-secure placements in New York City must maintain at least two staff on duty at all times regardless of size; group homes limited by state law to no more than 12 youth); Utah Department of Juvenile Justice Services Policy No. 05-08(III)(A)(7) (requiring awake staff-to-youth ratio of 1:8 during waking hours and 1:16 during sleeping hours in all facilities and programs operated by the department); Wash Admin. Code § 388-148-0725 (requiring staff-to-youth ratio of 1:8 during both waking and sleeping hours in group care facilities in Washington State).

[14] Sarah Hockenberry et al., *Juvenile Residential Facility Census, 2008: Selected Findings* 3 (July 2011).

final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

(d) All juvenile facilities shall have a minimum of two direct care staff on duty at all times to directly supervise residents.

~~(d)~~ **(e)** Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:

(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

~~(e)~~ **(f)** Each secure facility shall implement a policy and practice of having intermediate-level or higher level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

(5) The extent to which the provision can be expected to be effective in combating sexual abuse.

Alert, engaged staff supervision of youth plays a vital role in combating sexual misconduct in facilities that house youth. A minimum level of direct supervision ensures that staff can interact with youth in a way that increases the likelihood that they will identify red flags associated with victimization. When direct care staff are engaged with youth, they can prevent victimization because youth are focused on other activities and on positive interactions with staff. Control center and intake functions do not allow for this kind of engagement with a group of youth.

Staffing ratios are a key aspect of prevention and detection that complement other requirements in the PREA standards, such as staff training, youth education, supervision of staff, and reporting mechanisms. Without adequate direct supervision, staff training on the signs of victimization and dynamics of sexual misconduct cannot achieve its goals.

Throughout our comments, we provide evidence supporting the effectiveness of minimum staffing ratios at reducing sexual victimization. Here, we highlight five areas that reinforce that connection: (1) the Department's recent investigations of juvenile facilities; (2) findings and testimony from the Department's review panel on victimization in juvenile facilities; (3) expert testimony before the National Prison Rape Elimination Commission and the Commission's findings; (4) national standards and other expert reports; and (5) recent litigation over and investigations of sexual victimization in juvenile facilities.

We anticipate that commenters will argue against the inclusion of the staffing ratios in the standards, proposing that facilities have flexibility to set staffing levels according to their programming needs and the needs of youth in their care. The standard does not eliminate this flexibility. It does, however, establish a level below which facilities cannot go if they are to meet their responsibility to take an important step toward preventing and detecting sexual victimization. It allows agencies to analyze their particular facility structures, youth populations, youth with special needs, and other factors to determine staffing ratios above the mandated floor. As the Department noted in its comments accompanying the PREA standards, a majority of states already mandate staffing ratios in their facilities. They have done so because they, too, see the need to set a floor for minimum levels of direct supervision.

Arguing that facilities should set staffing levels without any minimum level of direct supervision because it is a "complicated" and "facility specific" inquiry also ignores the fact that it is this very arrangement – the status quo – that contributed to the current rate of sexual abuse in juvenile facilities. Given that over one in eight youth report being sexually victimized, and given the evidence described below, PREA requires that more be done to protect youth. Accordingly, we urge the Department to retain this standard with our proposed modifications.

The Department's Investigations of Juvenile Facilities

The Department has to look no further than its own recent investigations of juvenile facilities to see the connection between inadequate direct supervision and sexual misconduct in juvenile facilities. The Civil Rights Division's Special Litigation Section has documented numerous instances in which inadequate supervision contributed to victimization of youth and staff.

- Following a two year investigation of the Indianapolis Juvenile Correctional Facility (IJCF), the Department stated that the facility's "staffing pattern likely exacerbate[d] IJCF's problems with incidents of sexual misconduct."[15] For example, on numerous occasions, the Department observed a single male officer supervising a unit of approximately 25 girls when the girls were engaged in private activities such as

[15] Findings Letter from Thomas E. Perez, Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Mitch Daniels, Governor, State of Indiana, at 12 (Jan. 29, 2010), *available at* http://www.justice.gov/crt/about/spl/documents/Indianapolis_findlet_01-29-10.pdf.

showering, toileting, dressing, and undressing.[16] According to the Department, "[s]uch staffing patterns not only le[d] to violations of girls' privacy and facilitate[d] staff misconduct, but they also expose[d] staff members to false allegations of staff misconduct."[17]

- An investigation of Los Angeles County's Juvenile Probation Camps led to a 2008 findings letter that documented the failure to provide "sufficient staffing to adequately supervise youth."[18] The letter detailed a range of waking and sleeping staffing ratios at the 19 different camps throughout the county, and the Department drew a direct link between insufficient staffing and youth victimization: "Adequate numbers of staff must be deployed to supervise youth during waking and sleeping hours in order to protect youth from harm. The number of staff available to supervise youth is directly relevant to nearly all of the measures designed to protect youth from harm."[19]

- In Mississippi, an investigation of the Oakley Training School and Columbia Training School revealed "unsafe living conditions and . . . inadequate treatment and care," which the Department concluded stemmed from "staff shortages, ineffective management and supervision at every organizational level within both facilities, and the facilities' emphasis on control and punishment instead of rehabilitation."[20] The Department's 2003 findings letter documented instances of alleged victimization and sexual misconduct, including a situation where female youth complained that a security guard stood in front of the uncovered windows of their cottage and observed them while they were undressing.[21] The letter concluded that inadequate staff-to-youth ratios, which reached as high as 1:30 at the Oakley Training School, "compromised the safety of both staff and youth."[22]

- Following a March 2010 investigation of the Terrebonne Parish Youth Detention Center in Louisiana, the Department concluded that the facility's operations created "serious

[16] *Id.* at 10, 13.
[17] *Id.* at 13.
[18] Findings Letter from Grace Chung Becker, Acting Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Yvonne B. Burke, Chairperson, Los Angeles County Board of Supervisors, State of California, at 19 (Oct. 31, 2008), *available at* http://www.justice.gov/crt/about/spl/documents/lacamps_findings_10-31-08.pdf.
[19] *Id.* at 20.
[20] Findings Letter from Ralph F. Boyd, Jr., Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Ronnie Musgrove, Governor of Mississippi, 5 (June 19, 2003), *available at* http://www.justice.gov/crt/about/spl/documents/oak_colu_miss_findinglet.pdf.
[21] *Id.* at 13.
[22] *Id.* at 14.

risk of avoidable harm" to youth.[23] In its findings letter, the Department noted that it had "received a significant number of credible reports of sexual and physical misconduct by staff members on youth within their custody."[24] The letter cited TPYDC's inadequate levels of direct supervision as a contributor to the facility's problems. Specifically, the Department noted that TPYDC "claim[ed] to maintain a 1:8 [staff-to-youth] ratio during waking hours"[25] but that "typically[ ] direct supervision ratios [were] much lower and [fell] far below generally accepted professional standards."[26] TPYDC also improperly calculated its staffing ratios by including staff who did not directly supervise youth.[27] The Department later entered into a settlement agreement with TPYDC that provided for staffing ratios that match those in the PREA standards – 1:8 during waking hours and 1:16 during sleeping hours.

- During the summer of 2004, an investigation of the Plainfield Juvenile Correctional Facility in Indiana revealed "rampant" sexual activity among youth housed there, which the Department described as a "consequence of the inadequate supervision of youths."[28] The resulting findings letter singled out staffing as the core problem, stating that "[t]he most obvious and glaring reason for the frequency of physical assaults and OSB [overt sexual behavior] among juveniles at Plainfield is that there are not enough staff to supervise the residents adequately."[29]

- Following an investigation of two Arizona youth facilities from 2003 to 2004, the Department concluded that "[s]exual and physical assaults [were] more likely to occur because the facilities lack sufficient staff to supervise youth adequately, thus exposing youth to danger."[30] In the Department's findings letter, it noted that relevant policies required a minimum of 3 staff members to supervise up to 48 youth during waking

[23] Findings Letter from Thomas E. Perez, Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Michel Claudet, President, Terrebonne Parish, at 1 (Jan. 18, 2011), *available at* http://www.justice.gov/crt/about/spl/documents/TerrebonneJDC_findlet_01-18-11.pdf.
[24] *Id.* As a result of these allegations, seven staff members had been criminally charged as of January 2011. Of those seven staff members, two pled guilty to charges related to the alleged sexual misconduct, two had the charges against them dropped because prosecutors were unable to locate the alleged victim, one had the charges dropped at the victim's request, and two were found not guilty following a trial. *See* Eric Heisig, Sex Charges Dropped Against Former Terrebonne Juvenile-Center Guards, wwltv.com (Feb. 23, 2011).
[25] *Id.* at 13.
[26] *Id.* at 14.
[27] *Id.*
[28] Findings Letter from Bradley J. Schlozman, Acting Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Mitch Daniels, Governor of Indiana, at 5 (Sept. 9, 2005), *available at* http://www.justice.gov/crt/about/spl/documents/split_indiana_plainfield_juv_findlet_9-9-05.pdf.
[29] *Id.* at 7.
[30] Findings Letter from R. Alexander Acosta, Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Janet Napolitano, Governor of Arizona, at 14 (Jan. 23, 2004), *available at* http://www.justice.gov/crt/about/spl/documents/ariz_findings.pdf.

hours and only 1 staff member to supervise the same number of youth at night, which "deviate[d] substantially from generally accepted professional practices."[31]

These investigations draw a clear link between direct staff supervision and the sexual and physical victimization of youth.

Findings from the Department's Review Panel on Victimization in Juvenile Facilities

In October 2010, the Department released findings from its review panel on victimization in juvenile facilities.[32] As part of the review, the Department gathered data and received testimony on victimization in facilities that reported the lowest rates of sexual victimization and the highest rates of sexual victimization based on the 2009 report*, Sexual Victimization in Juvenile Facilities Reported by Youth*. Although the review panel noted that each facility had some unique characteristics, a comparison of staffing ratios reveals a distinction between them:[33]

Staff-to-Youth Ratios: Lowest Victimization Rates	Staff-to-Youth Ratios: Highest Victimization Rates
1:6 (Ft. Bellefontaine Campus, MO)	**NO MINIMUM RATIO** (Pendleton Juvenile Correctional Facility, IN)
1:8 (Rhode Island Training School, RI)	**1:12** (Woodland Hills, TN)
	1:12 (Corsicana, TX)

This difference is not surprising, particularly when considered alongside the testimony of those before the panel. For example, the director of the Missouri Department of Youth Services, which oversees the Ft. Bellefontaine Campus, emphasized the importance of direct supervision to keeping youth safe: "In all programs staff are required to see all youth at all times, except during hygiene, and even then staff are strategically placed and aware . . . By keeping youth productively engaged and structuring staff member involvement, opportunities for unproductive or harmful interactions are decreased."[34]

[31] *Id.*
[32] *Sexual Victimization in Juvenile Correctional Facilities: Hearing Before the Review Panel on Prison Rape,* U.S. Department of Justice (2010).
[33] *Id.*
[34] *Id.* at 9-10.

Leadership of the agencies at facilities with the highest victimization rates tied problems with sexual victimization to staffing issues. For example, the executive director of the Indiana Department of Corrections' Department of Youth Services, which oversees the Pendleton facility, stated that the "number one factor" contributing to victimization was overcrowding, with significant delays in hiring new staff.[35] The executive director of the Texas Youth Commission, which oversaw the Corsicana campus, also recognized the connection between staffing and sexual victimization, stating that her agency was "[i]ncreasing supervision ratios during evening shifts and weekend awake shifts to 1:4" in response to sexual victimization rates.[36]

PREA required the creation of the Review Panels on Prison Rape to identify the common characteristics of facilities with the highest rates of victimization and facilities with the lowest rates of victimization. As the hearing revealed, staffing levels are intimately linked with opportunities for sexual victimization by youth and staff.

Testimony to the National Prison Rape Elimination Commission and the Commission's Findings

The National Prison Rape Elimination Commission's report on sexual victimization in correctional facilities concluded that "[d]irect supervision is the most effective mode of supervision for preventing sexual abuse."[37] In public hearings before the Commission, testimony from victims of sexual victimization, corrections professionals, and experts offered many examples of why direct supervision is vital to efforts to prevent and detect victimization:

- "[A] direct-supervision model of managing jail facilities . . . not only increases your supervision capabilities, but it also increases communication, intelligence gathering that helps then allow the staff to take steps to prevent subsequent conflicts with sexual assault."[38]
  - *Michael Hennessey, Sheriff, San Francisco, CA*

- "There was no supervision in that jail. There was no guard who had a line of sight into the cell. The guards' office was pretty far away, and the T.V. was on all the time. This was zero supervision."[39]

[35] *Id.* at 20.
[36] Sexual Victimization in Juvenile Correctional Facilities: Hearing Before the Review Panel on Prison Rape, U.S. Department of Juvenile Justice (2010) (written testimony of Cheryln K. Townsend, Executive Director, Texas Youth Commission). Another administrator of an agency that oversaw a facility with above-average sexual victimization rates stated that he planned to increase staff supervision by reducing the facility's population. *See* Julie Bisbee, *Sex Abuse Study Cites L.E. Rader Center*, The Oklahoman (Jan. 8, 2010), *available at* http://newsok.com/sex-abuse-study-cites-l.e.-rader-center/article/3430543 (noting that "[t]he design of the units . . . make it difficult to monitor juveniles, as well as staff").
[37] National Prison Rape Elimination Commission, *Report* 6 (2009).
[38] *See* At Risk: Sexual Abuse and Vulnerable Groups Behind Bars, Hearing Before the National Prison Rape Elimination Commission, at 6 (Aug. 19, 2005).
[39] *Id.* at 3

- Chance Martin, testifying about being raped in a jail at the age of 18

- "[W]e shouldn't mislead ourselves and think [video monitoring is] going to solve the problem . . . I've been in facilities that do have lots and lots of cameras, and I've . . . talked to children who have been assaulted by staff in those facilities, and there are ways of getting out of camera view and cameras are not everywhere in the facilities . . . ."[40]
  -Mark Soler, Executive Director, Center for Children's Law and Policy

- "One of the things that we have to stop doing is trying to, with all due respect, get off on the cheap, because it takes folks to supervise those folks, it takes folks to train those folks, and all my facilities have cameras in them, all of them, and we have digital cameras, we have all of that, and we've still an incident of those things occurring in the facility. And, so, if cameras were the – was – I won't say the cure-all – then believe me, we wouldn't be having this discussion now."[41]
  - Leonard Dixon, President of the National Juvenile Detention Association and Director of the Michigan Bureau of Juvenile Justice

- "I think you've got to have units no more than 20 youth, you've got to have staff ratios no less than one-to-eight, and we really need to systematically get rid of these facilities that don't permit staff to directly observe what's going on."[42]
  -Barry Krisberg, President, National Council on Crime and Delinquency

- "We need to ensure that proper staffing ratios are maintained. Detention centers should maintain a staffing ratio of one-to-six in their high risk units and one-to-eight staff-youth ratios in their general population units."[43]
  -Carl Sanniti, Deputy Secretary, Maryland Department of Juvenile Services

- "[Michigan detention facilities] with incidents [of staff sexual misconduct] had a worse staff ratio (more residents under the direct supervision of one staff member) than those facilities without incidents . . . How is it that we can even begin to expect, much less assure, the safety of children and youth when a single staff person with minimal training is expected to provide direct/continuous supervision to as many as twenty (20) to thirty (30) youth or more on a shift?"[44]

[40] Elimination of Prison Rape: Focus on Juveniles, Hearing Before the National Prison Rape Elimination Commission, at 91 (Jun. 1, 2006).
[41] *Id.* at 93-94.
[42] *Id.* at 112.
[43] *Id.* at 230.
[44] *Id.* at 7, 36 (written testimony).

-David Roush and Earl Dunlap, National Partnership for Juvenile Services

The consistency of testimony from a broad range of individuals, combined with the National Prison Rape Elimination Commission's observations about direct supervision, strongly support the Department's inclusion of minimum staff ratios in the PREA standards.

National Standards and Reports

A wide range of nationwide standards include minimum staff-to-youth ratios, recognizing that adequate direct supervision of youth goes hand-in-hand with the safety of youth and staff in a facility. These include:

- The National Juvenile Detention Association;[45]
- The Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative Juvenile Detention Facility Standards;[46]
- The Institute for Judicial Administration and American Bar Association's Juvenile Justice Standards;[47] and
- The National Advisory Committee for Juvenile Justice and Delinquency Prevention's Standards for the Administration of Juvenile Justice.[48]

Even the Performance-based Standards established by the Council of Juvenile Correctional Administrators, while not mandating a particular ratio, acknowledge the relevance of staffing levels. The standards include the "[a]verage ratio of direct care staff to youth for each day during the collection month" as one of the five outcome measures for minimizing environmental risks and reducing harm in the use of restraints and isolation.[49]

Recent reports from experts also support the use of a minimum staff ratio to protect youth from sexual abuse and other types of victimization. For example, a 2009 report by the National Council on Crime and Delinquency stated that inadequate staffing and training contributed to rampant sexual assault in certain juvenile facilities and recommended that facilities maintain a

[45] National Juvenile Detention Association, Minimum Direct Care Staff Ratio in Juvenile Detention Centers, at 6 (June 8, 1999), available at http://npjs.org/docs/NJDA/NJDA_Position_Statements.pdf.
[46] Annie E. Casey Foundation, Juvenile Detention Alternatives Initiative, Juvenile Detention Facility Standards, §§ V(B)(2), (3) (mandating minimum ratio of 1:8 during awake hours and 1:16 during sleeping hours).
[47] Institute for Judicial Administration and American Bar Association, Juvenile Justice Standards § 7.11(F) (1996) (providing for a staff ratio of 1:4 during waking hours and 1:12 during sleeping hours in post-adjudication facilities). The standard contemplates small secure residential facilities of between 12 and 24 youth.
[48] National Advisory Committee for Juvenile Justice and Delinquency Prevention, Standards for the Administration of Juvenile Justice § 4.2192 (1980) (providing for a ratio of 1:3.4 during waking hours and 1:5 during sleeping hours in post-adjudication units that house aggressive youth who present behavioral challenges to facility staff). The National Advisory Committee's standards established general staff-to-youth ratios of 1:10 during waking hours and 1:20 during sleeping hours in detention and post-adjudication facilities. *Id.* at §§ 4.212, 4.262. We believe that knowledge of best practices has moved the benchmark forward since these standards were established 32 years ago.
[49] *See* Council of Juvenile Correctional Administrators, Performance-based Standards, Safety Standard 2 - Sa9.

minimum staff-to-youth ratio of at least 1:8.[50] The report noted that in some situations, victimized youth deliberately engaged in violent or psychologically abnormal behavior in order to be placed in restricted housing units with increased staff supervision.[51]

Additionally, in 2000, the Department's Office of Juvenile Justice and Delinquency Prevention released a bulletin "designed to present the most up-to-date knowledge" with respect to the operation of juvenile confinement facilities.[52] The publication recommended a staff-to-youth ratio of 1:8 or 1:10 "to ensure effective involvement and behavior management."[53]

Finally, the Child Welfare League of America's best practice guidelines for serving lesbian, gay, bisexual, and transitioning (LGBT) youth in institutional settings draws a direct connection between staffing ratios and victimization. Specifically, the report notes that "[i]ncidents of harassment or violence toward LGBT youth are much less likely to occur or to escape the staff's attention when a facility has high staff-to-resident ratios."[54] The authors note that enhanced supervision "maximize[s] the opportunities for interaction between staff and residents."[55]

The requirements contained in national standards and the perspectives of experts fully support the Department's inclusion of minimum staff-to-youth ratios as a way of combating sexual victimization.

Recent Litigation Over and Investigations of Sexual Victimization in Juvenile Facilities

In addition to the summaries of the Department's own investigations into victimization in juvenile facilities, recent litigation and investigations involving other facilities also exposes the connection between inadequate supervision and sexual victimization.

In July 2012, an audit of the Kansas Juvenile Correctional Complex (KJCC) in Topeka revealed that "[p]oor supervision in the dining area and living units has led to theft, injuries, and sexual misconduct."[56] In the report, auditors noted that KJCC was operating under a 1:15 staff-to-youth ratio.[57] The report describes an incident of sexual misconduct when youth engaged in sexual activity while a staff member's attention was directed to another group of youth.[58]

Additionally, a 2003 grand jury investigation of sexual abuse at the Florida Institute for Girls in Palm Beach County, Florida, noted the following in its final report:

[50] Barry Krisberg, Special Report: Breaking the Cycle of Abuse in Juvenile Facilities 6 (2009).
[51] *Id.* at 3-5.
[52] David Roush & Michael McMillen, *Construction, Operations, and Staff Training for Juvenile Confinement Facilities* 9, Office of Juvenile Justice and Delinquency Prevention Bulletin (Jan. 2000).
[53] *Id.*
[54] Shannan Wilber et al., Best *Practice Guidelines: Serving LGBT Youth in Out of Home Care* 51 (2006).
[55] *Id.*
[56] Legislative Division of Post Audit, Performance Audit Report - JJA: Evaluating the Kansas Juvenile Correctional Complex, Part I, at 10 (July 2012).
[57] *Id.* at 29.
[58] *Id.* at 11.

> "Male staff are prohibited [by policy] from being alone with a girl and entering a girl's room without a female staff in attendance. However, staff shortages contributed to circumstances allowing certain male staff to violate this policy resulting in allegations of inappropriate touching. Inadequate staffing also contributed to a protective culture among some of the staff, that fostered coverups and non-reporting of inappropriate behavior in at least one case . . . Inadequate staffing breeds and [*sic*] environment that has a potential for sexual abuse of the girls . . . ."[59]

Similarly, in recent litigation against the Hawaii Youth Correctional Facility (HYCF) for failures to protect LGBT youth from victimization, a federal district court found that the defendants had "failed to maintain . . . adequate staffing and supervision."[60] The court noted that the plaintiff's allegations that they "frequently experienced ward-on-ward harassment when [staff] were not paying attention or were absent [was] consistent with the . . . finding that defendants ha[d] employed an insufficient number of staff at HYCF to monitor youth."[61]

Cases such as these reinforce the connection between inadequate direct supervision and sexual victimization, and they support the Department's inclusion of a minimum staffing ratio in the PREA standards.

(6) The expected costs of the provision.

Although we are not in a position to estimate costs of the staffing ratio requirement for particular jurisdictions, we have several comments related to the estimates in the Department's Regulatory Impact Assessment (RIA). Specifically, we believe that the RIA's estimates of the costs of victimization are too low and that the actual cost of victimization and its associated consequences offset any investment required to comply with the staffing ratio standard.

The RIA projects an estimated average annualized cost of $53,666 per juvenile facility to come into compliance with all of the PREA standards, stating that the staffing standards represent 25.3% of the total cost.[62] The RIA also explains that the actual cost of compliance is likely to be less than the quoted figure.

We agree with this assessment. Many juvenile facilities already meet or exceed the 1:8 and 1:16 staffing ratios during awake and sleeping hours, respectively. In the comments accompanying the final standards, the Department noted that the proposed ratios matched or

[59] Palm Beach County Grand Jury, Final Report on the Investigation of Florida Institute for Girls 28, 60 (2003).
[60] *R.G. v. Koller*, 415 F. Supp. 2d 1129, 1157 (D. Haw. 2006).
[61] *Id.* at 1157 (internal quotation marks omitted).
[62] U.S. Department of Justice, Regulatory Impact Assessment - National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA) 71, 92 (May 17, 2012).

were less stringent than the ratios mandated by 12 states, plus the District of Columbia and Puerto Rico, for their juvenile detention facilities, juvenile correctional facilities, or both.[63] Our work with specific jurisdictions and research of publicly available state laws, regulations, and policies revealed at least 13 states with ratios that met or exceeded the Department's standard for both waking and sleeping hours, in addition to Puerto Rico and the District of Columbia.[64] The RIA properly observes that these facilities should have no costs for compliance with the staffing ratio standard.

We were pleased that the RIA considered monetary costs of victimization that are often ignored such as suffering and loss of quality of life, costs of mental health treatment, suicide acts, medical care, sexually transmitted infections, pregnancy, substance abuse, and serial victimization. However, the Department appears to omit other important costs related to the prosecution and litigation of sexual abuse claims and the costs associated with systemic reform.

For example, the RIA assigns only $871 to "Criminal Justice Investigation/Adjudication" for child rapes.[65] This figure would scarcely cover the costs of making court personnel available for one court appearance, let alone the many costs associated with litigating sexual abuse cases. For example, a study of court costs in Los Angeles County conducted during the 1980s found that the daily costs of operating a court were $2,318.[66]

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[63] National Standards to Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37123 (June 20, 2012) (amending 28 CFR Part 115).

[64] **Alabama:** Ala. Admin. Code r. § 950-1-13-.03 (1:6 in short-term detention facilities); **Idaho:** Idaho Department of Juvenile Corrections – JCC Lewiston Overview, *available at* http://www.idjc.idaho.gov/ProgramsFacilities/StateFacilities/JCCLewiston/tabid/111/Default.aspx (1:8 waking and 1:12 sleeping at Lewiston Juvenile Correctional Center); **Kansas:** Kan. Admin. R. § 28-4-353(e)(2)(B) (1:7 waking and 1:11 sleeping in detention and secure care centers); **Louisiana:** La. Adm. Code LAC 67:V.Chapter 75 §7511 (G) (1:8 waking and 1:16 sleeping in secure detention facilities); **Maryland:** Kelly Dedel & Peter Leone, Fourth Monitor's Report for the Baltimore City Juvenile Justice Center (BCJJC) (June 2009), *available at* http://www.djs.state.md.us/pdf/fourth-bcjjc-monitors-report.pdf (1:8 waking and 1:16 sleeping in Department of Juvenile Services Facilities; Baltimore City Juvenile Justice Center detention facility must maintain 1:6 waking and 1:12 sleeping); **Missouri:** Supreme Court Rule 129, Section 11.2 (1:8 in secure detention facilities); **Missouri:** Email from Scott Odum, Assistant Deputy Director, Treatment Section, Missouri Department of Youth Services, to Vivian Murphy, Director, Missouri Juvenile Justice Association (June 25, 2012) (1:5 or 1:6 in Department of Youth Services facilities); **Montana**: Mont. Admin. R. § 20.9.612(3) (1:8 waking and 1:12 sleeping in secure detention); **New Jersey**: N.J. Admin. Code § 13:92-10.6 (1:8 waking and 1:16 sleeping in secure detention); **New York:** 9 N.Y. Comp. Codes R. & Regs. § 180.9(15) (1:8 waking and 1:15 sleeping in secure detention); **Oklahoma:** Okla. Admin. Code § 377:3-13-44(4) (1:7 waking and 1:16 sleeping in secure detention); **Pennsylvania:** 55 Pa. Code §§ 3800.274(5), (6) (2011) (1:6 waking and 1:12 sleeping in detention and post-adjudication facilities); **Texas:** Tex. Admin. Code § 343.440 (1:8 in secure detention multiple occupancy housing units); **Utah:** Utah Department of Juvenile Justice Services Policy No. 05-08(III)(A)(7) (1:8 waking and 1:16 sleeping in all facilities operated by the Utah Department of Juvenile Justice Services).

[65] *Id.* at 44.

[66] Kent John Chabotar et al., *Analyzing Costs in the Courts*, U.S. Dept. of Justice Office of Communication and Research Utilization 110 (1987). *See generally* J.S. Kakalik & R.L. Ross, *Costs of the Civil Justice System*: *Court Expenditures for Various Types of Civil Cases* (1983).

It is impossible to estimate accurately the expense of litigation without including attorney fees and costs.[67] For example, when cases are handled by experienced attorneys, fees alone are likely to run several hundred dollars per hour. The *Laffey* matrix, a rubric commonly used by courts to determine the appropriate rates for attorney fees, pegs the hourly rate for an attorney with more than 20 years of experience at $495 per hour.[68]

In almost every case where there is a settlement or judgment in favor of the plaintiff, there is an award of attorney fees and costs. In many cases, the attorney fees and costs exceed the award to the plaintiff. For example, a teenager raped in a Utah prison was recently awarded $435,000 as part of a settlement, with punitive damages and attorney fees exceeding $1 million.[69] Unlike in other kinds of juvenile and correctional facility litigation, plaintiffs in rape and strip search cases may no longer be in custody, meaning that attorney fees are not restricted by the Prison Litigation Reform Act.

Additionally, rape and sexual abuse cases often require extensive investigations because they come down to a disputed version of what happened. They also frequently involve expert testimony on damages. Even injunctive cases, which seek to change practices rather than to compensate victims, can entail substantial attorney fees.[70] All of these costs must be borne by the losing party, which is often a state or local governmental agency.

There are also substantial costs associated with representing agency officials and staff members in sexual abuse cases, a task that often falls to the state's attorney general or a county counsel's office. Defense of these cases requires compliance with discovery requests, filing of responsive motions and briefs, settlement negotiations, and sometimes trial. Extensive time commitment by counsel for state or local governments may also be required when apparent patterns of problems at an institution trigger independent investigation by the Department of Justice or another monitoring entity. It is our experience that public agencies often turn to outside law firms for assistance in defending such cases, which entails payments for representation at

[67] This is a different question than the question of whether the PREA standards will decrease or increase litigation, which the RIA does address.

[68] United State's Attorney's Office for the District of Columbia, Laffey Matrix – 2003-2012, *available at* http://www.justice.gov/usao/dc/divisions/civil_Laffey_Matrix_2003-2012.pdf.

[69] Emiley Morgan, Utah prison guard ordered to pay $1.4M in rape case, *Deseret News* (Feb. 25, 2010). In another class action lawsuit stemming from strip searches of youth in a Florida jail, each of 1,312 claimants class members received an average settlement award of about $3,500, with attorney fees, costs, and expenses totaling $1.1 million. Margo Schlanger, Jail Strip Search Cases: Patterns and Participants, 71 *Law and Contemporary Problems* 65, 72 (2008). In two cases involving strip searches in Los Angeles and Washington, D.C., the attorney fees were $13 million. *Id.* A website, LawyersandSettlements.com, provides additional descriptions of civil and human rights case settlements and fees. *See* http://www.lawyersandsettlements.com/settlements/civil-human-rights-settlements/ (last visited July 5, 2012).

[70] For example, a case for injunctive relief over conditions in a juvenile detention facility in Sacramento County, California, recently resulted in a $700,000 attorney fee award. Andy Furillo, Sacramento County settles juvenile detention suit, *Sacramento Bee* (Dec. 14, 2009).

private law firm rates. These costs of legal services, along with the other costs described above, should be factored into the RIA's "break even" analysis.

Further, jurisdictions confronting widespread failures to prevent sexual misconduct often face many additional costs associated with systemic change. For example, the recent sexual misconduct scandal at the Texas Youth Commission involved more than 750 complaints over a period of less than 10 years.[71] While the RIA addresses the issue of multiple victims of sexual abuse, it does not fully address the costs of systemic sexual abuse, which may entail restructuring agencies, replacing key staff, and responding to public scrutiny in legislative hearings and other public forums. There are also costs associated with prosecuting and, in some cases, incarcerating staff or youth guilty of perpetrating misconduct.

Finally, we are concerned that the RIA's estimated cost of $675,000 per case of sexual abuse of a youth is too low and does not reflect the actual costs associated with victimization. We understand that the figure was calculated, in part, using quality of life awards and settlements in actual cases. The RIA does not provide the raw data on awards that were factored into the estimate, and we are concerned that some awards are significantly lower than what a victim ought to have received when compared with victims in other similar situations.

We are grateful for the research and thoughtful reasoning that the Department applied when developing the RIA. However, we urge the Department to incorporate the costs and considerations described above when assessing any expenses associated with the staffing ratio standard. The RIA concluded that the costs of compliance for juvenile facilities would be offset if the PREA standards helped prevent just 2.55% of the expected number of sexual assault incidents. Adequate in-person supervision of youth is critical element in meeting and exceeding that goal.

(7) Whether the required ratios may have negative unintended consequences or additional positive unintended benefits.

Because of the connection between staffing ratios and sexual misconduct, the proposed standard will play an instrumental role in achieving PREA's goal of effective sexual misconduct prevention, detection, and response. Whether intended or unintended, the inclusion of minimum staffing ratios will also yield a number of other positive benefits. These include:

- increased safety and security of institutions;
- greater support for existing direct care staff;
- reduced rates of staff injury and turnover;

[71] Doug Swanson, Complaints filed against guards at all 13 youth prisons documents show, *Dallas Morning News* (Mar. 7, 2007).

- fewer opportunities for abuse and harassment of a non-sexual nature;
- fewer opportunities for youth to engage in self-harming behavior;
- greater opportunities for interactions focused on helping youth develop positive skills; and
- fewer instances of canceled rehabilitative programming or services because of staff shortages.

Minimum staffing ratios will also help protect staff against false allegations of sexual abuse. For example, it is easier for a staff member to respond to false allegations of misconduct when a coworker who was present on the unit can corroborate the staff member's account of a situation.

We do not anticipate any negative unintended consequences of the staffing ratio standard, as any additional staff members will be subject to all of the PREA standards' requirements with respect to sexual misconduct prevention, detection, and response. To the contrary, our experience with juvenile facilities demonstrates that staff fully recognize the importance and benefits of direct supervision. When touring or working with juvenile facilities, we often ask staff and administrators what changes they would like to see in their facilities. The leading response is "more staff." Indeed, in a recent survey of stakeholders in the Texas' juvenile justice system, 70% of supervisors at a state-operated secure institutions responded that improved staff-to-youth ratios was a factor that they considered to be "most important" in maintaining the safety of youth and staff.[72]

For these reasons, we support the Department's inclusion of a minimum staff ratio. It will not only play a vital role in reducing sexual victimization, but it will also make juvenile facilities safer, more humane, and more rehabilitative.

(8) Question 8: Whether empirical studies exist on the relationship between staffing ratios and sexual abuse or other negative outcomes in juvenile facilities.

Although we are not aware of any peer-reviewed experimental research on the relationship between staffing ratios and sexual abuse in juvenile facilities, there is evidence from the juvenile justice and corrections literature linking direct supervision with the safety of youth.

In 2000, the Department's Office of Juvenile Justice and Delinquency Prevention released a bulletin, described above, "designed to present the most up-to-date knowledge" with respect to the operation of juvenile confinement facilities.[73] That bulletin recommended a staff-to-

[72] Texas Juvenile Justice Department, Stakeholder Survey 4 (Feb. 2012), *available at* http://www.tjjd.texas.gov/docs/BoardAgenda/Information%20Packet.pdf.
[73] David Roush & Michael McMillen, *Construction, Operations, and Staff Training for Juvenile Confinement Facilities* 9, Office of Juvenile Justice and Delinquency Prevention Bulletin (Jan. 2000).

youth ratio of 1:8 or 1:10 "to ensure effective involvement and behavior management." Specifically, the report noted the following:

> Higher staff-resident ratios at juvenile facilities allow for more effective interaction. When staff have many opportunities to work with residents, problems can be identified and resolved before they pose a threat to safety. Juveniles themselves will feel safer, will feel less exposed to unknown threats, and will be less likely to act out.[74]

In a 2009 study of factors that predict victimization of youth in juvenile facilities, researchers noted that "overcrowding and staffing ratios have been found by several prior researchers to be significant predictors of victimization when using aggregated facility-level data."[75] The study examined a range of factors, finding that facilities with a higher number of youth supervised by each staff member reported significantly more instances of physical abuse and fights.[76]

Unlike previous studies, the researchers also included individual-level variables in their analyses, such as youth's perceptions of facilities' rules and practices, school quality, and staff helpfulness. These individual-level variables significantly predicted victimization, which led the researchers to conclude that "one needs to understand how rules are communicated to inmates, how staff interact with inmates, and the content of facility schools, rather than only what rules are in place, how many staff are at a facility, or what classes are offered to inmates."

We agree with the researchers' conclusion that staffing levels are just one part of creating a safe environment. Fortunately, the PREA standards include a range of strategies aimed at reducing victimization, including staff training, youth education, supervision of staff, and data collection and review. However, we question the conclusion that individual perceptions may be better predictors of victimization than the level of direct supervision in a facility. For one, the researchers acknowledged that their data came from facilities that self-selected to participate in the research. Furthermore, the facilities that volunteered were a self-selected subset of the voluntary participants in the Council of Juvenile Correctional Administrators' Performance-based Standards (PbS).

The fact that the facilities in this study are part of the PbS program is not a problem in and of itself. To the contrary, the facilities' participation in PbS is laudable, as it means that the participating facilities have taken voluntary steps to monitor and regularly report data on a

[74] *Id.*
[75] Aaron Kupchik and R. Bradley Snyder, *The Impact of Juvenile Inmates' Perceptions and Facility Characteristics on Victimization in Juvenile Correctional Facilities*, 89 The Prison Journal 265, 280 (2009).
[76] *Id.* at 278.

range of factors related to the safety and security of their facilities. However, it means that the study's conclusions may not extend to facilities that suffer from greater problems with victimization that have not taken similar steps to engage in quality assurance efforts. The Department should, therefore, interpret this study's conclusions carefully.

Finally, a 2002 review of the impact of group size on outcomes in juvenile justice facilities also suggested a relationship between staff supervision and safety.[77] The study cited research that found that as the number of residents under one staff member's supervision increased, staff became more punitive in their interactions with residents.[78] Although the review did not focus specifically on the impact of staffing ratios on victimization and other outcomes, the author noted that "an increase in group size is associated with a reduction or decrease in positive correctional effects."[79]

(9) Whether specific objectively determined resident populations within a secure facility should be exempt from the minimum ratios.

The purpose of a staffing ratio requirement is to establish a minimum level of direct supervision necessary to prevent sexual victimization. Thus, no specific populations of youth should be exempt from the provision.

However, there are numerous situations that warrant higher levels of staff involvement. For example, youth in special housing units for medical or mental health needs, youth with disabilities, and youth who exhibit risk factors for suicide all require additional in-person supervision and interaction. Thus, the standard should add language that makes clear that staff must deploy additional staff in situations that require enhanced supervision.

Proposed revisions:

§ 115.313 Supervision and monitoring.

. . .

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. **This standard does not limit the ability of facilities to deploy additional staff in situations that require higher levels of supervision, such as times when units are housing**

[77] David W. Roush, *The Relationship Between Group Size and Outcomes in Juvenile Corrections: A Partial Review of the Literature*, 17 Journal for Juvenile Justice and Detention Services 1 (Spring 2002).
[78] *Id.* at 12.
[79] *Id.* at 11.

youth with medical or mental health needs, youth with disabilities, or youth who exhibit risk factors for suicide, or in any other context in which facility administrators determine that increased staffing is advisable. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

. . . .

(10) Whether additional categories of staff, beyond security staff, should be included in the minimum ratios.

We do not support expanding the definition of staff included in the minimum ratios beyond staff who provide in-person supervision of and interact with youth. In our response to Question 1, we proposed a definition of "direct care staff" that ensures that facilities would only include individuals who provide direct, in-person supervision of youth when computing their staff-to-youth ratios.

As written, this definition allows other individuals such as unit counselors or social workers to count toward the staffing ratio standard, so long as they are supervising and interacting with youth in a housing unit, recreational area, dining area, or other program area. However, this definition would not allow facilities to include counselors, social workers, and medical and mental health professionals in staffing ratios if they are engaged in one-on-one interactions with individual youth. We believe that this approach strikes an appropriate balance with respect to the goal of the staffing ratio standard.

(11) Whether the standard should exclude from the minimum ratio requirement facilities that meet a specified threshold of resident monitoring through video technology or other means, and, if so, what that threshold should include.

Video technology can complement efforts to prevent, detect, and respond to sexual abuse. However, cameras should not serve as a substitute for the minimum staffing requirement. Continuous, direct, and engaged supervision provides one of the best forms of protection against victimization, as staff can prevent and identify signs of developing problems among youth through regular interactions with them. Additionally, video surveillance systems rarely capture live audio, which severely diminishes the quality and effectiveness of video as a monitoring tool. Staff who directly supervise youth rely on what they hear, as well as what they see, to help prevent dangerous situations from developing, taking cues from residents' conversations and changes in tone or inflection. Because video surveillance systems lack this

feature, facilities that rely on that technology to meet their supervision needs are compromised in anticipating and responding to events.

The Department acknowledged the limitation of video technology as a tool to prevent sexual misconduct in its comments accompanying the PREA standards, noting that video surveillance "cannot substitute for more direct forms of staff supervision (in part because blind spots are inevitable even in facilities with comprehensive video monitoring), and cannot replace the interactions between inmates or residents and staff that may prove valuable at identifying or preventing abuse."[80] We agree. Thus, we strongly oppose any exemption from the staffing ratio requirement for facilities that meet a specified threshold of resident monitoring through video technology or other means.

(12) Whether the standard appropriately provides an effective date of October 1, 2017, for any facility not already obligated to maintain the staffing ratios.

We do not believe that the current timeline for compliance with the staffing ratio standard is appropriate, as it allows for a lengthy delay that will perpetuate ongoing victimization. Facilities can and should begin planning now to meet this requirement. Any postponement will come at a significant cost. The Department's survey of sexual victimization in juvenile facilities estimated that 3,220 youth nationwide reported incidents of sexual violence from April 2008 to June 2009. The survey likely underestimated victimization rates, as it was restricted to confinement facilities that held adjudicated youth for at least 90 days. Even so, multiplying the estimated number of victimized youth by the current four-year delay yields an additional 12,880 youth who will be sexually victimized during that period.

We do recognize that agencies may need to request appropriations to implement the standard, and we know that some state legislatures operate on a two-year budget cycle. Accordingly, we recommend that the Department require compliance by August 20, 2014, which will give jurisdictions a full two years to meet the standard.

Staffing ratios are one important part of a broader, coordinated approach to sexual misconduct prevention, detection, and response. The Department should not unnecessarily delay the implementation of a requirement that research, experience, and the Department's own investigations demonstrate to be crucial in combating sexual violence against youth.

[80] National Standards To Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106, 37125 (June 20, 2012) (amending 28 CFR Part 115).

Proposed revisions:

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. . . .

More sex abuse at understaffed juvenile facilities

More sex abuse at understaffed juvenile facilities

By REBECCA BOONE

June 29, 2016

https://apnews.com/ebb4f9dc44f546aa86085ed951e0d580

BOISE, Idaho (AP) — A new report from the U.S. Department of Justice shows that youths are sexually abused more frequently in juvenile detention centers that are understaffed, have more gang violence and more offender complaints.

The report, released Tuesday by the department's Bureau of Justice Statistics, examined the impact juvenile facilities have on sex abuse rates as well as the risk factors for victims. The work was intended in part to measure how effective federal rules designed to stop sex abuse behind bars actually are at reducing victimization inside youth detention centers.

The study found that lower rates of sexual victimization were reported in facilities with higher staffing levels, less violence and fewer overall complaints.

Lovisa Stannow, the executive director of prisoner advocacy group Just Detention International, said the findings are encouraging and exasperating.

"They are encouraging because they confirm that sexual abuse is a problem that strong youth detention leaders can solve, if they want to, and exasperating because so many leaders continue to insist, against all evidence, that sexual violence is outside of their control," Stannow said in a statement released Wednesday.

Congress passed the Prison Rape Elimination Act in 2003, and experts across the country worked over the next decade to create rules designed to stamp out rape behind bars. All states were supposed to be fully compliant with PREA in 2014, but some, such as Idaho, initially refused to meet the standards. Idaho officials later reversed course, and in 2015 announced that three state juvenile detention centers passed audits showing they were compliant with PREA standards.

The Idaho Department of Juvenile Corrections is currently facing several lawsuits from nearly a dozen current and former juveniles who say they were sexually abused by staffers while at a detention center in Nampa.

Compliance with many of the standards spelled out in the Prison Rape Elimination Act were associated with lower rates of staff sexual misconduct, the study found.

Youth who have previously been sexually assaulted are more likely to be assaulted in detention, the study found, as were kids who identified themselves as lesbian, gay or bisexual. Males and black youth were much more likely to be victims of sexual abuse by staff members.

The study included mostly state-owned facilities for youth being held in custody, including residential treatment centers, detention centers, training schools, group homes, boot camp or farm programs and youth homeless shelters.

The highest rates of youth-on-youth sexual assault were found in facilities that only housed females, and male-only facilities tended to have higher rates of staff sexual misconduct.

Collaborate to Educate – EDJJ report

Collaborate to Educate: Special Education in Juvenile Correctional Facilities

Sheri Meisel, Kelly Henderson, Mary Cohen and Peter Leone

National Center on Education, Disability, and Juvenile Justice (undated)

Collaboration among education and treatment professionals is fundamental to the provision of appropriate special education services for youth at-risk for delinquency and for those in correctional settings. On a systems level, collaboration between child-serving agencies, including juvenile justice, is widely acknowledged as a critical element in reform initiatives geared to improving outcomes for high-risk populations. However, as an integral aspect of comprehensive service delivery models within juvenile justice facilities, interdisciplinary collaboration enjoys more theoretical than practical support.

This chapter directs attention to collaboration as a "best practice" approach to improving education and special education services for youth in correctional facilities. Specifically, the chapter examines multidisciplinary collaboration as a key organizing principle for special education service delivery in these settings. We begin with an overview of the role of interagency and interdisciplinary collaboration in improving school experiences and outcomes for all high-risk youth, including youth with disabilities, their families, and the professionals who work with them. Next, we describe federal entitlements to special education for youth in detention and confinement, outline policies and practices that impede the provision of these rights, and describe strategies to design and implement special education services effectively and efficiently in the correctional environment. The chapter concludes by identifying core elements of successful education programs in juvenile detention and confinement facilities.

Delinquency, Disability, and Risk for School Failure

The term at-risk has various definitions and applications in education, but is commonly associated with youth who do not master the basic academic, vocational, social, and behavioral skills required to function successfully in school, in the workplace, and in the community. Delinquency is strongly associated with interrelated risk factors, including school dropout, substance abuse, teen pregnancy, history of sexual or physical abuse, insufficient supervision by the family, poverty status, and learning and behavioral disabilities. Although the pathways to delinquency are complex and not completely understood, incarcerated youth have multiple-risk factors that underscore the need for comprehensive and coordinated education and treatment services in juvenile correctional facilities.

However, educators, treatment providers, and line staff in correctional settings may understand and respond to the behaviors of troubled youth in different ways. These differences develop, in part, because professionals receive training in fields of study that are identified with distinct theoretical frameworks and treatment approaches. With respect to developing collaborative working relationships and intervention models, one of the major challenges facing service providers in juvenile correctional settings is bridging these conceptual differences to develop consistent priorities, goals, and strategies. For example, while juvenile facilities should be moving away from traditional intervention programs that are accessible to limited numbers of youth and that address only a narrow range of risk factors, they continue to target services to youth on the basis of categorical labels.

Labels that commonly are used to identify youth in correctional settings include delinquent, conduct disordered, socially maladjusted, behaviorally disordered, or emotionally disturbed. Delinquency denotes illegal behavior that has caused the individual to come in contact with the juvenile justice system. Social maladjustment describes rule-breaking behavior, disregard of the rights of others, or inability to function appropriately in social situations. Conduct disorder is a psychiatric diagnosis used to describe children and youth considered unmanageable because they demonstrate a pattern of antisocial behaviors. Behavior disorder is a generic term used in special education to include both externalizing (acting out or aggressive) and internalizing (withdrawn or anxious) behaviors that interfere with school progress.

Despite the use of terminology that reflects a specific orientation to the needs of troubled youth, practitioners and researchers in diverse fields agree that youth with learning disabilities (LD), mild to moderate mental retardation (MR), and emotional or behavioral disorders (EBD) are overrepresented in juvenile correctional facilities (Casey & Keilitz, 1990; Murphy, 1986; SRI, 1996). The prevalence of youth identified as eligible for special education prior to their incarceration generally is accepted to be at least three to five times the percentage of the public school population classified as disabled (Leone & Meisel, 1997).

Youth with learning, developmental, and behavioral disabilities have exceedingly high risks for school failure and poor adult outcomes. For example, adolescents identified as EBD can be considered the least successful students in the public schools. The National Longitudinal Transition Study of Special Education Students (Wagner et al., 1991), one of the first large-scale investigations of outcomes for youth with disabilities, found that almost 50 % of these students dropped out of school. Subsequent analysis confirmed that, for youth with disabilities, the consequences of school failure and delinquency are interrelated and persist into young adulthood. Almost 20 % of youth with EBD were arrested while in secondary school, 35 % were arrested at least once within two years of leaving school, and 73 % of the youth who dropped out of school were arrested within five years (Wagner, 1992). The same study reported that 31 % of youth identified as LD were arrested within three to five years of leaving school.

Federal Mandates for Special Education in Juvenile Corrections

Federal and state laws and regulations protect the educational rights of students with disabilities in juvenile correctional facilities, but many eligible youth do not receive the services to which they are entitled. All states implement regulations that are consistent with IDEA, and that describe the substantive and procedural rights to which eligible youth and their parents are entitled. In addition, local school systems, including special correctional education agencies, should delineate policies and practices for youth with disabilities that are consistent with IDEA and state requirements.

This section summarizes three seminal federal laws, and focuses primarily on The Individuals with Disabilities Education Act (IDEA; originally the Education for all Handicapped Children's Act). The IDEA is landmark civil rights legislation because it guarantees a free appropriate public education for all eligible children and youth with disabilities through age 21. IDEA has applied to public schools and state-operated programs, including juvenile detention and confinement facilities, since its passage in 1975.

Parents and professionals who advocated for IDEA initially focused their efforts on ensuring access to special education for all eligible youth, regardless of the nature or severity of their disability. This objective largely has been accomplished for most youth with disabilities in public school settings. At present, however, schools are under increasing criticism and scrutiny related to fostering equity for youth with disabilities through opportunities to achieve positive academic, vocational, and behavioral outcomes commensurate with those provided to nondisabled students.

While the requirement to apply the provisions of IDEA for incarcerated youth is clear, the implementation of IDEA in juvenile detention and confinement facilities compares to special education service delivery in the public schools 20 years ago. Substantial problems with both access and equity remain unresolved, and special education programs for incarcerated youth often fail to meet legal requirements and currently accepted professional standards. As a result, youth with disabilities in correctional settings do not participate in education programs to which they are entitled, and which can prepare them to reenter their schools and communities.

The previous educational experiences of youthful inmates with disabilities, the distance of youths from their homes and prior school districts, and the sometimes competing objectives of rehabilitation and punishment present unique problems to the design and delivery of special education services within juvenile facilities. However, appropriate education programs for youths with disabilities can be and have been developed in juvenile correctional facilities. This chapter addresses the implementation of fundamental requirements that are incorporated in IDEA, including

providing a free appropriate education in the least restrictive environment;

screening, evaluating, and identifying all eligible youth;

ensuring parent/guardian participation in special education decision-making; developing, implementing, and reviewing the Individualized Education Program (IEP); and

providing related services.

In addition to IDEA, Section 504 of the Vocational Rehabilitation Act of 1973 (Section 504), and Title II of the Americans with Disabilities Education Act (ADA) prohibit discrimination against persons with disabilities by any program or activity that receives federal funds including correctional facilities. The ADA and Section 504 apply to juvenile correctional facilities to the extent that students with disabilities are excluded from appropriate education service or are excluded from school for misbehavior that may be related to the students' disability, or to the failure of the school program to meet the students' needs.

Not all children with disabilities require or will be eligible for special education services under IDEA, but they may meet the guidelines for services under Section 504. In this case, a "504 plan" must be developed that specifies accommodations that will be provided to enable the student to participate in the general curriculum. Section 504 defines persons with handicaps as (a) having a physical or mental impairment which substantially limits one or more major life activities (b) having a record of such an

impairment or (c) being regarded as having such an impairment. Importantly, learning is identified as a major life activity subject to Section 504 protections for eligible youth. Educators and treatment providers in juvenile correctional facilities should be aware of academic and behavioral problems (for example, attention deficit disorder) that suggest a student may be eligible for program modifications under Section 504.

The ADA expands nondiscrimination protections of Section 504 for persons with disabilities in government facilities and in programs provided by government agencies. The ADA requires, for example, a self-evaluation conducted by the correctional facility to determine whether policies and practices prevent equal access for the participation of persons with disabilities in the facility's services.

Juvenile facilities face unique obstacles in meeting the provisions of special education law and regulations. However, special education services can and should comply fully with provisions of IDEA, Section 504, the ADA, and other applicable federal and state mandates.

Why is collaboration important to educate high risk youth? Collaboration is an active relationship in which education and treatment professionals in juvenile detention and confinement facilities agree to work together to achieve common goals. Successful partnerships require formalizing these relationships through a collaborative infrastructure that identifies individual and mutual responsibility for planning and implementing services. Multidisciplinary collaboration has distinct advantages for promoting positive change in several areas including enhancing outcomes for troubled youth, supporting appropriate models of service delivery, and using resources effectively.

The overall objective of multidisciplinary collaboration is to move away from traditional models for service delivery in juvenile correctional settings. Traditional approaches are limited by a restricted range of services, fragmented planning and service delivery, competition for resources, inconsistent organizational values and objectives, and limited flexibility in staff roles and responsibilities. Uncoordinated systems also may contribute to staff and youth perceptions that the overall treatment program lacks clear focus and consistent structure.

Youth enter correctional settings with interrelated academic, social, emotional, health, and behavioral needs. In previous sections of this chapter, we summarized the negative consequences of major risk factors associated with delinquency including school failure, substance abuse, learning and behavioral problems, and teen pregnancy. Without successful intervention, these behaviors and experiences appear to have a progressive trajectory associated with adult criminal behavior, incarceration, illiteracy, unemployment, substance abuse, and psychiatric disorders. The pathways to delinquency are woven together in such a complex manner that they demand integrating the efforts of service providers in the various education and treatment fields, and coordinating a number of different kinds of intensive services.

Troubled youth often require services that span traditional public sector agency boundaries. As their legal status changes and various dimensions of their needs become acute, services for these youth may be the responsibility of public schools and juvenile justice, mental health, and social services agencies. Although implementation of interagency collaboration has intensified in the last decade, uncoordinated

service delivery systems for troubled youth are still the norm. Youth with EBD, for example, may continue to be placed in restrictive residential and institutional settings -- including correctional facilities -- because intensive community-based treatment options and interagency systems of care are unavailable (Behar, 1990). As funds are increasingly committed to the building of detention and confinement facilities, collaboration among child-serving agencies will become an even more important advocacy strategy to foster the development of community-based treatment, and to provide support for appropriate education and treatment programs in juvenile facilities.

What are the most formidable barriers to appropriate special education services for youth in corrections? Although incarcerated youth eligible for special education services are entitled to the same substantive and due process rights afforded to youth in public school settings, correctional systems have been slow to respond to the mandates of IDEA, Section 504, the ADA, and other applicable requirements. Well-intentioned educators, treatment providers, and administrators undoubtedly implement effective education programs in some juvenile facilities. However, a number of barriers continue to impede the provision of appropriate special education services for most incarcerated youth. This section describes conceptual and institutional barriers that undermine multidisciplinary collaboration in juvenile correctional facilities.

Evolving Attitudes and Goals

The needs of youth in detention and confinement are often not well understood by the general public, politicians, legislators, the media, and some education and treatment professionals. Misinformation, fear, and stigma concerning these youth translate to short-sighted public policy and contribute to limited placement options, insufficient supports and services, and an overall unwillingness to acknowledge and address inequities in the juvenile justice system. These problems only can grow worse as concerns about crime and violence in schools and communities obscure the need for prevention, early intervention, and intensive intervention services for troubled youth.

Juvenile corrections often is defined by a number of competing purposes. While rehabilitation is one of these, incapacitation and punishment frequently are considered higher priorities (Krisberg & Austin, 1993; Leone & Meisel, 1997). Recent legislative efforts to "get tough" with juveniles who commit, or are accused of committing, crime reflect a growing public perception that locking away troubled children and youth will insulate society from future harm. The politically popular "zero tolerance" policies in our schools and courts often contribute to overcrowded juvenile facilities and to the increased use of public funds for additional detention facilities -- but rarely do policies address primary prevention and treatment designed to preempt or limit more severe infractions.

These attitudes have influenced legislation in many states that automatically transfers children to adult courts for certain offenses. Among other negative consequences, this trend increases overcrowding in juvenile detention centers as more youth are confined in those facilities awaiting transfer to adult prisons. The Juvenile Crime Control Act (HR5), under consideration by the Congress in 1997, will allow youth as young as 13 years of age to be waived into the adult prison system, and will provide $1.5 billion in grants for states that adopt tougher sanctions for juveniles. The 1997 reauthorization of IDEA (PL 105-

17) permits states to exempt adult correctional facilities from responsibility for providing special education to youth from 18 to 21 years of age if, prior to their incarceration, they were not identified as disabled and did not have an IEP in their last educational placement. While the numbers of youth affected by this provision will be relatively small, the decision to compromise special education entitlements and to deny services to youth with disabilities is alarming.

Adequate Academic and Vocational Programs

Special education services and programs are implemented in the context of the general academic and vocational programs provided in the correctional facility. However, school programs in correctional facilities often fall short of minimum professional standards associated with the operation of public schools. Although youth in correctional settings are among the least proficient academically and the most vulnerable to school dropout, they may receive substandard education services that deviate from currently accepted instructional practices. As Coffey and Gemignani (1994) point out, correctional education programs largely are isolated from the substantive changes that have influenced the regular and special education programs in local communities since the 1980s. Educators in juvenile correctional settings may be unaware of the curriculum and instructional strategies that have been identified by the educational reform movements and by "effective schools" research. As a result, teachers and administrators may continue to use strategies that have been demonstrated to be the least effective for students in need of intensive remedial education.

The problems associated with providing special education in correctional facilities will not be corrected until appropriate instructional programs are available for all incarcerated youth. Special education services must be linked meaningfully to academic and vocational programs in correctional facilities. Segregated, pull-out programs make little sense for most incarcerated youth, and special and general educators can work together to design and implement individualized education programs for all youth in correctional facilities. Just fixing specific aspects of special education programs without substantially correcting academic and vocational education programs will be a short-term solution at best. Ensuring that all students within juvenile correctional settings receive appropriate services requires systemic changes in the way that the education programs operate.

Funding and Governance

Funding for juvenile correctional education programs comes from a variety of federal programs; the largest sources are the Carl D. Perkins Vocational and Applied Technology Act, Title I of the Improving America's Schools Act (formerly the Elementary and Secondary Education Act), and IDEA (Coffey & Gemignani, 1994). States also have accessed monies from other federal programs including The Bilingual Education Act, the Job Training Partnership Act, and the Drug Free Schools and Communities Act. State contributions to their agencies which provide juvenile correctional education programs are limited. Miles (1993) reported that only a third of state juvenile correctional agencies surveyed spent $2,001 or more annually per student.

Access to adequate funding streams for education can be complicated further by the various governance arrangements for juvenile correctional agencies. The correctional education component

within state agencies may be delivered via a separate correctional education agency, the state education agency, or through contracts with a local public school district or private vendor. One of the consequences of these administrative arrangements is that many school principals have responsibility for the day-to-day operation of correctional education programs without the necessary authority for expenditure of funds. Without independent budget authority, principals may have to go hat-in-hand to correctional administrators to fund even the basic supplies associated with operating a school.

In addition, certain requirements of IDEA and other federal legislation, designed to protect the educational rights of youth and to target services to students with specialized needs, unintentionally have created disincentives for coordinated service delivery. Service provision is compromised by the categorical nature of federal and state funding sources. For example, only students meeting specific eligibility requirements have been able to participate in instructional and other services provided by personnel funded by IDEA or by Title I. These requirements also have contributed to the proliferation of segregated classes and service delivery models, isolating youth who met eligibility requirements from their peers and from opportunities to participate in the general education curriculum in correctional settings.

Recent changes in the Improving America's Schools Act (formerly the Elementary and Secondary Education Act), and amendments included in the 1997 reauthorization of IDEA, clarify that federal funds may be used to fund education programs even if they benefit youth who do not meet disability or other eligibility criteria.

Conditions of Confinement

Educational services in juvenile corrections also exist within institutional contexts including the conditions of confinement for youth. In 1991, nearly one in four incarcerated youth was in a facility under court order or consent decree related to conditions of confinement (Parent et al., 1994).

Conditions in many juvenile facilities impair the ability of staff to implement effective special educational services in several ways. Overcrowding and understaffing are major impediments with sometimes extreme consequences for education and treatment programs. While these conditions pressure juvenile facilities to restrict education and treatment services, the differences in age, gender, ethnicity, academic performance, and offense history among youth exacerbate the need for differentiated programming.

Allocation of resources for educational and treatment programs has not kept pace with the increasing numbers of youth confined in correctional facilities. Between 1987 and 1991, average populations in all types of juvenile facilities increased by 11 %; the trend was most dramatic in reception centers which experienced a 66 % increase (Parent et al., 1994). Almost 50 % of incarcerated youth were in facilities whose average daily population exceeded capacity. Overcrowding and lack of funding contributes to standardized one-size-fits-all service delivery approaches, reductions in scheduled instructional time as youth attend school in shifts, and insufficient space for school activities. More than one-fourth of youth are in correctional facilities which do not routinely assess academic, vocational, and personal needs; and

40 % do not meet minimum standards of mental health care established by the American Correctional Association (Parent, et. al., 1994).

Interpretation of Federal Mandates

Whether through lack of awareness of the components of appropriate special education services, or due to policies and procedures designed more to satisfy institutional needs than the educational needs of youth, IDEA requirements are not implemented for many incarcerated youth with disabilities.

A cardinal principle specified in IDEA is that the planning and delivery of special education services should be suited to the unique strengths and needs of each eligible student. The concept of special education incorporated in IDEA is defined as "specially designed instruction…for the unique needs of the learner." All students eligible for special education are entitled to an Individualized Education Program (IEP) to guide instruction. It is important to emphasize that the well-developed IEP contains information about the strengths and needs of the student that will be useful not only for special and general education teachers but also for treatment providers in the correctional setting. The IEP should include a statement of the student's current level of educational performance, measurable annual goals and short-term objectives, and special education and related services that will be provided. Special and general educators, parents/guardians, other treatment providers involved with the student (for example counselors, psychologists, speech pathologist), and the student, if possible, must participate in the IEP development and must attend the IEP meeting. The IEP for each student, beginning no later than age 16, must include a statement of needed transition services to prepare the youth to reenter the community better prepared for responsible adulthood. Parents, the student, and if applicable, representatives of other public agencies that will provide transition services must be invited to participate in the IEP meeting.

In accordance with the requirement to plan and deliver individualized services in the least restrictive environment, decisions about the type and amount of services, and the setting in which services will be provided, should be made before the development of the IEP. However, in many correctional education programs, this decision-making process is modified, and the intent of the IEP as a meaningful service delivery plan is thwarted, in at least two ways: first, by formulating standardized IEP documents that specify generic instructional goals and objectives; and second, by specifying services that match the model of service delivery available in the facility rather than the student's educational needs. These practices contradict the intent of IDEA requirements and result in the development of IEPs that specify identical instructional objectives, educational placements, and amount of special education for students with vastly different academic profiles.

Provisions in IDEA that are designed to ensure procedural safeguards for youth and their parents also have been confused, ignored, or misinterpreted within juvenile facilities. Implementing procedural requirements in these settings can be challenging, particularly for youth with short lengths of stay (Parent et al., 1994), but the difficulties should not be attributed to the due process protections themselves. Rather, the use of practices that are not well suited to the correctional environment, inefficient administrative procedures, inadequate funding, extreme conditions of confinement, and the

lack of formal collaborative structures and processes play a much more prominent role in the failure to meet special education mandates.

How can appropriate special education services be provided to all youth with disabilities in juvenile correctional facilities?

While the model for special education service delivery specified in IDEA inherently is multidisciplinary and collaborative, special education in correctional settings often is not meaningfully linked to academic and vocational programs or to treatment services. To illustrate, we review five situations that present problems in correctional settings, and provide recommendations to meet the letter and the spirit of IDEA for incarcerated youth.

Problem Situation One: Juvenile correctional facilities do not screen, evaluate, and identify all eligible youth with disabilities. All schools, including those in correctional facilities, are required to implement a referral process to locate, screen, and assess youth suspected of having a disability within prescribed timelines. This requirement includes identifying youth without a prior history of receiving special education, as well as youth who received services from prior school systems but who do not have a current IEP.

Recommendation: Screening should include the opportunity for self, parent, and staff referral; interviews with the youth to determine receipt of special education from previous school systems; and sufficient review of all available records to determine the possible presence of disabilities that affect educational performance. Screening activities should be coordinated among the school psychologist and the medical and mental health and educational units of the facility. In addition, training should be provided so that all staff can recognize student behaviors that trigger the need for screening for special education, and can use referral procedures for special education.

Although the screening process should not rely on self-report data, a personal interview with youth when they are admitted to the facility, conducted by an experienced staff familiar with special education, can be a good source of information. Sample questions that are helpful in eliciting information about a prior history of special education include:

What was the name of the last school you attended? How long ago did you last attend school?

What was the last grade you attended?

About how many students were in your classes?

What were your best or favorite subjects in school? What subjects gave you the most trouble?

Did you see a teacher or counselor to get extra help with those subjects, or with your behavior?

How about a speech teacher, or a social worker -- did they ever help you out?

Did you attend a special program? Did you ever attend an alternative school, or a special school?

Did your parent go to school to attend an IEP meeting?

Were you ever enrolled in special education? Did you have an IEP?

If responses indicate directly that the student was enrolled in special education, or had difficulty in school that is associated with a disability, a referral for special education is appropriate. Making this referral does not constitute a diagnosis; rather, it indicates that educators and other service providers need to take a closer look at a particular youth's needs and determine eligibility for special education.

Problem Situation Two: The correctional facility does not obtain prior school records for all youth. Prior school records provide information that is critical for individualized planning and service delivery and for the identification of youth with disabilities. Access to prior school records may be especially difficult for youth with a history of nonattendance or a record of numerous school placements. This problem may be particularly acute for access to an IEP, since information in that document can be critical to familiarize corrections staff with youths' needs, and to expedite the implementation of an appropriate education program.

Recommendation: Correctional school programs need an effective and efficient administrative mechanism to request prior school records and to track responses to the requests, and for youth who return to school on release from confinement, to transfer correctional school records. The correctional education agency can request assistance from state departments of education to establish improved responses to requests for student records from local school systems. State education agencies typically implement regulations that govern the transfer of school records between local school systems in a timely manner. In addition, states increasingly are providing access for local school systems, including correctional school districts, to automated databases that provide information concerning youths' history of receiving special education.

Correctional facilities also maintain files for all youth including medical records, mental health profiles, social histories, and court records that can provide a great deal of relevant information. Treatment and

institutional staff routinely should examine these records when youth are admitted to the facility and share information with school staff. Information contained in these records that will assist the identification of youth with disabilities includes: psychiatric or psychological diagnosis; academic failure and grade retention; high rates of school absenteeism; labels such as mental retardation, conduct disorder, learning disability, or emotional disturbance; and history of placement in alternative or special schools.

Problem Situation Three: Parent/guardian/parent surrogates are not involved in special education. Parent involvement in making decisions about their child's education is one of the cardinal principles of IDEA and of sound educational practice generally. Parents have the right to participate meaningfully in the development and implementation of the IEP. Under certain conditions, school systems must recruit, train, and assign parent surrogates for students with disabilities including youth who are wards of the state.

Recommendations: Strategies to promote parent, guardian, and parent surrogate participation in IEP development that can be successful in correctional facilities include using a speakerphone during the IEP conference when parents cannot attend, involving parents directly by scheduling the IEP conference to coincide with scheduled family visitation, and implementing parent surrogate procedures. Parent surrogates cannot be employees of a state agency and are usually community volunteers. In implementing parent surrogacy requirements, correctional facilities have the opportunity to develop positive relationships with community members who are interested in serving in this role.

Problem Situation Four: Related services are not provided to all eligible youth. In addition to special education, eligible students with disabilities are entitled to related services designed to ensure that they benefit from their educational program. Related services are defined as "developmental, corrective, or other supportive services designed to enable the youth to benefit from special education." Related services typically provided in the public schools include counseling, psychological services, school social work services, speech/language pathology, physical and occupational therapy, and parent training. The need for related services must be considered by the IEP committee, and goals and objectives related to the need for related services must be incorporated in the IEP.

Recommendations: Correctional facilities can provide related services through a variety of administrative arrangements, including an interagency contract with the local public school system, a contract with private providers in the community, or employment directly by the correctional education agency. In addition, while a student's need for counseling may be specified on the IEP, the provision of counseling will not constitute a related service unless counseling is integrated with the goals and objectives of the IEP, and provided by persons knowledgeable about the student's disability and about school settings.

Problem Situation Five: Youth with disabilities are excluded from education when they are placed on disciplinary or administrative segregation. Youth may experience the complete cessation of education and special educate services on administrative or disciplinary segregation. Youth with emotional or behavioral disabilities, learning disabilities, and developmental delays are especially vulnerable to

repeated disciplinary infractions in school and throughout the facility, particularly when they have not received adequate special education and related services to assist them in meeting the facility's disciplinary rules, and when all school, treatment, and line staff do not have the appropriate training to work effectively with these youth.

Recommendations: All youth, including those placed in segregation, should have uninterrupted access to appropriate instruction and to suitable instructional materials. The facility should implement an appropriate behavior management approach to prevent disciplinary problems and to support youth in complying with behavioral expectations. Punitive models of discipline are not an effective method of behavior management because they do not provide the opportunity to learn and practice alternative prosocial skills. In addition, the IEP committee should discuss behavioral needs of youth with disabilities who experience repeated disciplinary problems. This may include addressing behavior problems that are related to the student's disability by developing a structured program of behavior management including positive behavior support. All staff should have responsibility for implementing behavior management programs, and should receive training, including interdisciplinary training, to work with students with learning and behavior problems and to model appropriate behavioral skills.

What are the key components of effective academic, vocational, and special education programs in juvenile correctional facilities?

The effective schools literature identifies essential building blocks of quality education programs in all settings including correctional facilities. These practices ensure that all students have access to culturally-relevant and age-appropriate curriculum, high expectations, proactive classroom management and motivational techniques, opportunity to develop a supportive relationship with at least one adult, and engagement with school activities. Although a full description is outside the scope of this chapter, the practices associated with effective schools are the context for the development of appropriate education programs in correctional settings. Key components of educational programs in juvenile facilities are described below.

1. Integrated, multidisciplinary framework for service delivery: A multidisciplinary approach supports the capacity of detention and confinement facilities to provide quality educational services for high-risk youth. The overall expectation for multidisciplinary collaboration is that special and regular educational programs in correctional facilities will be linked meaningfully with treatment services and with the responsibilities of line staff. An illustration of this principle that would change traditional practice in many juvenile facilities is to involve the corrections staff in the school program as instructional assistants while they are present in the classroom to assist with security.

2. Competency-based curriculum options: Curriculum defines the content of the school program -- in other words, what is taught. The scope and sequence of the curriculum should include a continuum of options for the development of functional academic, vocational, social, and behavioral skills for all youth. Teachers should monitor and report student progress systematically in the curriculum at regular intervals to document mastery of specific objectives and to modify goals as required.

While the majority of youth in detention and confinement demonstrate severe to moderate skill deficits, and have prior school experiences marked by truancy, suspension, and expulsion, other students may be performing at or above grade level. A comprehensive range of options will include:

Literacy and functional skills for students with limited academic and social skills and significant cognitive, behavioral, or learning problems;

Academic courses and skills, associated with Carnegie unit credits for students likely to return to the public schools or who are eligible to earn a diploma in the correctional education program;

General Educational Development (GED) preparation for students who are not likely to return to public schools; and

Pre-vocational and vocational education that is related to student interests and to meaningful employment opportunities in the community.

3. Direct and peer-mediated instructional strategies: Instructional strategies define how the curriculum is taught. Instructional strategies should engage students actively in the curriculum. Two approaches are recommended: Direct instruction is a step-by-step strategy incorporating presentation of the topic, modeling of the skill or task, guided practice, monitoring and corrective feedback, and review. Peer-mediated instructional strategies include cooperative learning and peer tutoring. Instruction also should include attention to the development of higher-order problem-solving and decision-making skills. In contrast, completion of independent drill and practice exercises or xerographic worksheets -- the strategies that continue to be used in many correctional settings -- are not successful approaches to motivate high-risk youth or to remediate skill deficits.

4. Functional curriculum-based assessment: Assessment procedures and instruments should be selected to suit the purposes for the evaluation, needs of the student, and the curriculum of the school (Howell, 1987). As relates to IEP development, assessment should be geared to assist the development of specific functional IEP objectives that are measurable. Evaluation in the classroom, such as teacher-made tests, also should be functional -- that is, aligned with the curriculum to inform the selection and modification of objectives and instructional strategies.

5. Prosocial Skills Curriculum: Youth who are at-risk and delinquent typically have significant interpersonal, impulse control, anger management, and other social skill deficits. Training to improve social competence should be developed and implemented jointly by educators, treatment providers, and line staff, and should be considered an essential component in correctional education programs.

6. Business and community involvement: Securing meaningful corporate and community participation demands alternatives to the approaches typically used in public school settings. This type of involvement is important to build understanding of, and support for, the needs of troubled youth and the functions of correctional education programs. Individual community volunteers and corporate groups can enrich programming in juvenile facilities through activities such as academic tutoring,

mentoring, serving as surrogate parents for youth receiving special education services, and sponsorship of career exploration and work opportunities.

7. Professionalism, leadership, and advocacy: Skillful administrative leadership is essential to maintain a focus on the needs of educational and treatment programs as a priority within correctional facilities, to encourage collaborative structures, to provide ongoing support for staff, and to build links with parent and community groups. Leadership also is critical to advocate for social policies that support correctional education programs as public sentiment increasingly grows unsympathetic to funding educational and treatment services for youthful offenders. Communicating the importance of correctional education programs to the general public, elected officials, legislators, and the media is fast becoming an essential professional skill.

The IDEA has been a very successful advocacy tool in litigation to obtain educational services for youth with disabilities in detention and confinement. However, the education community needs broader advocacy strategies and tools. An alternative strategy available to parents, guardians, and advocates is to press correctional facilities for appropriate services for young people on an individual basis. This process can begin with a careful examination of the youth's prior school history. A record of school failure, truancy, suspension, expulsion, disciplinary problems, and grade retention may raise concerns that a disability is contributing to poor educational performance. Parents, guardians, or advocates who suspect that a youth may have a disability can, and should, make a referral to the correctional education program.

Educational programs in juvenile detention and confinement facilities should meet professional standards and accreditation criteria. Currently, there are no widely adopted standards for correctional education programs or for correctional special educators. However, standards for special educators working in other settings have been developed by The Council for Exceptional Children and can be adapted for the juvenile correctional environment (See Council for Exceptional Children, (1996). The Correctional Education Association and the American Correctional Association have adopted less well specified standards for special educators in juvenile facilities.

Correctional programs also can seek accreditation from a professional association of schools and colleges. This is a promising avenue for improving services that has been pursued successfully by programs in recent years. Federal agencies could play an important role in the effort to achieve accreditation by structuring incentives for states and local jurisdictions in the form of model demonstration programs, technical assistance, and linking of grant awards to practices that are consistent with the accreditation criteria of professional organizations.

8. Ongoing professional development: School, treatment, and correctional agency staff need opportunities for ongoing professional development to implement education and special education programs and services. Priority should be given to training in curriculum and instructional strategies; social skills programming; classroom and behavior management; special education requirements including accommodations for youth with disabilities in the general education classroom; functional assessment; and collaborative practices. A high priority should be placed on assisting all staff to meet

certification requirements in their area of teaching responsibility. Correctional education agencies can provide this assistance through onsite inservice training, financial subsidy for completion of college coursework, and cooperative agreements that enable correctional educators to attend inservice training workshops sponsored by local public schools.

9. Sufficient fiscal resources: Adequate financial support for education and treatment programs is basic to the ability of juvenile facilities to implement appropriate education and treatment programs, to maintain sufficient numbers of personnel, to allocate adequate physical space for programs, and to maintain appropriate supplies and equipment including, for example, instructional and administrative technology, texts, and library books.

Summary

Dissemination of promising practices is not widespread among juvenile facilities, contributing to the operation of education programs in isolation from each other and from professional influences in the larger education community (Coffey & Gemignani, 1994), and to the difficulty of synthesizing successful practices into an accessible knowledge base. Professionals in these settings should be encouraged to share innovative programs and strategies through publication and conference presentation. Sufficient descriptive detail should be provided to enable staff to determine how the practices can be applied in other settings.

Multidisciplinary collaboration increasingly is an important framework for providing appropriate special education services in detention and confinement facilities for three basic reasons: meeting the interrelated and intensive needs of troubled youth; surmounting institutional barriers; and directing attention to the value of correctional education as social and political support for incarcerated youth erodes, and enthusiasm for punishment and behavioral control increases.

Practitioners in all fields have a common interest in providing the opportunity for troubled youth to develop academic, social, and behavioral skills. Multidisciplinary collaboration can assist in this objective by integrating the positive practices of each professional field. Providing high-quality programs and services in juvenile correctional settings is imperative. The consequences associated with school dropout and delinquency are staggering for the youth we have failed and for their families, for educators and treatment professionals, and for all citizens.

Citation

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Meisel, S., Henderson, K., Cohen, M., & Leone, P. (1998). Collaborate to educate: Special education in juvenile correctional facilities. In Building Collaboration Between Education and Treatment for At-risk

and Delinquent Youth (pp. 59-72). Richmond: National Juvenile Detention Association, Eastern Kentucky University.

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Resources

The following resources provide practical suggestions about implementing special education programs in juvenile facilities:

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PREA Juvenile Facility Standards – Final

PRISON RAPE ELIMINATION ACT

JUVENILE FACILITY STANDARDS

United States Department of Justice Final Rule

**National Standards to Prevent,
Detect, and Respond to Prison Rape
Under the Prison Rape Elimination Act (PREA)**

28 C.F.R. Part 115
Docket No. OAG-131
RIN 1105-AB34
May 17, 2012

PRISON RAPE ELIMINATION ACT NATIONAL STANDARDS – JUVENILES

Sec.

115.5 General definitions.

115.6 Definitions related to sexual abuse.

Prevention Planning

115.311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.

115.312 Contracting with other entities for the confinement of residents.

115.313 Supervision and monitoring.

115.314 Reserved.

115.315 Limits to cross-gender viewing and searches.

115.316 Residents with disabilities and residents who are limited English proficient.

115.317 Hiring and promotion decisions.

115.318 Upgrades to facilities and technologies.

Responsive Planning

115.321 Evidence protocol and forensic medical examinations.

115.322 Policies to ensure referrals of allegations for investigations.

Training and Education

115.331 Employee training.

115.332 Volunteer and contractor training.

115.333 Resident education.

115.334 Specialized training: Investigations.

115.335 Specialized training: Medical and mental health care.

Screening for Risk of Sexual Victimization and Abusiveness

115.341 Obtaining information from residents.

115.342 Placement of residents in housing, bed, program, education, and work assignments.

115.343 Reserved.

Reporting

115.351 Resident reporting.

115.352 Exhaustion of administrative remedies.

115.353 Resident access to outside support services and legal representation.

115.354 Third-party reporting.

Official Response Following a Resident Report

115.361 Staff and agency reporting duties.

115.362 Agency protection duties.

115.363 Reporting to other confinement facilities.

115.364 Staff first responder duties.

115.365 Coordinated response.

115.366 Preservation of ability to protect residents from contact with abusers.

115.367 Agency protection against retaliation.

115.368 Post-allegation protective custody.

Investigations

115.371 Criminal and administrative agency investigations.

115.372 Evidentiary standard for administrative investigations.

115.373 Reporting to residents.

Discipline

115.376 Disciplinary sanctions for staff.

115.377 Corrective action for contractors and volunteers.

115.378 Interventions and disciplinary sanctions for residents.

Medical and Mental Care

115.381 Medical and mental health screenings; history of sexual abuse.

115.382 Access to emergency medical and mental health services.

115.383 Ongoing medical and mental health care for sexual abuse victims and abusers.

Data Collection and Review

115.386 Sexual abuse incident reviews.

115.387 Data collection.

115.388 Data review for corrective action.

115.389 Data storage, publication, and destruction.

Audits

115.393 Audits of standards.

Auditing and Corrective Action

115.401 Frequency and scope of audits.

115.402 Auditor qualifications.

115.403 Audit contents and findings.

115.404 Audit corrective action plan.

115.405 Audit appeals.

State Compliance

115.501 State determination and certification of full compliance.

Standards for Juvenile Facilities

§ 115.5 General definitions.

For purposes of this part, the term—

Agency means the unit of a State, local, corporate, or nonprofit authority, or of the Department of Justice, with direct responsibility for the operation of any facility that confines inmates, detainees, or residents, including the implementation of policy as set by the governing, corporate, or nonprofit authority.

Agency head means the principal official of an agency.

Community confinement facility means a community treatment center, halfway house, restitution center, mental health facility, alcohol or drug rehabilitation center, or other community correctional facility (including residential re-entry centers), other than a juvenile facility, in which individuals reside as part of a term of imprisonment or as a condition of pre-trial release or post-release supervision, while participating in gainful employment, employment search efforts, community service, vocational training, treatment, educational programs, or similar facility-approved programs during nonresidential hours.

Contractor means a person who provides services on a recurring basis pursuant to a contractual agreement with the agency.

Detainee means any person detained in a lockup, regardless of adjudication status.

Direct staff supervision means that security staff are in the same room with, and within reasonable hearing distance of, the resident or inmate.

Employee means a person who works directly for the agency or facility.

Exigent circumstances means any set of temporary and unforeseen circumstances that require immediate action in order to combat a threat to the security or institutional order of a facility.

Facility means a place, institution, building (or part thereof), set of buildings, structure, or area (whether or not enclosing a building or set of buildings) that is used by an agency for the confinement of individuals.

Facility head means the principal official of a facility.

Full compliance means compliance with all material requirements of each standard except for *de minimis* violations, or discrete and temporary violations during otherwise sustained periods of compliance.

Gender nonconforming means a person whose appearance or manner does not conform to traditional societal gender expectations.

Inmate means any person incarcerated or detained in a prison or jail.

Intersex means a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female. Intersex medical conditions are sometimes referred to as disorders of sex development.

Jail means a confinement facility of a Federal, State, or local law enforcement agency whose primary use is to hold persons pending adjudication of criminal charges, persons committed to confinement after adjudication of criminal charges for sentences of one year or less, or persons adjudicated guilty who are awaiting transfer to a correctional facility.

Juvenile means any person under the age of 18, unless under adult court supervision and confined or detained in a prison or jail.

Juvenile facility means a facility primarily used for the confinement of juveniles pursuant to the juvenile justice system or criminal justice system.

Law enforcement staff means employees responsible for the supervision and control of detainees in lockups.

Lockup means a facility that contains holding cells, cell blocks, or other secure enclosures that are:

(1) Under the control of a law enforcement, court, or custodial officer; and

(2) Primarily used for the temporary confinement of individuals who have recently been arrested, detained, or are being transferred to or from a court, jail, prison, or other agency.

Medical practitioner means a health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice. A "qualified medical practitioner" refers to such a professional who has also successfully completed specialized training for treating sexual abuse victims.

Mental health practitioner means a mental health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice. A "qualified mental health practitioner" refers to such a professional who has also successfully completed specialized training for treating sexual abuse victims.

Pat-down search means a running of the hands over the clothed body of an inmate, detainee, or resident by an employee to determine whether the individual possesses contraband.

Prison means an institution under Federal or State jurisdiction whose primary use is for the confinement of individuals convicted of a serious crime, usually in excess of one year in length, or a felony.

Resident means any person confined or detained in a juvenile facility or in a community confinement facility.

Secure juvenile facility means a juvenile facility in which the movements and activities of individual residents may be restricted or subject to control through the use of physical barriers or intensive staff supervision. A facility that allows residents access to the community to achieve treatment or correctional objectives, such as through educational or employment programs, typically will not be considered to be a secure juvenile facility.

Security staff means employees primarily responsible for the supervision and control of inmates, detainees, or residents in housing units, recreational areas, dining areas, and other program areas of the facility.

Staff means employees.

Strip search means a search that requires a person to remove or arrange some or all clothing so as to permit a visual inspection of the person's breasts, buttocks, or genitalia.

Transgender means a person whose gender identity (i.e., internal sense of feeling male or female) is different from the person's assigned sex at birth.

Substantiated allegation means an allegation that was investigated and determined to have occurred.

Unfounded allegation means an allegation that was investigated and determined not to have occurred.

Unsubstantiated allegation means an allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred.

Volunteer means an individual who donates time and effort on a recurring basis to enhance the activities and programs of the agency.

Youthful inmate means any person under the age of 18 who is under adult court supervision and incarcerated or detained in a prison or jail.

Youthful detainee means any person under the age of 18 who is under adult court supervision and detained in a lockup.

§ 115.6 Definitions related to sexual abuse.

For purposes of this part, the term—

Sexual abuse includes—

(1) Sexual abuse of an inmate, detainee, or resident by another inmate, detainee, or resident; and

(2) Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer.

Sexual abuse of an inmate, detainee, or resident by another inmate, detainee, or resident includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse:

(1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;

(2) Contact between the mouth and the penis, vulva, or anus;

(3) Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument; and

(4) Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation.

Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer includes any of the following acts, with or without consent of the inmate, detainee, or resident:

(1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;

(2) Contact between the mouth and the penis, vulva, or anus;

(3) Contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

(4) Penetration of the anal or genital opening, however slight, by a hand, finger, object, or other instrument, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

(5) Any other intentional contact, either directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

(6) Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1)-(5) of this section;

(7) Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate, detainee, or resident, and

(8) Voyeurism by a staff member, contractor, or volunteer.

Voyeurism by a staff member, contractor, or volunteer means an invasion of privacy of an inmate, detainee, or resident by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals, or breasts; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions.

Sexual harassment includes—

(1) Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one inmate, detainee, or resident directed toward another; and

(2) Repeated verbal comments or gestures of a sexual nature to an inmate, detainee, or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

Standards for Juvenile Facilities

Prevention Planning

§ 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.

(a) An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

(b) An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

(c) Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

§ 115.312 Contracting with other entities for the confinement of residents.

(a) A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.

(b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

§ 115.313 Supervision and monitoring.

(a) The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:

(1) Generally accepted juvenile detention and correctional/secure residential practices;

(2) Any judicial findings of inadequacy;

(3) Any findings of inadequacy from Federal investigative agencies;

(4) Any findings of inadequacy from internal or external oversight bodies;

(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);

(6) The composition of the resident population;

(7) The number and placement of supervisory staff;

(8) Institution programs occurring on a particular shift;

(9) Any applicable State or local laws, regulations, or standards;

(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and

(11) Any other relevant factors.

(b) The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

(d) Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:

(1) The staffing plan established pursuant to paragraph (a) of this section;

(2) Prevailing staffing patterns;

(3) The facility's deployment of video monitoring systems and other monitoring technologies; and

(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

(e) Each secure facility shall implement a policy and practice of having intermediate-level or higher level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

§ 115.314 Reserved.

§ 115.315 Limits to cross-gender viewing and searches.

(a) The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

(b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances.

(c) The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

(d) The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

(e) The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

(f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

§ 115.316 Residents with disabilities and residents who are limited English proficient.

(a) The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading

skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

(b) The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

(c) The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations.

§ 115.317 Hiring and promotion decisions.

(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—

(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);

(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or

(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

(b) The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

(c) Before hiring new employees who may have contact with residents, the agency shall:

(1) Perform a criminal background records check;

(2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and

(3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

(d) The agency shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with residents.

(e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

(f) The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

(g) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

(h) Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

§ 115.318 Upgrades to facilities and technologies.

(a) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse.

(b) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

Responsive Planning

§ 115.321 Evidence protocol and forensic medical examinations.

(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

(c) The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

(e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section.

(g) The requirements of paragraphs (a) through (f) of this section shall also apply to:

(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and

(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

(h) For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

§ 115.322 Policies to ensure referrals of allegations for investigations.

(a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

(b) The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.

(c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

(d) Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

(e) Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

Training and Education

§ 115.331 Employee training.

(a) The agency shall train all employees who may have contact with residents on:

(1) Its zero-tolerance policy for sexual abuse and sexual harassment;

(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;

(3) Residents' right to be free from sexual abuse and sexual harassment;

(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;

(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;

(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;

(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;

(8) How to avoid inappropriate relationships with residents;

(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and

(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;

(11) Relevant laws regarding the applicable age of consent.

(b) Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

(c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

(d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.

§ 115.332 Volunteer and contractor training.

(a) The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

(b) The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

(c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

§ 115.333 Resident education.

(a) During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

(b) Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

(c) Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.

(d) The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

(e) The agency shall maintain documentation of resident participation in these education sessions.

(f) In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

§ 115.334 Specialized training: Investigations.

(a) In addition to the general training provided to all employees pursuant to § 115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

(b) Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

(c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

(d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

§ 115.335 Specialized training: Medical and mental health care.

(a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:

(1) How to detect and assess signs of sexual abuse and sexual harassment;

(2) How to preserve physical evidence of sexual abuse;

(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and

(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

(b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

(c) The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

(d) Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.331 or for contractors and volunteers under § 115.332, depending upon the practitioner's status at the agency.

Screening for Risk of Sexual Victimization and Abusiveness

§ 115.341 Obtaining information from residents.

(a) Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

(b) Such assessments shall be conducted using an objective screening instrument.

(c) At a minimum, the agency shall attempt to ascertain information about:

(1) Prior sexual victimization or abusiveness;

(2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;

(3) Current charges and offense history;

(4) Age;

(5) Level of emotional and cognitive development;

(6) Physical size and stature;

(7) Mental illness or mental disabilities;

(8) Intellectual or developmental disabilities;

(9) Physical disabilities;

(10) The resident's own perception of vulnerability; and

(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

(d) This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

(e) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

§ 115.342 Placement of residents in housing, bed, program, education, and work assignments.

(a) The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

(b) Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

(c) Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

(d) In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

(e) Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

(f) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

(g) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

(h) If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:

(1) The basis for the facility's concern for the resident's safety; and

(2) The reason why no alternative means of separation can be arranged.

(i) Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

§ 115.343 Reserved.

Reporting

§ 115.351 Resident reporting.

(a) The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

(b) The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

(c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

(d) The facility shall provide residents with access to tools necessary to make a written report.

(e) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

§ 115.352 Exhaustion of administrative remedies.

(a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

(b)(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.

(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.

(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.

(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

(c) The agency shall ensure that—

(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and

(2) Such grievance is not referred to a staff member who is the subject of the complaint.

(d)(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.

(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.

(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.

(4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

(e)(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.

(2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.

(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.

(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

(f)(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.

(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

(g) The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

§ 115.353 Resident access to outside support services and legal representation.

(a) The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

(b) The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

(c) The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

(d) The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

§ 115.354 Third-party reporting.

The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

Official Response Following a Resident Report

§ 115.361 Staff and agency reporting duties.

(a) The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

(b) The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

(c) Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

(d)(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.

(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

(e)(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified.

(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians.

(3) If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

(f) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

§ 115.362 Agency protection duties.

When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

§ 115.363 Reporting to other confinement facilities.

(a) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency.

(b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.

(c) The agency shall document that it has provided such notification.

(d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

§ 115.364 Staff first responder duties.

(a) Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to:

(1) Separate the alleged victim and abuser;

(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;

(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and

(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

(b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

§ 115.365 Coordinated response.

The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

§ 115.366 Preservation of ability to protect residents from contact with abusers.

(a) Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

(b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern:

(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.372 and 115.376; or

(2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.

§ 115.367 Agency protection against retaliation.

(a) The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

(b) The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

(c) For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, ornegative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

(d) In the case of residents, such monitoring shall also include periodic status checks.

(e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

(f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

§ 115.368 Post-allegation protective custody.

Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342.

Investigations

§ 115.371 Criminal and administrative agency investigations.

(a) When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

(b) Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334.

(c) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

(d) The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

(e) When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

(f) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

(g) Administrative investigations:

(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and

(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

(h) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

(i) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

(j) The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

(k) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

(l) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

(m) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

§ 115.372 Evidentiary standard for administrative investigations.

The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

§ 115.373 Reporting to residents.

(a) Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

(b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

(c) Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:

(1) The staff member is no longer posted within the resident's unit;

(2) The staff member is no longer employed at the facility;

(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or

(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

(d) Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:

(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or

(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

(e) All such notifications or attempted notifications shall be documented.

(f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Discipline

§ 115.376 Disciplinary sanctions for staff.

(a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

(b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

(c) Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

(d) All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

§ 115.377 Corrective action for contractors and volunteers.

(a) Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

(b) The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

§ 115.378 Interventions and disciplinary sanctions for residents.

(a) A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

(b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

(c) The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

(d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

(e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

(f) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

(g) An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

Medical and Mental Care

§ 115.381 Medical and mental health screenings; history of sexual abuse.

(a) If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

(b) If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

(c) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

(d) Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

§ 115.382 Access to emergency medical and mental health services.

(a) Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

(b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners.

(c) Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

(d) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

§ 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers.

(a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

(b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

(c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.

(d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

(e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

(f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

(g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

(h) The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Data Collection and Review

§ 115.386 Sexual abuse incident reviews.

(a) The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

(b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

(c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

(d) The review team shall:

(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;

(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;

(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;

(4) Assess the adequacy of staffing levels in that area during different shifts;

(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and

(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

(e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

§ 115.387 Data collection.

(a) The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

(b) The agency shall aggregate the incident-based sexual abuse data at least annually.

(c) The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

(d) The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

(e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

(f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

§ 115.388 Data review for corrective action.

(a) The agency shall review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:

(1) Identifying problem areas;

(2) Taking corrective action on an ongoing basis; and

(3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

(b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

(c) The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.

(d) The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

§ 115.389 Data storage, publication, and destruction.

(a) The agency shall ensure that data collected pursuant to § 115.387 are securely retained.

(b) The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means.

(c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.

(d) The agency shall maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

Audits

§ 115.393 Audits of standards.

The agency shall conduct audits pursuant to §§ 115.401–405.

Auditing and Corrective Action

§ 115.401 Frequency and scope of audits.

(a) During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once.

(b) During each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited.

(c) The Department of Justice may send a recommendation to an agency for an expedited audit if the Department has reason to believe that a particular facility may be experiencing problems relating to sexual abuse. The recommendation may also include referrals to resources that may assist the agency with PREA-related issues.

(d) The Department of Justice shall develop and issue an audit instrument that will provide guidance on the conduct of and contents of the audit.

(e) The agency shall bear the burden of demonstrating compliance with the standards.

(f) The auditor shall review all relevant agency-wide policies, procedures, reports, internal and external audits, and accreditations for each facility type.

(g) The audits shall review, at a minimum, a sampling of relevant documents and other records and information for the most recent one-year period.

(h) The auditor shall have access to, and shall observe, all areas of the audited facilities.

(i) The auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information).

(j) The auditor shall retain and preserve all documentation (including, e.g., video tapes and interview notes) relied upon in making audit determinations. Such documentation shall be provided to the Department of Justice upon request.

(k) The auditor shall interview a representative sample of inmates, residents, and detainees, and of staff, supervisors, and administrators.

(l) The auditor shall review a sampling of any available videotapes and other electronically available data (e.g., Watchtour) that may be relevant to the provisions being audited.

(m) The auditor shall be permitted to conduct private interviews with inmates, residents, and detainees.

(n) Inmates, residents, and detainees shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

(o) Auditors shall attempt to communicate with community-based or victim advocates who may have insight into relevant conditions in the facility.

§ 115.402 Auditor qualifications.

(a) An audit shall be conducted by:

(1) A member of a correctional monitoring body that is not part of, or under the authority of, the agency (but may be part of, or authorized by, the relevant State or local government);

(2) A member of an auditing entity such as an inspector general's or ombudsperson's office that is external to the agency; or

(3) Other outside individuals with relevant experience.

(b) All auditors shall be certified by the Department of Justice. The Department of Justice shall develop and issue procedures regarding the certification process, which shall include training requirements.

(c) No audit may be conducted by an auditor who has received financial compensation from the agency being audited (except for compensation received for conducting prior PREA audits) within the three years prior to the agency's retention of the auditor.

(d) The agency shall not employ, contract with, or otherwise financially compensate the auditor for three years subsequent to the agency's retention of the auditor, with the exception of contracting for subsequent PREA audits.

§ 115.403 Audit contents and findings.

(a) Each audit shall include a certification by the auditor that no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

(b) Audit reports shall state whether agency-wide policies and procedures comply with relevant PREA standards.

(c) For each PREA standard, the auditor shall determine whether the audited facility reaches one of the following findings: Exceeds Standard (substantially exceeds requirement of standard); Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period); Does Not Meet Standard (requires corrective action). The audit summary shall indicate, among other things, the number of provisions the facility has achieved at each grade level.

(d) Audit reports shall describe the methodology, sampling sizes, and basis for the auditor's conclusions with regard to each standard provision for each audited facility, and shall include recommendations for any required corrective action.

(e) Auditors shall redact any personally identifiable inmate or staff information from their reports, but shall provide such information to the agency upon request, and may provide such information to the Department of Justice.

(f) The agency shall ensure that the auditor's final report is published on the agency's website if it has one, or is otherwise made readily available to the public.

§ 115.404 Audit corrective action plan.

(a) A finding of "Does Not Meet Standard" with one or more standards shall trigger a 180-day corrective action period.

(b) The auditor and the agency shall jointly develop a corrective action plan to achieve compliance.

(c) The auditor shall take necessary and appropriate steps to verify implementation of the corrective action plan, such as reviewing updated policies and procedures or re-inspecting portions of a facility.

(d) After the 180-day corrective action period ends, the auditor shall issue a final determination as to whether the facility has achieved compliance with those standards requiring corrective action.

(e) If the agency does not achieve compliance with each standard, it may (at its discretion and cost) request a subsequent audit once it believes that is has achieved compliance.

§ 115.405 Audit appeals.

(a) An agency may lodge an appeal with the Department of Justice regarding any specific audit finding that it believes to be incorrect. Such appeal must be lodged within 90 days of the auditor's final determination.

(b) If the Department determines that the agency has stated good cause for a re-evaluation, the agency may commission a re-audit by an auditor mutually agreed upon by the Department and the agency. The agency shall bear the costs of this re-audit.

(c) The findings of the re-audit shall be considered final.

State Compliance

§ 115.501 State determination and certification of full compliance.

(a) In determining pursuant to 42 U.S.C. 15607(c)(2) whether the State is in full compliance with the PREA standards, the Governor shall consider the results of the most recent agency audits.

(b) The Governor's certification shall apply to all facilities in the State under the operational control of the State's executive branch, including facilities operated by private entities on behalf of the State's executive branch.

FAQ applicability of PREA – 9-12

NATIONAL PREA RESOURCE CENTER
A project of NCCD

Frequently Asked Questions

The final Department of Justice PREA Standards became effective on August 20, 2012. The Department will have more information forthcoming about compliance and monitoring of the standards, and that information will be available on the PRC website.

General
Audit and Compliance
Applicability of the Standards to Individual Settings

1. What facilities are covered under PREA and the PREA standards?

PREA directed the attorney general to promulgate standards for all confinement facilities including, but not limited to, local jails, police lockups, and juvenile facilities. See 42 U.S.C. § 15609(7). DOJ has promulgated standards for prisons and jails (28 C.F.R. §§ 115.11 – 115.93), lockups (28 C.F.R. §§ 115.111 – 115.193), residential community confinement facilities (28 C.F.R. §§ 115.211 – 115.293), and juvenile facilities (28 C.F.R. §§ 115.311 – 115.393).

Additionally, on May 17, 2012, the President directed "all agencies with federal confinement facilities that are not already subject to the Department of Justice's final rule" to develop rules or procedures that comply with PREA.

2. Do the standards apply to locally operated facilities?

Yes. PREA standards apply equally to locally operated facilities, such as lockups, jails, juvenile detention centers, and locally operated residential community confinement facilities. The statute imposes certain financial consequences on states that do not comply with the standards. However, for local facilities or facilities not operated by the state, PREA provides no direct federal financial penalty for not complying.

If a local facility has a contract to hold state or federal inmates, however, it may lose that contract if it does not comply with PREA standards. If a governor should certify compliance, he/she must certify that all facilities under the state's authority, including all local facilities the state contracts with to hold inmates, are in compliance. Furthermore, states that operate unified systems must demonstrate that all state-operated facilities, including jails, comply with the PREA standards.

Finally, all agencies, state or local, have obligations under federal and state constitutions to provide safety for individuals in their custody. While PREA does not create any new cause of

action, private civil litigants might assert noncompliance with PREA standards as evidence that facilities are not meeting constitutional obligations.

3. Do the standards apply to non-confinement community correctional settings such as probation and parole?

No, the PREA standards do not apply to non-confinement community corrections functions such as probation and parole supervision. The PREA standards do apply to residential community confinement facilities such as halfway houses operated by community corrections agencies. The PREA standards apply to confinement facilities defined in section 115.5 General Definitions as "a community treatment center, halfway house, restitution center, mental health facility, alcohol or drug rehabilitation center, or other community correctional facility (including residential reentry centers), other than a juvenile facility, in which individuals reside as part of a term of imprisonment or as a condition of pre-trial release or post-release supervision, while participating in gainful employment, employment search efforts, community service, vocational training, treatment, educational programs, or similar facility-approved programs during nonresidential hours." DOJ declined to adopt recommendations to adopt a set of standards that included pre-trial release, probation, and parole.

4. Do community corrections standards apply to juvenile community confinement settings?

No. Juvenile community confinement facilities are covered by the juvenile facility standards. See 28 C.F.R. § 115.5 (definition of community confinement facility). The community confinement facility standards do not apply to juvenile community confinement facilities.

5. Do the standards apply to facilities that hold youth in the custody of a juvenile justice agency if those youth are not the totality of the population held in that particular facility? For example, are contracted secure juvenile facilities; contracted halfway houses, group homes, and community correctional facilities; and state department of social services secure facilities that provide services to juveniles who are under juvenile court jurisdiction through a contract with the state juvenile justice agency all covered? If so, to what extent?

The PREA standards make clear that a *juvenile facility* is one that is *primarily* used for the confinement of juveniles. If a majority of a facility's residents are under the age of 18 (unless under adult court supervision *and* confined or detained in a prison or jail), it will fall within the scope of the juvenile facility standards, even if non-delinquent youth are part of the facility's population. One example is a facility that houses 10 youth and only two of those youth are under the jurisdiction of juvenile justice agencies. According to the standard, because less than a majority of the youth in that facility are in the custody of the juvenile justice department, the facility does not need to comply with PREA juvenile facility standards. For example, if the facility is used to house individuals "as part of a term of imprisonment or as a condition of pre-trial release or post-release supervision…" then the community confinement standards would apply. See 28 C.F.R. § 115.5 (definition of community confinement facility).

In addition, as in all custodial settings, agencies have state and federal legal obligations to protect those in custody, irrespective of obligations under PREA.

Finally, PREA Standard 115.312 provides that "a public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards and any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards."

6. Is PREA Standard 115.14 Youthful Inmates applicable to juvenile settings? Often juvenile settings can house youth committed to the department of juvenile justice until age 21. Do youth in juvenile custody need to be sight and sound separated if they are over 18?

No. Individuals confined in juvenile facilities are defined as "residents" and may reside in juvenile facilities until the age allowable by state law, which in most states is 21, and in some as high as 25. The PREA standards do not provide for any sight and sound separation of residents in juvenile facilities either because of age or court of conviction. Neither the standard on youthful inmates (115.14) nor the standard for youthful detainees (115.114) is applicable in juvenile facilities. The Youthful Inmate standard requiring separation of those under age 18 from those over 18 is "setting specific," applicable only in prisons, jails, and lockups. Even where state law provides for automatic prosecution in adult court of individuals at age 16 (e.g., NC, NY) and age 17 (e.g., GA, NH, IL, LA, MD, MA, MI, SC, TX, WI) when those persons are detained or confined in an adult prison, jail, or lockup, such individuals must be sight and sound separated from those over the age of 18.

PREA Resource Center – Staffing Ratios 2013

NATIONAL PREA RESOURCE CENTER

February 7, 2013

What is adequate staffing?

The PREA standards do not mandate specific minimum staffing ratios for adult and non-secure juvenile settings. Instead, the PREA rule provides guidance on how agencies can determine adequate staffing levels to protect inmates, residents, and detainees from sexual abuse. For prisons, jails, and juvenile facilities, the standards require that agencies consider 1) generally accepted practices; 2) judicial findings of inadequacy; 3) findings of inadequacy from federal investigative agencies; 4) findings of inadequacy from internal or external oversight bodies; 5) all components of the facility's physical plant (including "blind spots," or areas where staff or residents may be isolated); 6) composition of the inmate/resident population; 7) number and placement of supervisory staff; 8) number and types of programs occurring on a particular shift; 9) applicable state or local laws, regulations, or standards; 10) prevalence of substantiated and unsubstantiated incidents of sexual abuse; and 11) any other relevant factors. 28 C.F.R. §§ 115.13(a) and 115.313(a). The lockup and community confinement standards provide a similar, albeit abbreviated, list of factors.

In secure juvenile facilities, DOJ defined minimum staffing ratios under PREA Standard 115.313 (c) as 1:8 during resident waking hours and 1:16 during resident sleeping hours. Agencies may depart from these minimum ratios during limited and discrete exigent circumstances, which are fully documented for audit purposes. Id. DOJ noted that many states and localities, as a matter of law or policy, already have minimum staffing ratios in juvenile settings; some state and local facilities exceed the minimum staffing ratios proscribed in the PREA standards and are strongly encouraged to maintain those ratios. In order to provide agencies with sufficient time to readjust staffing levels and, if necessary, request additional funding, the standard provides that any facility that is not already obligated by law, regulation, or judicial consent decree to maintain the required minimum staffing ratios has until October 1, 2017, to achieve compliance. Id.

Staffing Ratio

115.13

Excerpt from Comments to Final PREA Regulations on Juvenile Staffing Ratios

Excerpt from Comments to Final PREA Regulations on Juvenile Staffing Ratios

(DEPARTMENT OF JUSTICE 28 CFR Part 115 Docket No. OAG-131; AG Order No. RIN 1105-AB34 National Standards to Prevent, Detect, and Respond to Prison Rape, pages 34-35)

NPRM (from Notice of Proposed Rulemaking) Question 7: Some States mandate specific staff-to-resident ratios for certain types of juvenile facilities. Should the standard mandate specific ratios for juvenile facilities?

Comment. Many advocacy groups commented that specific staffing ratios are appropriate and commonly utilized for juvenile facilities, and specifically proposed establishing a minimum 1:6 ratio for supervision during hours when residents are awake and a 1:12 ratio during sleeping hours. These commenters stated that minimum juvenile staffing ratios fall within the guidelines established by various States and correctional organizations, and that two jurisdictions already require the 1:6 and 1:12 staffing ratios. In contrast to adult correctional agencies, juvenile agencies were less opposed to mandatory staffing ratios for juvenile facilities. However, some juvenile justice administrators expressed the same concerns raised with regard to adult facilities—that specific ratios would constitute a cost-prohibitive, unfunded mandate and that it would be impractical to establish one ratio to fit all facilities. Multiple agency commenters noted that they were already subject to mandatory staffing ratios and that any such ratios in the PREA standards would be duplicative or conflicting.

Response. The Department adopts a standard requiring a minimum staffing ratio in secure juvenile facilities of 1:8 for supervision during resident waking hours and 1:16 during resident sleeping hours. Unlike for adult facilities, it is relatively common for juvenile facilities to be subject to specific staffing ratios by State law or regulation. The Department's research indicates that over 30 States already impose staffing ratios on some or all of their juvenile facilities. 35 The standard's ratios include only security staff. Of the States identified as requiring specific staffing ratios, approximately half count only "direct-care staff" in these ratios.8 (For most of the remaining States requiring specific staffing ratios, the Department has not been able to determine precisely which categories of staff are included.) In addition, the National Juvenile Detention Association's position statement, "Minimum Direct Care Staff Ratio in Juvenile Detention Centers," which recommends respective day and night minimum ratios of 1:8 and 1:16, specifically limits the included staff to direct-care staff.9 The 1:8 and 1:16 staffing ratios adopted by the final standard match or are less stringent than the ratios currently mandated by twelve States, plus the District of Columbia and Puerto Rico, for their juvenile detention facilities, juvenile correctional facilities, or both. The Department's Civil Rights Division has consistently taken the position that sufficient staffing is integral to keeping youth safe from harm and views minimum staffing ratios of 1:8 during the day and 1:16 at night as generally accepted professional standards in secure juvenile facilities. For this reason, the Civil Rights Division has entered into multiple settlement agreements that require jurisdictions to meet minimum staffing ratios in order to ensure constitutional conditions of confinement for juveniles. In addition, as noted above, the National Juvenile Detention Association's 1999 position statement on "Minimum Direct Care Staff Ratio in Juvenile Detention Centers" supports a minimum ratio of 1:8 during the day and 1:16 at night. Given the widespread practice of setting minimum staffing ratios for juvenile facilities, the Department believes these ratios accord with national

practice, are an integral measure for protecting juveniles from sexual assault, and can be implemented without excessive additional costs. In order to provide agencies with sufficient time to readjust staffing levels and, if necessary, request additional funding, any facility that, as of the date of publication of the final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the required staffing ratios shall have until October 1, 2017, to achieve compliance. The standard excludes non-secure juvenile facilities from this requirement. Juveniles in non-secure facilities typically have less acute violent and abusive characteristics than those in secure facilities. Many jurisdictions utilize a risk screening instrument to determine whether a juvenile requires a secure placement; juveniles who are identified as having a high likelihood for assaultive behavior and re-offense are generally held in secure facilities. Accordingly, many non-secure and community-confinement-type facilities do not require as intensive staffing levels to protect residents from victimization.

DOJ Los Angeles Camps Findings Letter 10-31-08

U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

October 31, 2008

Ms. Yvonne B. Burke, Chairperson
Los Angeles County Board of Supervisors
500 West Temple Street, Suite 856
Los Angeles, CA 90012

Re: Investigation of the Los Angeles County Probation Camps

Dear Ms. Burke:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Los Angeles County Probation Camps ("the Camps"). On November 9, 2006, we notified you of our intent to conduct an investigation of the Camps pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). We informed you that our investigation of the Camps would focus on whether youth were adequately protected from harm. As we noted, both CRIPA and Section 14141 give the Department of Justice ("the Department") authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions.

Prior to the investigatory tours, the Department and Los Angeles County ("the County") agreed that the Department would tour a sample of the Camps, and that the Department's inspection of the sample would stand as representative of all of the Camps.[1] On January 22-26, February 5-8, and March 5-8, 2007, we conducted on-site inspections of Camp Vernon Kilpatrick ("Camp Kilpatrick"), Camp Joseph Scott ("Camp Scott"), and Camp Karl Holton ("Camp Holton"), as well as five of the camps at the Challenger Memorial Youth Center ("Challenger" or "the Challenger Camps"). We toured with expert consultants in juvenile justice

[1] The Los Angeles County Probation Camps include 19 juvenile justice facilities. The Department toured eight of them.

administration and, at the Challenger Camps, an expert consultant in mental health. Before, during, and after our visit, we reviewed an extensive number of documents including, but not limited to, policies and procedures, incident reports, housing logs, and orientation materials. However, the County refused to provide us access to all child abuse investigations and to some medical records and logs.[2] Additionally, in conducting our on-site investigations, we interviewed administrators, professionals, staff, and youth. We observed the youth in a variety of settings, including on their living units, while dining, in classrooms, and during recreation.

Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we conducted exit conferences at each facility we visited upon the conclusion of the tour, during which our expert consultants conveyed their initial impressions and concerns.

Under the leadership of Robert Taylor, Chief Probation Officer of the Los Angeles County Probation Department ("Probation Department"), the County has unequivocally indicated its clear desire to improve the facilities. We commend the Probation Department staff for their helpful, courteous, and professional conduct throughout the course of this investigation. We hope to continue to work with the County and facility staff in the same cooperative manner going forward.

Consistent with our statutory obligation under CRIPA, we set forth below the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described below, we conclude that youth confined at the Los Angeles Juvenile Camps suffer harm or the risk of harm from constitutional deficiencies, specifically in the areas of protection from harm and mental health care. Notwithstanding the

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[2] By law, our investigation must proceed regardless of whether County officials choose to cooperate fully. Indeed, when CRIPA was enacted, lawmakers considered the possibility that State and local officials might not cooperate in our federal investigations. See H.R. Conf. Rep. 96-897, at 12 (1980), reprinted in 1980 U.S.S.C.A.N. 832, 836. As we informed the County's attorney, the County's decision to deny us access to these records permits us to draw negative inferences about their contents. We have drawn negative inferences with respect to the adequacy of abuse investigations and the adequacy of the discipline for staff who violate the rights of youth.

foregoing, we are pleased that the County informed us of some preliminary steps it intends to take to remedy deficiencies we reported during our exit conferences.

I. BACKGROUND

A. Description of the Facilities

The Los Angeles County Probation Department operates 19 detention camps. Approximately 2,200 post-adjudicated youth are housed in the Camps, which provide an intermediate sanction between community supervision and detention in the secure facilities operated by the California Department of Corrections and Rehabilitation, Division of Juvenile Justice. The Probation Department also operates the Los Angeles County Juvenile Halls ("Juvenile Halls"), which house approximately 1,500 to 1,800 youth who generally range in age from 11 to 19 and are awaiting adjudication.[3] Many youth from the Halls are transferred to the Camps following adjudication.

1. THE CHALLENGER CAMPS

The Challenger Camps are six separate camps located on 44 acres in the town of Lancaster in Los Angeles County's Antelope Valley. In January 2007, one of the six camps, Camp Onizuka, which housed girls, was closed. The remaining five camps - Jarvis, McNair, Resnick, Scobee and Smith - have the capacity to house 110 youth each.

Each camp is a large, concrete, single-story facility, configured in a semi-circle, divided in half by a continuous line of classrooms. The classrooms divide the facility into two identical halves, each with a large grass field area in its center. There are three camps on each side of the facility's divide. Although all youth in each camp move to school and to outdoor recreation together, programming and meals are conducted separately in the dayrooms of each side of each camp.

Youth housed at the Challenger Camps tend to include those with histories of violence and/or escape. All youth with medical and mental health needs are housed in the Challenger Camps. A significant percentage of the population is prescribed

[3] On August 26, 2004, the Department, Los Angeles County, and the Los Angeles County Office of Education entered into an agreement to resolve the Department's investigation regarding conditions of confinement at the Juvenile Halls.

psychotropic medication. Youth housed at the Challenger Camps range in age from 14 to 18 and most are fulfilling commitments of three, six, or nine months.

There is also a 60-bed disciplinary unit called a Special Housing Unit ("SHU") that operates as a separate program at the Challenger Camps. The SHU also serves as a local detention facility for up to 10 youth arrested by police in the community immediately surrounding the Challenger Camps.

2. CAMP SCOTT

Camp Scott is a secure facility for girls located in the rural Santa Clarita community of Los Angeles County. Camp Scott is configured as a semi-circle of single story buildings. Camp Scott has a rated capacity of 125 youth, although the population on the first day of our visit was 79 youth. The girls, who range in age from 12 to 18, sleep in a single dorm designed to house up to 113 youth. Girls are generally committed to Camp Scott for periods of three, six, or nine months. The newest building on the campus is an Assessment Center (which also functions as a disciplinary housing unit), with a capacity of 12 youth housed in single cells. All of the camp's buildings open onto the main grass field and recreation area. Girls are able to walk the short distances from their dorm to the school, culinary unit, administration building, assessment center, and other buildings on the campus.

3. CAMP HOLTON

Camp Holton is located in the rural Sylmar community of Los Angeles County. This secure, all male facility is constructed largely of cinderblock with a single dorm used as living quarters for all youth. Although the facility can house up to 119 youth, 77 were assigned to the facility on the first day of our tour. Youth are typically committed to the camp for three, six, or nine months, with an average length of stay reported to be approximately 90 days. The single dorm is divided into four sections, each with approximately 25 bunks. The sections are separated by a low, cinderblock wall running down the center of the dorm with a control center located in the middle of the dorm. Youth ages 13 and under tend to be housed in one quadrant of the dorm while honors youth occupy another and general population youth occupy the remaining two quadrants.[4] The various buildings

[4] At the time of our visit, it appears that the youngest youth housed in the camps we toured was 12 years old.

that make up the facility - - the school, administrative area, culinary unit, Special Housing Unit and a gym - - are arranged in a fully enclosed, semi-circle around a large, open area with basketball courts, a track, and a grass field for recreation. Youth walk the relatively short distances from building to building.

4. CAMP KILPATRICK

Camp Kilpatrick is a secure facility for boys built in 1964 in the hills of Los Angeles County's Malibu community. The facility is unique among the Camps because of its focus on sports; Kilpatrick is a certified high school and its sports teams compete with area high schools in football, basketball, baseball, and soccer, at both the junior varsity and varsity levels. Built mostly of cinderblock, the facility is in a general state of physical and cosmetic disrepair. For example, the gymnasium was rendered structurally unsound after an earthquake in 1994 and has not been usable since.

Kilpatrick is configured in a fully enclosed, semi-circular fashion around a large dirt field and basketball courts. The facility's rated capacity is 112 youth, although only 91 were assigned on the first day of our tour. The youth ranged in age from 13 to 18 years old. Youth are assigned to one of two identical dorms, based largely on programming preferences. Each dorm houses approximately 45 youth in single bunks arranged in four rows with a control center in the middle of each dorm. The various buildings that make up the facility - - the school, culinary unit, administration building, and Special Housing Unit - - open on to the field and recreational space and each is within easy walking distance to the dorms. Youth at Kilpatrick are typically committed for periods of three, six, or nine months, with three-month commitments being the most common. Camp Kilpatrick is next to Camp Miller, with which it shares kitchen facilities and its Special Housing Unit, although the camps operate as two separate and distinct camp programs.

B. Legal Background

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional rights and the federal statutory rights of juveniles in juvenile justice facilities. 42 U.S.C. § 1997. Section 14141 of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, makes it unlawful for any governmental authority with responsibility for the incarceration of juveniles to engage in a pattern or practice of conduct that

deprives incarcerated juveniles of constitutional or federal statutory rights. Section 14141 grants the Attorney General authority to file a civil action to eliminate the pattern or practice.

The Due Process clause of the Fourteenth Amendment to the U.S. Constitution governs the standards for conditions of confinement of juvenile offenders who have not been convicted of a crime. Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987); Jones v. Blanas, 393 F.3d 918, 931 (9th Cir. 2004). Confinement of youth in conditions that amount to punishment, or in conditions that represent a substantial departure from generally accepted professional standards, violates the Due Process clause. Youngberg v. Romeo, 457 U.S. 307 (1982); Bell v. Wolfish, 441 U.S. 520 (1979); Alexander S. v. Boyd, 876 F. Supp. 773, 796-799 (D.S.C. 1995), aff'd in part and rev'd in part on other grounds, 113 F.3d 1373 (4th Cir. 1997). The Fourteenth Amendment prohibits imposing on incarcerated persons who have not been convicted of crimes conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. at 539-540.

The County has an obligation to assure the reasonable health, safety, and freedom from undue restraint of the youth in its custody. See Youngberg v. Romeo, 457 U.S. 307 (1982); Gary H. v. Hegstrom, 831 F.2d 1430 (9th Cir. 1987); Alexander S. v. Boyd, 876 F. Supp. at 786-7; Santana v. Collazo, 793 F.2d 41 (1st Cir. 1984); D.B. v. Tewksbury, 545 F. Supp. 896 (D. Or. 1982). Confined juveniles must receive adequate medical treatment, including adequate mental health treatment and suicide prevention measures. See Youngberg, 457 U.S. at 323-24 & n.30; Oregon Advocacy Ctr. v. Mink, 322 F.3d 1101, 1120 (9th Cir. 2003); Gibson v. County of Washoe, 290 F.3d 1175, 1187 (9th Cir. 2002); Carnell v. Grimm, 74 F.3d 977, 978-79 (9th Cir. 1996); Cabrales v. County of Los Angeles, 864 F.2d 1454 (9th Cir. 1988), vacated and remanded, 490 U.S. 1087 (1989), reinstated, 886 F.2d 235 (9th Cir. 1989); Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994); Gordon v. Kidd, 971 F.2d 1087, 1094 (4th Cir. 1992).

II. FINDINGS

Youth residing in Los Angeles County's Camps are not adequately protected from harm. Further, the County fails to provide adequate suicide prevention and mental health care to youth.

A. Failure to Protect Youth From Harm

Youth housed at the Camps are subjected to harm and risk of harm as a result of the following failures by the County: (1) failure to protect youth from harm by staff, including failure to protect youth from use of excessive force by staff, excessive and inappropriate use of Oleoresin Capsicum ("OC") spray, and staff misconduct at Camp Holton; (2) failure to protect youth from harm by other youth; (3) failure to provide adequate staffing; (4) failure to provide adequate staff training; (5) failure to adequately investigate allegations of abuse; (6) failure to provide an adequate classification system; and (7) failure to provide an adequate grievance process.

1. Failure to Protect Youth From Harm by Staff

a. Use of Excessive Force by Staff

Youth at the Camps have a right to be free from unnecessary restraint and the use of excessive force. Youngberg, 457 U.S. at 315-16. With the noteworthy exception of Camp Kilpatrick, our investigation uncovered systemic physical abuse of youth by staff. We found a disturbing consistency in the youth's accounts of the use of unnecessary physical restraint and excessive force by staff at the Camps. Most of the youth we interviewed reported staff abuse they had received themselves or had witnessed. Youth repeatedly corroborated each other's allegations in separate interviews, with no opportunity to discuss the allegations between interviews. In each instance, we attempted to track down whether the abuse had been reported (by reviewing the Suspected Child Abuse Report ("SCAR") forms we received from the County), or a grievance had been filed. Some allegations had been reported to or discovered by the County. Others, for various reasons, were reported to us in the first instance, suggesting both that youth lack trust in the County to report abuse and that the County systemically fails to detect abuse occurring at the Camps.

i. The Five Challenger Camps

At the Challenger Camps, many of the youth we interviewed reported several allegations of mistreatment at the hands of staff. Other youth witnesses corroborated the original youth's accounts of these events. In two instances that we describe below, staff knew about the incidents, yet did not take the required steps to report them to the Los Angeles Department of Children and Family Services ("DCFS") or initiate an

investigation. Generally, we found that staff did not understand their responsibilities as mandatory child abuse reporters or know what procedures to follow when receiving an allegation of abuse. As a result, the protections that would have been afforded by DCFS involvement were never accessed, and youth reported that they did not feel safe enough to voice their concerns about mistreatment directly to staff. Consider the following illustrative examples:

- B.P.[5] reported that a Camp McNair probation officer, while attempting to restrain L.N., slammed L.N. to the ground and dislocated the youth's shoulder. L.N. reported that the incident occurred in December 2006 in the dining hall after another youth threatened to spit in his food. He stated that he got mad and started fighting the youth. L.N. reported that staff ordered the youth to stop fighting and that L.N. complied by backing away from the other youth. Nevertheless, the officer grabbed him and slammed him to the floor on his shoulder.[6] (We observed a bone sticking out of L.N.'s shoulder. He told us that he was seen by camp medical staff and told that he would have to see a bone specialist).

- One youth described being given what he believed was a new jacket by a member of the staff, but learned later that the jacket actually belonged to another youth in the camp. The other youth demanded that his jacket be returned. The reporting youth refused. The two youth fought soon thereafter. The staff member who had given

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[5] The initials used to refer to youth are pseudonyms to protect their privacy. We will provide a key to the youth's real names to the County under separate cover.

[6] Youth reported that staff "slam" youth in the following manner: Youth are either slammed against the wall, or staff grab youth, lift them in the air, and forcibly take them to the ground. In some cases, officers land on top of youth, injuring both the youth and the officers involved in the process. As discussed below, staff at all of the Camps consistently reported to us that the Probation Department did not have a use of force continuum and that staff had received no additional training on use of force techniques after their initial new hire training. Abusive practices such as "slamming" are the predictable consequences of a systemic lack of adequate training on the use of force.

the jacket to the first youth intervened by physically taking one youth to the ground. The youth reported that, during this contact, he suffered a broken jaw. Facility administrators reported that although staff knew about this incident, they had not investigated the veracity of any complaints of excessive force or that the staff had purposefully instigated the incident. With our urging, the Probation Department's Special Investigations Unit ("SIU") was notified of this incident.

- V.T. reportedly observed staff physically restrain a youth in the dining hall because the youth continued to talk after being instructed to be quiet. After the restraint, V.T. reported that he observed the youth with a bloody mouth and a "knot" on his forehead.

- A.K. reported that two Camp Resnick probation officers allegedly punched, kicked, and sprayed a youth with OC while he was handcuffed.

Youth reported the following incidents at Camp Smith:

- L.O. alleged that he was grabbed, slammed, and dragged across the control center steps in Camp Smith because he refused to exercise with the dorm.

- Youth reported observing staff break a youth's jaw and beat him while restraining him (the youth purportedly suffered a broken jaw after staff allegedly "slammed" the youth to the ground).

- C.R. reported that he observed staff beat a youth who had assumed the "OC [Oleoresin Capsicum spray] position"[7] on the ground.

We received additional noteworthy reports of staff-on-youth assaults at Camp McNair, such as the following:

[7] Staff order youth to assume the "OC position" as a means of gaining control of the youth, meaning that the youth must immediately lie down on the floor in the prone position with his eyes shut.

- N.T. alleged that in December 2006, a Camp McNair probation officer caught two youth "locking legs."[8] The officer "slammed them," sprayed them with OC, and kicked them.

- J.I. allegedly witnessed staff members using excessive force on V.T. J.I. observed that, following the use of force, V.T. had a bloody mouth and a big knot on his forehead.

- F.D. alleged that he was physically assaulted by staff for no reason. The youth is visibly physically disabled, and of short stature. He reported suffering from a bone weakening disease that causes his bones to be fragile and undeveloped. Staff allegedly dragged F.D. across the recreation field, causing severe injury to his knee. The County began an investigation of this incident after we brought it to the County's attention. The County preliminarily reported after our exit conference that F.D. was suspected of drug possession. The County agreed, however, that regardless of the youth's offense, the staff should have handled the incident differently.

The allegations described above had indicia of credibility and we did not receive any documents refuting these accounts. More generally, allegations like these, both founded and unfounded, are not uncommon in secure facilities such as the Camps. It is therefore essential, for the protection of the youth and the staff, that such allegations be promptly and properly reported, and thoroughly investigated. For this to occur, staff must understand their legal obligations in this regard and must know the formal steps required to properly report incidents of alleged child abuse.

ii. Camp Holton

We also uncovered abusive practices at Camp Holton. Youth reported that some staff verbally and physically mistreated youth when their drill performance fell below expectations. Youth

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[8] "Locking legs" is a discreet method of fighting where youth sit on the ground or on a bunk facing each other and interlock their legs at the knee so only a few inches separate them. They then begin to hit each other. The loser is determined, in part, by which youth first "unlocks" his or her legs and moves away.

revealed that some staff become agitated and impatient with youth when “facing movements” (a method of lining up youth in formation and moving them safely and efficiently from building to building) and when other required regimens are not carried out in a swift and organized manner.

Additionally, we uncovered a number of disturbing allegations of staff assault. These allegations include:

- One 15-year-old youth stated that staff kicked him twice in the ribs during his first week at Camp Holton. He explained that while he was in the dorm during shower time, staff allegedly directed him and others to line up. Because he did not line up quickly enough, staff allegedly directed him to come to the control center area. Upon arriving at the control area, which is a slightly elevated staff observation area surrounded by a wall standing approximately four feet in height, staff directed the youth to sit in a chair against the wall. This positioning made it difficult for other youth in the dorm or the video surveillance system to observe the youth. While seated, the youth reported that a staff member kicked him twice in the ribs and slapped him once on the back of his head with an open hand.

- Another youth reported that in February 2007, a staff member reportedly told him, “I can do whatever I want,” and pushed him with both hands on the youth’s chest, tackled him to the concrete floor, and twisted his arm and leg behind his back.

- K.Z. reported that in January 2007, after an argument with staff, staff bumped into the youth but claimed that the youth hit the staff. Using this as cause to restrain the youth, staff reportedly grabbed the youth’s arm and foot, causing the youth to fall forward. Once on the ground, staff pushed the youth’s head to the floor. Another youth corroborated this incident and stated that he heard the youth scream. The following day, the Director reported this incident to law enforcement; two days later, a deputy responded to the facility to interview the youth involved. We do not know the results of the investigation.

- D.B. reported that staff pushed him against a wall and put his arm behind his back in a painful hammer lock allegedly because he was moving too slowly. He

reported that staff then placed him on the floor and put their knees to his head and against his ribs. He suffered scratches on his leg and neck and swelling around his eye as a result of this incident. Another youth corroborated this story, stating that the alleged victim told him he had been beaten up by staff. Although a mental health professional completed a Suspected Child Abuse Report ("SCAR") about the alleged incident, the incident was not reported to DCFS or law enforcement at that time. The Camp Director filed a report with law enforcement four days later, on January 21, 2007, but law enforcement had yet to respond at the time of our initial tour.

- Another youth, whose arm was in a sling as a result of a fractured clavicle, reported that, in December 2006, two staff who had been escorting him had taken him forcefully to the ground.[9] He further reported that one of the officers drove his knee into the youth's shoulder and pulled the youth's arm up behind his back, causing considerable pain and aggravating the fracture. The youth reported that the officers then lifted him to his feet and slammed him into the wall twice. He complained about excessive pain to his injured arm but reported that medical staff did not see him until the following day. He reported the incident to his case manager, who had him complete an affidavit. A police report was filed, but staff from the SIU interviewed the youth. We do not know the results of the SIU's investigation.[10]

Additionally, youth reported that Holton staff order youth to go to the Command Center ("CC") and assume the "bob sled position" (meaning that youth are made to sit on the ground with their knees close to their chests and their arms interlocked around their knees). Youth reported that by "assuming the bob sled position" in the CC, "no one can see what is happening to you." One youth reported that staff also turn the lights off and kick the youth when they are forced to assume the bob sled position. The youth reported that this practice occurs as often

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[9] We believe that the youth's clavicle was broken prior to the incident, but we cannot confirm or deny this belief because we were denied access to the youth's medical files.

[10] As discussed later in the report, the County refused to provide us with any of their child abuse investigations.

as two to three times per week. S.C. reported that he had been forced to assume the bob sled position twice. P.S. reported that youth sit in the bob sled position out of camera range where "staff can slap and yell at you."

iii. Camp Scott

Youth at Camp Scott repeatedly reported that staff twist youth's arms behind their backs to control their behavior, and one staff person in particular was mentioned repeatedly as using inappropriate force by tackling youth, twisting their arms behind their backs, and slamming them to the ground.

Staff at Camp Scott also lack of knowledge of both the proper thresholds for reporting allegations of abuse and the authorities to whom to report such allegations. These inadequacies are clearly evident in the way in which recent allegations of staff abuse have been handled. Although supervisors and administrators took some action in most of the situations described later in this letter, their actions stopped far short of a formal report to the proper authority, and fell substantially below generally accepted professional standards.

iv. Camp Kilpatrick

We are very pleased to report that we did not uncover any reports of staff abuse at Camp Kilpatrick. Although staff training on the use of force is inadequate at all of the Camps, including Kilpatrick (as discussed below), youth interviews and documents consistently indicated that staff at Camp Kilpatrick exercise a continuum of non-physical interventions prior to using physical force. Moreover, although proper medical documentation was not available for review, the documents we did review indicated that staff intervention in altercations did not cause or exacerbate injuries to youth. Youth at Camp Kilpatrick also consistently reported that they could talk to staff about their problems or concerns without fear of retaliation.

b. Excessive and Inappropriate Use of OC Spray at Challenger

Probation officers throughout the Challenger Camps are using OC spray excessively. See Alexander S. v. Boyd, 876 F. Supp. at 786 (finding that the use of CS gas (a form of tear gas) in a juvenile justice facility for purposes other than the protection of staff or other juveniles, or where there is a threat of serious bodily harm, is unconstitutional). Probation Department policy on the use of chemical agents in the Camps appropriately

requires that such agents be used only as a last resort. The policy requires that staff follow a use of force continuum and attempt to de-escalate a situation before deploying OC spray. The Probation Department fails to comply with this policy.

For example, N.T. reported that a probation officer at Camp McNair (one of the Challenger Camps) slams youth into a prone position on the ground, sprays them with OC spray, and then kicks them. A number of youth similarly reported excessive uses of OC spray at Camp Smith. L.O. allegedly observed a youth sprayed with OC while the youth was restrained on the ground. C.R. reportedly observed a youth sprayed in the face for no apparent reason as he entered the dorm. At Camp Resnick, J.I. alleged that he observed a probation officer empty a can of OC spray on two youth who had been fighting but had complied with his order to get on the ground. As previously mentioned, A.K. alleged that probation officers punched, kicked, and sprayed a handcuffed juvenile at Camp Resnick.

Further, a probation officer told us about an incident in which OC spray was used in the SHU in April 2006. Allegedly, several Camp McNair youth were sent to the SHU after a disturbance. Many of the youth were yelling and banging on their cell doors for hours. Another supervisor identified a couple of youth who were banging especially hard. That supervisor and an officer moved to one of the cells and opened the door. They gave a verbal OC warning. The youth jumped back in what the officers perceived to be a threatening manner. A probation officer then sprayed the youth and quickly closed and locked the door to the youth’s cell. The probation officer and the supervisor then moved to two other cells, where they sprayed one of the two youth inside.

Probation Department policy also appropriately prohibits the use of OC spray on youth who suffer from medical or respiratory conditions such as asthma, youth who are on psychotropic medication, obese youth, and youth with mental health disorders.

As a mental health director reported, nearly half the youth at the Challenger Camps are being actively seen by mental health staff, and roughly one-third are on at least one psychotropic medication. We were repeatedly told during our tours that youth with mental health needs, and particularly troubled youth, are sent to one of the Challenger Camps. Yet, we were told that the Challenger Camps are, paradoxically, the only camps at which staff are authorized to carry OC spray. One supervisor told us that he believed that allowing staff to carry and use OC spray made sense given the “mental health population” at the Challenger

Camps. This rationale not only contradicts policy, but also generally accepted professional standards.

In addition to adequate policies, the County must also have clear procedures guiding the use of OC spray to ensure that youth who have the disqualifying conditions listed above are not sprayed. The probation officers with whom we spoke alleged that they were not provided with this information. Indeed, we received varying answers from staff regarding the types of youth on whom it is impermissible to use OC spray. When asked, probation officers were unable to identify the conditions that should prevent the use of OC spray, except for asthma or some other respiratory disorder. Some staff could list a few youth who had asthma, but most answered our inquiries about who could be sprayed by saying, "I assume that all of them can." Further, officers offered a variety of explanations as to precisely how they would identify a youth as having one or more of the disqualifying conditions. Some officers stated that they simply have no way of knowing whether a youth should not be sprayed, others reported that youth with excluded conditions wear green t-shirts bearing the letters "MED," while others told us that different colored wrist bands were used to indicate the prohibited condition status of a youth.

We interviewed several youth who had been sprayed with OC in the three months prior to our tour; several of them reportedly had one of the disqualifying conditions listed above. For example:

- W.G. reported having asthma. Although he reported to us that he was not on any psychotropic medications, he reported earlier spending two months at the Dorothy Kirby Center (the County's psychiatric residential treatment center), suggesting that he has a mental health diagnosis that would prohibit him from being sprayed.

- G.R. was sprayed in mid-January 2007 and reported having been sprayed on at least one other occasion. He reported taking psychotropic medications.

- E.V. was sprayed in January 2007 after he and two other youth were involved in a fight over a chair in the dorm. He reported taking psychotropic medication.

Failing to inform staff about which youth have disqualifying conditions for the use of OC spray is not only negligent, but

also amounts to a gross deviation from generally accepted professional standards.

Further, no one at the Challenger Camps or in the leadership ranks of the Probation Department has recognized that the use of OC spray at the Challenger Camps is a problem. The Superintendent at the Challenger Camps reported that she had heard of improper uses of OC spray in the past, but believed that these had occurred "a long time ago."

Finally, the facilities do not have adequate procedures and documentation governing the issuance of OC spray canisters to officers, nor do they have any procedures to weigh OC canisters on a regular basis to detect the unauthorized discharge of spray. After our tour, the Probation Department started to establish a "Use of Force Review" to assess the extent to which policies surrounding the use of OC spray have been followed. Although we have not had an opportunity to assess the implementation and adequacy of this reform, it is evident that the use of force review will not be meaningful until these policies are clearly articulated and staff have been adequately trained on them.

c. Inappropriate Staff Conduct at Camp Holton

We found the treatment of youth at Camp Holton by some of the staff who work there particularly troubling. We conducted a second, follow-up tour on March 7 and 8, 2007, to investigate newly arising allegations of mistreatment and intimidation of youth by Camp Holton staff, as well as reports that some staff maintained and consumed alcohol on the facility premises during the course of their 56-hour shifts. The implications of these allegations were so troubling that we modified our previously established plans and revisited Camp Holton to interview youth, staff, and Camp administrators, and to re-tour portions of the facility.

Youth reported on our follow-up tour that during our initial visit in January 2007, staff allegedly warned them not to "embarrass" staff by reporting mistreatment. We also learned of alleged remarks by staff during our second tour that were clearly intended to intimidate youth and prevent them from reporting staff misbehavior to us. A number of youth reported that one evening after we conducted interviews, staff purportedly made comments like, "We're going to have cheese sent up from the kitchen for the rats." Or, "C Dorm is still waiting for cheese from the kitchen." We heard numerous and serious allegations of staff physically mistreating youth and intimidating them by threatening physical harm or administrative sanctions if youth

cooperated with our investigation. Youth repeatedly named three staff and one former staff member as staff who threatened, intimidated, and put their hands on youth in a violent manner.

Additionally, on our second visit to Camp Holton, we discovered two bottles of alcoholic beverages in some of the staff's sleeping quarters.[11] The use or possession of alcoholic beverages by staff while on shift is expressly forbidden in policy, and foments a serious and unnecessary risk of harm to youth and staff in a secure institutionalized setting. It is also our understanding that Camp Holton leadership may allegedly have been aware of allegations of mistreatment and alcohol consumption by some of these staff.

We commend the County for taking immediate steps to address the serious concerns raised as a result of this tour by ensuring that the youth and staff who spoke with us were protected, and conducting an extensive follow up investigation. We understand that the County is also discussing this matter with the Probation Officers' union. We do not know the current status of the investigation or the discussions, but believe that appropriate

exit interviews.

2. Failure to Protect Youth from Harm by Other Youth

The high incidence of youth-on-youth assaults, particularly at the Challenger Camps and at Camp Scott, evidences another failure of the County to keep youth safe. At the Challenger Camps, youth reported that fights occur daily in the dorms. A review of the logbooks confirmed these reports. Youth reported that movement from the five camps to school - where groups of 90 or more youth are escorted by approximately seven staff - was perhaps the most likely time for a fight to break out. The combination of large numbers of youth and relatively few staff was cited by several youth as being a factor in fights occurring during movement. We learned that fights occur not only within the staff's field of supervision, but many occur out of staff's line of sight, in places that could not be well supervised given the small number of staff.

Youth are aware of the severe shortage of staff and describe two primary "types" of fights - those that occur in the open and are seen and responded to by staff, and those that are conducted

[11] Staff who are in the sleeping quarters are still on duty.

in a more discreet fashion without staff becoming aware. The more discreet method of fighting is called "locking legs," as described above. This form of fighting generally occurs in the back of the dorm room where large fans obscure the sound, and other youth obscure the vision of officers. At Camp Scott, girls reported "locking legs" in the back of the dorm area and stated that such fights occur daily. Although youth reported that staff seldom noticed these fights, some youth believed that staff were aware of the fights and allowed them to take place.

At Camp Scott, fights also typically occur undetected in the laundry room and shower area. For example, two youth fought undetected in the laundry room of the dorm. Staff did not see them until after the fight had ended, when a staff person noticed that one of the girls appeared to be injured. The girl required emergency medical treatment for a concussion sustained when the other girl repeatedly shoved her head against the wall. Another girl, H.N., alleged that she was repeatedly punched and stomped in the face and head in the laundry room. A third girl had to intervene to stop the fight because staff were not around. H.N. alleged that she had to be taken to the hospital as a result of her injuries and was purportedly told by a probation officer that if the officer gets into trouble due to the incident, "I'm filing a 'triple-seven'[12] on both of you." In another incident of youth-on-youth assault, two girls engaged in a premeditated fight outdoors, out of the view of staff. Later, while the girls were working on kitchen duty, kitchen staff noticed their injuries as the girls washed their blood away in the sink.

Fights that occur in full view of staff are referred to as "going live."[13] Youth know that when they "go live" they will probably be caught and punished. Some youth alleged that staff have encouraged youth occasionally to "go live."

Fights are not the only evidence of the County's failure to adequately protect youth from harm. Many youth at the Challenger Camps also reported being "stressed" about other youth tampering

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[12] A "777" refers to a formal probation violation filed with the judge who retains jurisdiction in a youth's case. Such filings can and, according to both staff and youth, often do, result in additional time in custody for the subject youth.

[13] Many of the fights that occur at the Camps are concealed, i.e., youth lock legs or fight in some other manner that is undetected by staff. "Going live" means that caution is abandoned and the fight occurs in plain view of staff and others.

with their food, stealing their personal property, spitting on their beds, filling neoprene gloves with urine and throwing them, filling soap cups in the shower with urine, as well as engaging in gang-related conflicts. In several interviews, youth noted that their stress levels interfered with their ability to sleep and that they had sought and received medication to aid them in this area. Several youth expressed fear that they would not be able to "make it" at the Challenger Camps.

Each of these concerns from youth point, in part, to a need for enhanced staff supervision. Youth described the common practice of staff congregating for long periods in the command center area of the dorms, rather than circulating through the dorms as required. Some staff believed that other staff, particularly new staff, were afraid of the youth. This fear of the youth by some staff reportedly resulted in those staff either turning a blind eye to inappropriate activities or in a tendency to keep their distance from youth, typically remaining in the units' command center areas.

Increasing staff-to-youth ratios and ensuring that the youth remain under supervision at all times would likely reduce youth's stress, decrease staff apprehension, and lessen youth-on-youth violence at all of the Camps.

Additionally, the lack of an adequate behavior management system at the Camps contributes to youth-on-youth violence and the staff's inability to keep youth safe. If staff had a range of options with youth rather than either, generally, the threat of a "triple-seven" or sending the youth to the SHU for an infraction, and were provided with clear guidelines on the use of positive as well as negative incentives, the level of safety in the Camps would increase.

3. Inadequate Staffing

The biggest factor preventing the Camps from keeping youth safe is the lack of sufficient staff to adequately supervise youth. Without adequate numbers of trained staff, it is impossible to respond in a safe and timely manner when violence and other crises occur. Staff themselves discussed the stress they experience when a violent altercation breaks out in their dorm, and they must choose between intervening in a fight or ensuring that other youth do not become involved in it. Moreover, without adequate numbers of qualified staff, probation officers do not have the time to build the relationships with

youth that are necessary to identify potential conflicts, prevent incidents from occurring, and engage youth in meaningful rehabilitation.

Adequate numbers of staff must be deployed to supervise youth during waking and sleeping hours in order to protect youth from harm. The number of staff available to supervise youth is directly relevant to nearly all of the measures designed to protect youth from harm. For example, each housing unit is staffed with a combination of supervisory and line probation officers. Although seven staff may be assigned to a dorm holding 100 youth, at any given time, only four of them are assigned primary supervision duties, with two on one side of the dorm, and two on the other side of the dorm. The requirement that they attend to the needs of so many youth prevents staff from being able to de-escalate tensions effectively. This has serious repercussions as some staff purportedly may not intervene in fights immediately, choosing instead to await the arrival of backup staff, which creates the potential for youth to inflict more serious injuries during physical altercations.

Because staff at the Camps work 56-hour shifts (16 hours on, eight hours off, 16 hours on, eight hours off, and a final eight hours on shift before departing for four days off), they are given regular breaks throughout each of these stretches on duty. We observed several meal periods during which only two staff were present to supervise approximately 50 youth lining up, receiving food, sitting down to eat, and cleaning up. The other staff were either on break or doing casework (e.g., preparing court reports, contacting the youth's families, etc.). When the youth were on the housing unit, only two line staff were assigned to each side, resulting in a 1:27 ratio, at best. All staff assigned to the unit are deployed to assist with movement to and from school, which may bring the ratio down to 1:15 if seven staff are assigned to the dorm. When interviewed, however, staff indicated that they are frequently required to operate with fewer than seven staff.[14] In any event, a ratio of 1:15 during waking hours substantially departs from the generally accepted professional standard, which is 1:8/10 during the day.

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[14] The definition of "direct care staff" is inconsistent across the Camps' facility administrators and Probation Department policy. The generally accepted practice is to count only those staff whose primary duty is youth supervision, and to exclude those who are assigned as administrative, supervisory, and office staff.

a. Challenger Camps

Inadequate staffing during school hours at the Challenger Camps is a major concern. The youth in each camp are distributed across five classrooms allocated to that camp (youth from various camps do not mix in the school setting, except in special education classes). During school hours, only one staff from each camp was assigned as the School Liaison, which translates to a dangerous 1:110 ratio during the school day. The School Liaison sits in "the bubble" (the equivalent of a control center at the school) and watches a monitor which, when functioning, provides a three-second glimpse of each classroom in rotation. Each classroom has a telephone and a stationary panic button that the teachers are to use when an incident begins. Over the six months prior to our tour, the panic buttons were inoperable for long stretches of time, resulting in one instance where a teacher was unable to summon help when several students assaulted him in his classroom. Although other staff assigned to the dorm reportedly will respond when the School Liaison summons them on the radio, those staff are often coming from far across campus and therefore are not immediately available to assist. Teachers also complained that the phone was often busy when they tried to call the bubble to request assistance from the assigned officer. The Superintendent at the Challenger Camps stated that the School Liaison is required to patrol the corridor outside the classrooms and to check in on each class periodically. Neither teachers nor probation officers reported that this occurs with any regularity.

The Probation Department's Regional Director indicated that the Challenger Camps had recently received additional staffing, sufficient to bring the waking hours ratio in all camps but Jarvis up to generally accepted standards. Although 62 new positions had been funded, 47 of these were vacant and the remainder were in pre-service training. Thus, the enriched staffing had yet to be put into place within the Camps during our tour. In addition, the facility had 18 staff on worker's compensation leave, meaning that they were on leave after having been injured on the job. Moreover, the filling of vacancies in the recent past reportedly came, at least in part, at the expense of filled case worker positions. According to the Regional Director, 70% of case workers have returned to line staff positions, leaving significant vacancies in the case worker staff.

The failure to meet generally accepted staffing levels at the Challenger Camps results in significant and tangible harm to youth. As discussed earlier, physical altercations between youth are very common. As detailed above, some of these fights

occurred within the staff's field of supervision but many occurred out of the line of sight, in places that could not be well supervised given the small number of staff.

At the Challenger Camps, directors and the Superintendent were seldom observed circulating in the dorms or other common areas where youth could see them. Youth commonly said that they did not know who the Camp Directors were. The lack of a high-level staff presence at the Challenger Camps seems particularly unwise given the camps' large number of new staff and generally challenging population.

b. Camp Holton

Camp Holton also lacks sufficient staff to adequately protect youth housed there. Exacerbating the risk of harm presented to youth by chronic understaffing at Camp Holton is an apparent lack of oversight and supervision. As previously mentioned, youth repeatedly identified a specific group of staff as particularly abusive. Also as noted, the leadership at Camp Holton allegedly was aware of some of the allegations concerning abuse, threats, intimidation, and alcohol, and we could not find evidence that adequate steps had been taken to address these serious allegations. For example, during our January 2007 tour, we expressed concern regarding the presence of alcohol at the camp. In response to this concern, the Camp Director reportedly issued a memorandum to all staff regarding the bringing of contraband items into the camp. Nonetheless, when we returned to Camp Holton in March 2007, we found alcohol on site.

c. Camp Scott

We also found inadequate staffing at Camp Scott. A review of staff schedules revealed that overtime is used extensively, but the lack of staff greatly affected facility operations. In February 2007, for example, the facility could not find additional overtime staff to cover several shifts. A review of the supervisor's log revealed that, on one night, staffing fell dangerously low, to only two staff from 10pm to 6am for populations of 76 and 106 youth, respectively.

Inadequate staffing has led to staff being pulled from the orientation/isolation unit (the Assessment Unit ("AU")) at Camp Scott. A minimum of two staff is needed to keep this unit operational. When the staffing complement is insufficient, the unit is closed. A review of this unit's Movement Log revealed that the unit was closed on 10 of 63 days between January 1 and March 4, 2007, because of staff shortages. Thus, the essential

functions of new resident orientation, small group counseling, and disciplinary isolation were not available on those days.

Many youth corroborated that they either did not receive orientation or were not sent to isolation as a result of the lack of staff. In fact, during the several weeks prior to our visit, new girls moved almost immediately into the dorms without receiving the benefit of proper camp orientation. One girl we interviewed had been at Camp Scott for one week without having had orientation and without having been assigned to a caseworker. As a result of not having been assigned a case worker, she was at a loss for how to access mental health services, gain access to personal items that family members brought to the facility for her, file a grievance, access medical care, or become familiar with the behavior management system. She reported feeling depressed and wanting to speak to someone from mental health, but she did not know how to access mental health services, believing all girls were expected to make such requests through their caseworker. Camp staff and administrators informed us that the chronic staffing shortages have forced them to rely on youth who fill “leadership” positions to perform orientation and other duties more appropriately performed by staff.

d. Camp Kilpatrick

Camp Kilpatrick also suffers from the lack of adequate staff. At the time of our visit, seven assigned staff were unable to report to work because of worker’s compensation leave, family leave, or sick leave. Two other staff positions were vacant. These nine slots accounted for about one-quarter of the facility’s 38 line staff positions. Although extra staff have been budgeted to ease some of this difficulty (i.e., staffing relief factor), the significant number of staff who are unable to report to work presents a significant burden for remaining staff.

During our initial tour of Camp Kilpatrick, we entered a housing unit at approximately 6:00 pm where only one staff person was present, providing supervision from a position in the command center. At the time, approximately 35 youth were involved in varying activities the dorm. Camp Kilpatrick’s staff-to-youth ratios often fell below generally accepted standards. The disparity was particularly notable on the night shift, when a single staff member was commonly assigned to dorms housing as many as 56 youth. During our visit, the ratio was approximately 1:45. The generally accepted standard for staff-to-youth ratios at night is 1:16/20.

4. Inadequate Staff Training

Not only must the facilities have an adequate number of staff, but these staff must also be well trained to manage youth behavior appropriately, to de-escalate tensions and intervene effectively in crises, and to use force appropriately when less restrictive means have failed. The gross lack of staff training exacerbates all of the problems associated with the lack of staffing at the Camps with respect to keeping youth safe. The gross lack of training available to staff, coupled with the lack of adequate staff, means that staff are ill-equipped to ensure that fights between youth are stopped quickly, appropriately, and safely.

The County has no policy regarding staff training, when it is required, its content, or how staff skills and knowledge will be assessed. Staff at the Camps do not receive adequate training to perform critical job functions such as protecting youth from harm. For example, staff at the Challenger Camps reported that they do not receive sufficient guidance, either through formal training or on-the-job mentoring and supervision, on how to properly restrain youth.

The lack of staff training is particularly problematic at the Challenger Camps. Given the characteristics of these camps' population as described by the facility Superintendent -- that is, youth who are on various forms of medication for mental health reasons, who have violent offense histories, who have medical concerns, and who are generally considered to be "high risk" -- staff training is essential to the safe operation of these facilities. This training is sorely lacking in all critical areas, and was noted by many staff as being among the greatest unmet needs at the Challenger Camps. One supervisor noted that this is particularly important given the large number of new staff at the facilities. This supervisor noted that some staff lacked basic knowledge about how to perform their jobs and conduct themselves in a safe and professional manner. Specifically, the supervisor mentioned staff understanding of proper use of force techniques, as well as a wide range of unprofessional conduct, including staff use of foul language and talking on cell phones while on duty, as priority training areas.

Training on the use of force should have, as its foundation, a set of detailed policies governing the use of physical, mechanical, and chemical restraints. The paucity of information in formal policy relevant to the use of force and the lack of a Probation Department-approved use of force curriculum illustrate the lack of standardization and attention to this issue.

Training documentation revealed that only 14% of Challenger staff had received formal training in the use of force since January 2006, while an additional 20% had received training at some point earlier in their careers. At Holton, only 10% had received training in the use of force since January 2006, and 24%, at some point earlier in their careers. At Camp Kilpatrick, only 9% percent of staff had received formal training in the use of force since January 2006, and only an additional 9% had such training at some point earlier in their careers. Two-thirds of staff at both Challenger (66%) and Camp Holton (67%), had never received formal training in the safe use of physical restraint measures; more than three-quarters of Camp Kilpatrick staff (82%) had never had formal training in such techniques. Undoubtedly related to this gross lack of training, as detailed above, youth uniformly reported the widespread use of slamming and other inappropriate uses of force by staff at virtually all the Camps.

Staff interviews at all of the camps that we toured confirmed that no Probation Department-approved use of force continuum exists, nor could staff name or demonstrate any specific physical restraint techniques that were approved for use. Except for two individuals who were recently hired or recently transferred to the Challenger Camps from one of the County's Juvenile Halls, none of the staff had received any training in the use of force since their initial training after being hired. For some staff, this meant that they had not received any use of force training in more than 10 years. Several staff indicated that they were not paid to attend training that was scheduled outside of their normal shifts, and they therefore refused to attend.

Staff's lack of knowledge and the lack of a standardized curriculum was highlighted in the incident reports we reviewed, nearly all of which lacked details about the specific ways in which staff intervened in fights between youth, what restraint was used, and which staff participated in the restraint. Most often, the incident report indicated that the youth was "*assisted to the ground*" or "*placed on the ground*," but no details were given as to how this was accomplished. (Emphasis added).

It is critical that training in the proper use of physical restraint to break up a fight between youth be given to Camp staff. Youth and staff consistently reported a high number of youth-on-youth assaults throughout the Camps. Many youth reportedly sustained injuries during these fights (although the rate of injury could not be determined because the County denied us access to the youth's medical charts despite our repeated requests). Youth and staff also reported a high number of staff

injuries as a result of attempts to intervene in the fights. The lack of training available to staff, coupled with the lack of adequate numbers of staff discussed previously, mean that staff are ill-equipped to ensure that fights between youth are stopped quickly, appropriately, and safely. Of the 47 staff injured on the job in 2006, nearly half (48%) were injured during the course of a restraint.

Further, our observations and reports from youth demonstrate that staff are not properly trained to de-escalate conflict between youth. Rather than using the typical methods of de-escalation (e.g., calm tone of voice, clear directions, providing opportunities for youth to express themselves), some staff reportedly instigate, antagonize, and otherwise encourage youth to assault each other. For instance, one youth reported that in response to a brewing altercation between him and another youth, the staff allegedly said, “Come on, you motherfuckers, I haven’t seen anyone ‘go live’ in months.” These, and other statements like them reported by several youth, escalate, rather than de-escalate, conflict. Many youth described unprofessional behavior by staff and offered graphic examples of improper uses of force. Youth described staff provoking youth, ridiculing youth in front of their peers, swearing at youth, calling them stupid, using sexual innuendos, fostering racial tension among youth, punishing large numbers of youth for the behavior of one, and using excessive force. Youth also stated that some staff even engaged in “gang talk” with them. A youth from Camp Resnick (a Challenger Camp) indicated that a staff refused to let another youth use the restroom after the youth stated that he felt ill. The youth, in fact, vomited and the staff antagonized the youth by saying, “Stop acting like a bitch! Suck it up! Stop being a pussy!” The reporting youth filed a grievance regarding this incident and received a response two weeks later, stating that the youth and staff had been “counseled.”

Staff also are inadequately trained on procedures and safe practices regarding the use of OC spray. The County’s OC Spray policy fails to include a use of force continuum that would serve as a guide to its officers on when it is appropriate to use OC spray. The policy also does not comment on the training and certification requirements for staff. We were also told that the training officers received upon hiring was inconsistent regarding the proper use of OC spray, and that Challenger staff received a separate training on the topic from a member of the Challenger staff who also maintained all staff training records on this topic. We were unable to verify this because, according to the Superintendent, the training records were lost. Although we were informed that efforts were underway to re-establish both OC spray

training and a record system to track the training, we were provided with no documents reflecting the status of these efforts.

5. Inadequate Investigation of Abuse Allegations

a. Failure to Report Abuse

When an allegation of abuse is made, it must be reported to the proper authorities to investigate the veracity of the allegation. Generally accepted professional standards require that all staff working at a juvenile justice facility be mandated child abuse reporters. As such, they must report all instances of alleged abuse, no matter how credible, to the state Child Protective Services agency. The allegations or information must be reported without filtering or making subjective decisions about which are serious or credible enough to be reported. Disturbingly, most of the staff we interviewed at the Camps were unaware of their duties to report.

At all of the Camps, three separate agencies have been designated to handle allegations of abuse - the Department of Child and Family Services ("DCFS"), local law enforcement, and the SIU. Staff uniformly reported that they were responsible for reporting allegations they received to their supervisors, but had no knowledge of their responsibility to make an independent report to any agency. Indeed, none of the administrators or Probation Department officials knew what the staff's obligations were in this regard.

At Camp Holton, two of four abuse allegations that were reported to staff in the six months prior to our tour were not passed on to DCFS in a timely manner. In November 2006, a youth made an allegation of abuse to an officer and to a member of the mental health staff. Neither of these individuals made a DCFS Suspected Child Abuse Report (SCAR), choosing instead to wait for the Camp Director to return from vacation two weeks later to find out how to handle the allegation. In January 2007, another youth reported an allegation to a member of the mental health staff, yet that staff person also failed to make a SCAR report. The Camp Director made the report four days later. The failure to make a SCAR report is of great concern and severely threatens the integrity of the process for protecting youth from harm by staff. It does not appear that any of these staff were held accountable for their failure to take required suspected child abuse reporting actions.

Staff at the Camps reported that they had not received any training on child abuse reporting in the previous year prior to our tour. Training documentation revealed that only 16% of Challenger staff had received formal training in child abuse reporting since January 2006. An additional 38% had received this training at some point earlier in their career. None of Camp Holton's staff had received formal training in child abuse reporting since January 2006, but two-thirds (67%) had received training at some point earlier in their careers. Only 4% of Camp Scott staff had received formal training in child abuse prevention and reporting since January 2006; 49% had received such training at some point earlier in their careers.

Alarmingly, nearly half (46%) of Challenger staff had never received formal training in child abuse reporting. One-third (33%) of Camp Holton staff had never received formal training in child abuse reporting, and nearly one-half of Camp Scott staff (47%) have never received any kind of training in child abuse reporting.

At Camp Scott, the lack of knowledge surrounding the proper thresholds and authorities for reporting allegations of abuse is apparent in the way in which allegations of abuse have been handled. Although supervisors and administrators took some action in most situations, their actions stopped short of a formal report to the proper authority. For example:

- In November 2006, a youth provided a written statement recounting an event that had allegedly occurred in August 2006: "[staff] pushed me down on the control center and literally put his knee on top of my chest, holding my breath out/in, while his other hand was around my neck choking me for at least 5-10 seconds. I black [sic] out for about 2 seconds and woke up." The youth stated that she told the Administrator on Duty who replied that the staff was doing his job and that the youth needed to calm herself down. The Licensed Clinical Social Worker ("LCSW") receiving this complaint, completed a written report, and gave it to the Camp Director. The Camp Director, however, failed to report the allegation to the appropriate authorities.

- A youth alleged an inappropriate relationship between another youth and a staff member at Camp Scott in January 2006. Although the youth's statement named the staff member, the facility never reported the alleged inappropriate relationship to DCFS. The facility

administrator reported to us that the SIU had investigated this matter, but stated that she did not have a copy of the resulting report. Of particular concern, the same staff person involved in this incident was implicated in two other allegations of misconduct in August and December 2005. Even if the staff member's behavior had not amounted to "abuse," it certainly should have been evaluated for compliance with the Probation Department's policies surrounding appropriate professional boundaries.

- In November 2006, a youth's written statement clearly alleged excessive force and verbal abuse by a staff person: "[staff] grabbed my thumb and bent it back" and also called her a derogatory name. This youth's statement was never reported to or investigated by any of the three agencies (DCFS, law enforcement, or SIU).

Camp Scott's failure to promptly report allegations of abuse to the proper authorities substantially departs from generally accepted practice and the Probation Department's own regulations.

At Camp Kilpatrick, although there have been complaints of verbal abuse, there had been no allegations of physical abuse or mistreatment in the six months prior to our visit. Nevertheless, it is of concern that staff reported they had not received any training in child abuse reporting, and some were not aware of their duties in this regard. Training documentation revealed that none of Camp Kilpatrick's staff have received child abuse training since January 2006. Approximately two-thirds (68%) had received training at some point earlier in their careers. About one-third (32%) had never received formal training in child abuse reporting.

b. Failure to Take Adequate Investigatory Actions Once Abuse is Reported

Once an allegation of abuse has been made, proper investigation is required to protect youth from staff abuse by collecting evidence to verify or disprove the allegation. These investigations are essential to identify staff in need of training and/or termination, as well as to clear staff who have been wrongfully accused. The investigation process must have reasonable integrity, preserve all physical evidence (e.g., videotape footage, documentation and photographs of injuries, clothing, etc.), obtain statements from all youth and staff involved in the incident and those who witnessed the incident, and utilize other sources of information to corroborate or refute

the allegation (e.g., logbooks, other sources of facility documentation).

i. Failure to document medical treatment following a use of force

The integrity of the investigative process includes documenting the youth's injuries. Generally accepted professional standards require that youth subject to a use of force be seen and treated, if necessary, by a medical professional. Medical staff can also be an avenue for youth to report abuse or mistreatment. Further, even when youth do not report abuse or mistreatment, under generally accepted professional standards, medical staff are mandated reporters of child abuse if abuse is suspected. Oftentimes, the nature of a youth's injury would lead a medical professional to suspect abuse.

Staff and County officials repeatedly claimed that if medical attention was received, it would be documented on the incident report. The documentation provided by the County did not suggest that medical attention is automatically provided to youth involved in uses of force. At Camp Holton, the medical portion of the incident reports we reviewed was left blank in nearly all instances; only two of the 30 incident reports included any documentation by a medical professional. Thus, in the event that the youth actually did receive treatment and the error was one of documentation, we requested access to the medical charts of the youth involved in the undocumented incidents. This request was denied, and therefore no evidence was provided that indicated youth receive medical treatment by licensed medical staff following their involvement in a use of force.

At Camp Scott, the available documentation also did not substantiate that medical attention was automatically given to youth involved in uses of force. Of the 27 incident reports reviewed, 18 recounted events that required some form of medical attention (e.g., fights, uses of force, suicide gestures, etc.). Of these 18, only five provided evidence to verify that the youth involved received prompt medical attention. Several others provided documentation for only one of the youth involved, and several revealed long delays in obtaining medical attention, even during times when the nurse was at the facility.[15] Six incident

[15] At some of the Camps, nurses are not on duty after certain hours or on weekends.

reports did not include any documentation that the youth had been seen by a nurse following his involvement in the incident. Once again, we were unable to review the medical files to determine if this was simply a failure of documentation or practice.

Efforts should also be made to increase the involvement of medical staff as an avenue to uncover information about youth mistreatment. The nurses can conduct confidential interviews with the youth to gather information about the incidents.

ii. Failure to take adequate action following an allegation of staff abuse

Youth we interviewed reported several allegations of mistreatment at the hands of staff. Pending the outcome of the investigation of these allegations, generally accepted professional standards require that these staff be placed in non-contact positions. Most of the staff we interviewed reported that accused staff are “usually” moved to security, where they are deployed to the key room, office, or other positions where they do not have contact with youth. However, staff were also aware of other accused staff who continued to work directly with youth. One staff reported that he, himself, had been accused of mistreating a youth, but was simply transferred to another unit, rather than to a non-contact position. By moving accused staff to a position in which they do not have direct contact with youth, the facility protects youth from the risk of harm and protects itself from liability if the staff person were to commit additional misconduct pending the outcome of the initial investigation.

Obviously, because some allegations are unfounded, it is vital that child abuse investigations be completed in a timely manner so that wrongly accused staff can be can return to their normal post. All of the Challenger Camp staff with whom we spoke voiced a concern regarding the length of time required for the investigation process to clear staff, if the allegation was not substantiated. Reports of investigations pending for over a year were not uncommon. The length of time required for this process contributes to the generally low morale reported by many staff, who feel unsupported in doing their work.

At Camp Scott, the Director stated that accused staff are assigned to non-contact positions at Camp Headquarters pending the outcome of the investigation. However, as discussed above, several of the allegations of abuse occurring over the past 12 months were administratively screened out and not reported to the proper authorities. In one of the cases discussed above, the

same individual was implicated in three separate incidents (all alleged misconduct). None of the accused staff were removed from direct supervision. Failures to report allegations of abuse and to move staff into non-contact positions place youth at Camp Scott at significant risk of harm.

According to Camp Holton's Director, staff at the camp are not automatically placed in non-contact positions pending the outcome of an abuse investigation. The reasons for this practice are not clear, although it is likely influenced by the impact on facility staffing levels. Indeed, a total of 11 staff were involved in child abuse allegations from November 2006 to the time of our tours, representing approximately one-quarter of the facility's staff. If all were to be placed on non-contact status, the facility would have a very difficult time covering each shift. Although difficult operationally, the responsibility to protect youth from harm is paramount, and thus transfer to non-contact status is essential. The SCARs discussed above, along with several other youth and one staff, made repeated references to a small core group of staff at Camp Holton who allegedly abuse and terrorize youth. Indeed, these are the same staff who the youth we spoke with described as being heavy-handed during the course of restraint. Camp Holton's failure to place these staff on non-contact status at the first allegation of abuse not only created an opportunity for additional allegations of abuse to occur, but also led to the sentiment among both staff and youth that staff are not held accountable for their behavior. This lack of accountability leads directly to the culture of fear and intimidation that pervades youth's experiences at Camp Holton.

Normally, our site inspection protocol includes a careful review of the investigations of each allegation of abuse occurring over the past 12 months. However, we were denied access to these documents. The reason for the denial provided by the County was the staff's right to privacy. This was despite our repeated offers to ensure confidentiality and privacy, including our offer to sign a confidentiality agreement. Without these documents, we are unable to verify that the County adequately protects youth from abuse by staff because we are unable to make any finding regarding the actual existence of such investigations or their quality. Accordingly, we draw negative inferences and find that the investigations are inadequate.

Our site inspection protocol also includes a review of all disciplinary action taken against staff found to be guilty of misconduct or abuse. We were also denied access to these records, and therefore cannot verify that the County protects

youth from abuse by appropriately disciplining staff. Accordingly, we draw a negative inference and find that discipline of staff who violate the rights of youth is inadequate.

c. Failure to Provide Safe Avenues to Report Threats and Intimidation at Camp Holton

Avenues for youth to report abuse at Camp Holton are ineffective due to the culture of fear that pervades the facility and the failure to hold staff accountable for mistreating youth. As previously mentioned, of great concern during both tours at Camp Holton were reports that youth were threatened and intimidated by staff in an effort to prevent youth from speaking with us. During the first tour, we had difficulty locating several youth who were supposed to have been confined at Camp Holton. These youth, it turned out, had been recently transferred to Barry J. Nidorf Juvenile Hall ("Barry J."). Facility staff were not able to tell us the time of return to Camp Holton so that they could be interviewed by members of our team. Our subsequent efforts to contact some of these youth at Barry J. were unsuccessful because, by the time we visited Barry J., they had been transferred back to Camp Holton. Additionally, as previously mentioned, during our second tour, youth reported that staff made public announcements suggesting that the youth who cooperated with our interviews were "rats." Other youth reported that staff warned youth "not to embarrass [them]" by talking candidly with our team. The various avenues for youth to report mistreatment, no matter how well designed, are rendered ineffective in a facility that permits staff to threaten and intimidate youth to prevent them from exercising their right to discuss their conditions of confinement with federal investigators.

6. Inadequate Classification System

The absence of an adequate classification system also contributes to the County's inability to keep youth safe. Generally accepted professional standards require that youth be housed and supervised based on a reliable classification system which includes the following considerations: a youth's age, charged offense, history of violence and escape, gang membership or affiliation, health and mental health concerns, and institutional history.

The youth at the Camps are, at best, classified in an ad hoc manner, rendering it impossible to safely house youth. Compounding the problem of inadequate placement criteria is the

physical structure of the housing units and lack of adequate numbers of staff. At the Challenger Camps, the facility Superintendent indicated that initial camp placements are loosely based on the programmatic focus at the camp. However, we did not find this to be the case. The Challenger Camps do not utilize a structured decision-making tool to make housing decisions within each camp. Instead, they rely on the subjective assessments of staff, none of whom have received classification training. Youth who are considered to be "at risk" are reportedly assigned bunks in the front of each dorm. However, staff were not consistent in their definition of "at risk." Most often, youth were judged to be at risk due to a particular medical condition. None of the staff included youth who were vulnerable (due to age, size, etc.), had serious mental health issues, or who were at risk of self-harming behavior. Occasionally, staff discussed the need to separate members of rival gangs, but there was no method for doing so.

Similar to the practice at the Challenger Camps, at Camp Holton, youth who are considered "at risk" are reportedly assigned bunks close to the command center. However, this practice appeared to be applied with questionable consistency. At Camp Holton, our findings rest almost exclusively on reports from staff and administrators. We were unable to verify whether, in fact, at risk youth are placed in beds closer to the command center because they did not maintain adequate records of bed assignments. We requested the bed charts for one of the dorms for 20 randomly selected days, but staff were able to produce only four of them. Not only are these records important to determine whether any classification system has been properly implemented, but they are essential when investigating serious incidents or child abuse allegations that occur in the dorm.

At Camp Kilpatrick, youth are separated into two dorms, with one dorm reserved for those participating in the sports program and the other dorm housing everyone else. Youth considered by staff to be "at risk" are assigned bunks closest to the control center within each dorm. But we found no definition of the term "at risk," and staff are left to interpret its meaning. Youth who misbehave as well as vulnerable youth and youth with medical conditions are all considered at risk at Camp Kilpatrick. Although an at-risk determination certainly is appropriate for each of these groups, not separating violent and non-violent youth is contrary to generally accepted practice.

The primary form of classification at Camp Scott is to place youth into one of four platoons: one for dorm leadership, one for youth with jobs, one for recently admitted youth, and one for

general population. These distinctions bear little relationship to protecting youth from harm or improving outcomes for youth in the facility, which are the intended purposes of classification. The platoon assignments do not account for a youth's particular vulnerabilities, interpersonal conflicts, or past involvement in institutional misconduct. Similarly, the concentration of those holding leadership positions into a single platoon limits the ability of these youth to serve effectively as role models for other youth, which was noted by staff and administrators as being a primary role of leadership.

One of the problems plaguing Camp Scott on an episodic basis is the involvement of youth in consensual sexual activity. A review of relevant incident reports indicate that, although staff attempt to note and address the behavior from a variety of angles, the use of a formal classification strategy was not among them. Youth found to be involved in this type of behavior are often assigned to the bunks farthest from the control center, and have opportunities to manipulate the environment to provide cover for their activities. The use of a structured classification system to guide housing decisions would accurately identify youth involved in these behaviors.

The current classification process in the Camps does not adequately address known risk factors for institutional misconduct, and could lead to the proximal housing of youth who should be separated in order to adequately protect them from harm. The Regional Director for the Camps reports that each of the Camps will have an entirely different focus as a result of Camp Redesign, an ongoing 14-point project aimed at a variety of improvements throughout the Camps.[16] In the meantime, however, the Camps' method of classification does not ensure that youth are protected from harm, and substantially departs from generally accepted professional standards.

7. Inadequate Grievance Process

Youth at the Camps are not provided with adequate access to a grievance system designed to address their complaints regarding their treatment at the facilities. Generally accepted professional standards mandate that youth should have readily available access to a grievance process. Where courts have considered this, they have uniformly found that detained youth have a constitutional right to file grievances with facility

[16] The project is protected to continue at least through the end of 2008, if not far beyond.

administrators regarding their treatment. Bradley v. Hall, 64 F.3d 1276, 1279 (9th Cir. 1995); D.B. v. Tewksbury, 545 F. Supp. 896, 905 (D. Or. 1982); Morales v. Turman, 364 F. Supp. 166, 175 (E.D. Tex. 1973). An objective grievance system should be well known and easily accessible. Grievances also provide an important quality-control mechanism by which camp administrators can monitor whether facility staff are adhering to policies and procedures.

Youth at the Challenger Camps knew of the existence of a grievance process, but very few had pursued it as a remedy for concerns or complaints. Most youth interviewed had no confidence in the grievance process as a useful avenue for addressing concerns about staff or camp conditions. Of the relatively few youth who had raised issues regarding staff directly with supervisors or via the grievance process, it was reported that such actions resulted in staff calling them “snitches.” During the tours of all the facilities, we noticed grievance forms and boxes in the housing units. Staff reported that the boxes had been installed just prior to our visit. The procedure previously had inappropriately required youth to submit their completed grievance forms to a staff member. The availability of the submission boxes appropriately increases the confidentiality afforded to youth.

Although they did not have great confidence in the grievance system, youth did use it to address some of their concerns about their treatment at the Challenger Camps. We reviewed approximately 75 grievances from all five Challenger Camps between January 2006 and January 2007. Approximately 20 of the grievances complained about food, maintenance issues, and personal products. Approximately 25 grievances complained about the denial of medical care or tensions between staff and youth. Approximately 15 grievances alleged verbal abuse or mistreatment by staff. For example, a youth from Camp Resnick alleged that a staff had cursed at the youth repeatedly and made fun of him for being gay. This grievance was never responded to or resolved. A large number of other grievances alleged mistreatment by this same staff person.

Approximately six of the grievances alleged physical abuse or the excessive use of force by staff. For example:

- In June 2006, a youth from Camp McNair alleged that a staff used OC spray on him without cause, stating that he (the youth) had assumed the “OC position” to indicate he was not involved in the incident. The

response to the grievance was only: "I will speak to [the staff] about the incident."

- In January 2006, a youth from Camp Resnick alleged that he was physically restrained by a staff for five or 10 minutes after an incident occurred. The disposition on the grievance form inappropriately concluded that the grievance was "resolved" because the youth was transferred to another camp. It does not appear that the youth requested the transfer.

- In June 2006, another Camp Resnick youth alleged that he was threatened by a staff who later grabbed the youth by the neck and pushed his face into the ground. Again, the grievance was "resolved" when the youth was transferred to another camp.

- In June 2006, a youth from Camp Scobee alleged that a teacher kicked him. There was no response or apparent resolution of the grievance.

Although a few of the grievances pertaining to maintenance, hygiene, and access to medical care appear to have been appropriately resolved, in many situations, releasing the youth to the community or transferring him to another camp led to the determination that an issue had been "resolve[d]." All of these complaints were about conditions at the facilities that would not change in any meaningful way simply because the youth was no longer there. Although the youth made the effort to address the issue, the staff responsible for resolving the matter chose not to do so. Further, many of the grievances took an inordinate amount of time to resolve, and many others did not have a date of receipt or date of resolution written on them, making their compliance with required timelines impossible to ascertain. One youth marked his grievance "urgent" and went on to explain his desire to be placed in protective custody. After 16 days, the grievance was considered "resolved" because the youth had been transferred to another camp.

Thus, although a grievance system exists at the Challenger Camps, it lacks many of the components needed for it to be a viable avenue for youth to state their concerns. For the grievance system to meet generally accepted standards, the timeliness and thoroughness of the responses must be improved and those indicating mistreatment or abuse by staff must follow the required procedures for child abuse reporting. Finally, whether or not the youth is transferred to another camp or released to

the community, the underlying issues for all grievances must be appropriately addressed.

The grievance system at Camps Holton and Scott is similarly inadequate. At Camp Holton, only two grievances had been submitted between approximately July 2006 and January 2007. One alleged abuse by staff and was properly reported to DCFS, but not before the receiving staff member replied: "Denied. If you followed instructions and did not resist, nothing would have happened." The other protested a disciplinary write-up, and was resolved in the youth's favor. The system lacks a set of local policies to identify responsible parties, timelines, and required investigatory procedures. Further, contrary to policy, no grievance log is maintained at either Camp Holton or Camp Scott.

At Camp Scott, a new staff had been appointed to serve as the Grievance Coordinator. In this new role, the Grievance Coordinator noted that he checks the grievance boxes daily and tries to respond to each grievance within 48 hours, and to resolve each within five working days. These efforts to strengthen the grievance process, however, have yet to take root. Most of the youth interviewed were familiar with the grievance process, but the process is used very rarely. Although under development, the system as it currently exists lacks a clear set of policies to identify responsible parties, timelines, and required investigatory procedures. The absence of a consistent and fully developed orientation program, during which new youth should be adequately informed of the grievance process, may also contribute to the limited usage of the grievance system. Some of the girls interviewed acknowledged using the grievance system, or at least considering it as one means of formally expressing a complaint. Others expressed a total lack of confidence in the system, stating that they had complained previously about broken windows and clogged air vents in the dorm, to no avail.

B. Inadequate Suicide Prevention and Mental Health Care

The Constitution requires that confined juveniles receive adequate medical treatment, including adequate mental health treatment and suicide prevention measures. See Youngberg, 457 U.S. at 323-24 & n.30; Oregon Advocacy Ctr. v. Mink, 322 F.3d 1101, 1120 (9th Cir. 2003); Gibson v. County of Washoe, 290 F.3d 1175, 1187 (9th Cir. 2002); Carnell v. Grimm, 74 F.3d 977, 978-79 (9th Cir. 1996); Cabrales v. County of Los Angeles, 864 F.2d 1454 (9th Cir. 1988) vacated and remanded, 490 U.S. 1087 (1989), reinstated, 886 F.2d 235 (9th Cir. 1989); Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994); Gordon v. Kidd, 971 F.2d 1087, 1094 (4th Cir. 1992). The Camps fail to meet

these constitutionally minimal standards. Below, we describe deficiencies in the areas of suicide and self-harm prevention; mental health screening and identification; clinical assessment, treatment planning, and case management; medication management practices; mental health counseling and other rehabilitative services; and quality assurance programs.

1. Inadequate Suicide Prevention Plan

Juvenile institutions are required to adequately protect youth from self harm. Generally accepted professional standards require juvenile facilities to have a well-established suicide prevention plan. The plan should be implemented on a systematic basis and all staff members should understand it. The plan should include procedures for the placement of youth under varying levels of enhanced supervision, immediate evaluation by a mental health professional, and, if necessary, safe transfer to a psychiatric facility better capable of handling a psychiatric emergency. Staff members must be well trained on an ongoing basis in identifying and preventing youth suicides, and the facility should have a system for providing ongoing follow up to youth who have expressed suicidal ideations while in detention. The Camps fail to protect youth from self harm in the following ways: (i) staff fail to adequately assess youth for risk of suicide; (ii) the Camps fail to provide sufficient mental health services to youth on suicide precautions; (iii) staff fail to supervise youth on suicide precautions and in seclusion sufficiently; and (iv) staff lack preparation and training to respond appropriately to suicide attempts.

As an initial matter, it is critical to note that Camps Kilpatrick, Scott, and Holton have absolutely no formal suicide prevention plan in place. And the Challenger Camps' policies, practices, and training regarding suicide prevention are grossly inadequate. These deficiencies at all of the Camps place youth at grave risk of harm.

a. Insufficient Suicide Risk Assessment

A formal screening for suicide risk is necessary for all youth upon entry to the Camps. This screening should be conducted using a validated suicide risk assessment instrument. Contrary to these generally accepted practices, the Camps fail to adequately assess youth's risk for suicide upon admission, thereby exposing youth to grave risk of harm.

Not one of the Camps has procedures in place to screen youth for suicide risk upon admission. Nor does any Camp actually

provide such screening. Instead, staff and administrators reported that youth are screened at the Juvenile Halls, prior to their arrival at the Camps. The lack of screening upon entry to the Camps is troubling for a variety of reasons. First, the screening at Juvenile Halls may take place months prior to a youth's arrival at one of the Camps. A youth's risk of self harm could drastically change during that time, particularly in light of the stress and change the youth experiences as he or she transitions from the Juvenile Halls to the Camps. Second, a youth's mental health case file often does not accompany him/her from the Juvenile Halls, so relevant historical indicators and even suicide attempts may go unnoticed. Finally, the screening conducted at the Juvenile Halls provides no protection for youth transferred to the Camps from other facilities or from an extended stay elsewhere.

b. Insufficient Mental Health Services for Youth on Suicide Precautions

Youth on suicide precautions should receive appropriate follow-up care from mental health staff to assess the need for ongoing restrictions associated with such precautions and to provide treatment. In addition, a qualified mental health professional must be available for consultation during hours when staff are not scheduled to be at the facility, and this professional should be able to respond promptly when a youth requires crisis evaluation. The Camps fail to provide sufficient mental health services to youth on suicide precautions, exposing youth to grave risk of harm.

When a youth is transported to a Special Housing Unit ("SHU") on suicide precautions, the generally accepted practice is to place him on the highest level of supervision, one-to-one, until a qualified mental health professional can make an adequate risk assessment and assign an appropriate level of supervision. Contrary to this generally accepted practice, at the Challenger Camps, when youth are transported to the SHU, non-mental health professionals - individuals who are <u>not</u> trained in conducting such assessments - make the initial determinations of risk level and required level of supervision. For example, we encountered one youth whose level of supervision changed frequently, apparently as a result of determinations of risk assessment by line staff. Troublingly, this youth was never seen by mental health staff while in the SHU. In general, the role of mental health professionals in addressing the risk of self harm among youth was largely unknown to line staff.

At the Challenger Camps, we encountered numerous instances where youth at obvious risk of self harm were not seen by mental health staff within a reasonable time. For example:

- One youth was referred to mental health on 11/30/06. He was seen 11 days later, on 12/11/06. The day after he was seen, the youth made a self-harm gesture. Contrary to stated policy and practice, the youth was not transported to the SHU following this gesture. And, he was not seen by mental health staff for another three days.

- Another youth was referred to mental health on 9/23/06 and again three days later. He was not seen until 10/9/06 – more than two weeks later. Just over a month later, the youth made a suicidal gesture and was placed in the SHU. He was not seen by mental health staff at all while he was in the SHU. And, he was not seen by mental health again until 12/27/06 - more than *seven* weeks after his self-harm gesture.

- Another youth, who had a history of self-harming behavior while in a Juvenile Hall, was referred to mental health at a Challenger Camp on 12/8/06. He was not seen by mental health until 12/28/06 –- a troubling 20 days after his initial referral, and 22 hours after he had engaged in another self-harming behavior at the Challenger Camp.

- Another youth was sent to the SHU at 9:30 a.m. on 2/4/07, after he had cut his wrist during the night with a piece of metal from his wristband. Another youth on the unit had alerted the nurse to this behavior. The troubled youth was sent to the SHU with a notation indicating “recent cutting, verbalizes SI [suicidal ideation].” The youth was not seen by a mental health or a medical professional until 7:30 a.m. the following day - 22 hours after he had been sent to the SHU.

- In another incident, two youth who were brought to the SHU the previous evening on suicide precautions were not seen the next morning. When we asked mental health staff why the youth had received no mental health care, the psychiatrist stated “I forgot.”

Once placed on suicide precautions, youth at the Challenger Camps receive inconsistent follow-up care. Despite a Probation

Department policy requiring that youth on suicide precautions be seen daily by mental health staff for the first five days, as previously noted, youth often spend days in the SHU without the benefit of regular clinical contact. Moreover, none of the staff with whom we spoke knew the requirements for monitoring youth pending an assessment by a mental health professional. Staff at the Challenger Camps also do not help youth learn skills to reduce their suicidal ideations or behaviors.

Like the Challenger Camps, Camps Kilpatrick, Holton, and Scott fail to provide adequate mental health services to youth on suicide precautions. As noted above, none of these camps has a formal suicide prevention plan in place. Instead, staff are simply instructed to send youth either back to a Juvenile Hall, to a psychiatric hospital, and/or to the Challenger Camps if a chronic condition persists or a risk of self-harm develops. In the interim, however, not one of these camps has formal procedures in place to protect youth from self-harm as they await transfer to a more appropriate setting. Procedures appear to be ad-hoc in nature and not guided by formal policy and procedures.

Moreover, although staff at Camps Holton, Kilpatrick, and Scott stated that they would fill out a mental health assessment form if they felt a youth was particularly vulnerable, we found the benefits of filling out such a form to be questionable at best. At Camp Holton, the time frame within which the form would be received and a mental health professional would see the youth was unknown. At Camp Kilpatrick, as noted above, the psychologist is available only part-time and is assigned to at least two other facilities; he therefore cannot be relied upon for timely availability to youth. And, although Scott appeared to have a good practice for referring, monitoring, and transferring vulnerable youth so they could obtain mental health services, the camp does not document this practice, so it could not be verified.

c. Inadequate Supervision of Youth on Suicide Precautions and in Seclusion

Generally accepted professional standards require adequate supervision of youth on suicide precautions and in disciplinary seclusion. Staff who conduct periodic checks of such youth should document their observations and the times of their checks. Safety checks should be conducted at random intervals at least four times per hour for lower risk youth, and more often for youth at higher risk. Per the Camps' policy, a sheet is to be displayed on the door of each occupied cell with a notation of the time the youth was last visibly observed, along with the

initials of the staff member who conducted the observation. In addition, prior to their admission to the unit, youth and the room in which they will be placed should be searched to ensure that no hazards or other materials that could be used in a self harm attempt are available.

We observed a number of disturbing practices regarding supervision of youth on suicide precautions and in seclusion; these practices expose youth to grave risk of harm. Of particular concern was the falsification of Observation Forms and logs - critical papers that document the facility's supervision (or lack thereof) of youth who have been placed in the SHU and may be at risk of self harm. Specifically, at the Challenger Camps, we observed that staff certified on forms that they had conducted checks at times that had not yet arrived (for example, noting at 9:30 a.m. that a check had been done at 10:15 a.m.). We observed a similar practice on at least one form at Camp Scott. Moreover, at both the Challenger Camps and at Camp Holton, we observed logs that had times pre-printed on them; staff thus again were failing to record the actual times when safety checks had occurred. At the Challenger Camps, we also observed staff filling in the logs by writing in observation times after we noticed that the log was blank or had not included an observation time within the last hour.

Because these forms are to be completed when an actual visual check has been conducted, pre-completed forms suggest that staff assigned to these high-risk youth are actually not monitoring them in accordance with safe practices. This falsification of records calls into question the reliability of supervision for youth on such special security status, and suggests that supervision is insufficient to ensure that staff uphold these serious responsibilities. Moreover, pre-printing of set times on forms does not allow for checks of youth at random times, as dictated by generally accepted professional standards.

Despite questions about the validity of the Observation Forms in light of the disturbing falsification we observed, we requested random samplings of Observation Forms for youth in the SHU at the Challenger Camps, Camp Holton, and Camp Kilpatrick, and the Assessment Unit log for youth at Scott. At the Challenger Camps, Camp Holton, and Camp Kilpatrick, only a handful of the forms we requested could even be located. Our review of the forms revealed multiple additional failures to follow generally accepted practices to protect youth on suicide precautions or in disciplinary seclusion from self harm. Deficiencies included the following:

- Safety checks were not being conducted randomly at least four times per hour (the Challenger Camps, Camp Scott, Camps Kilpatrick).

- Many of the forms revealed gaps of 30 minutes to several hours during which youth were not monitored at all (Camp Holton).

- Forms contained no documentation of visits by medical or mental health staff (Camp Holton, Camp Kilpatrick). At both camps, youth reported having seen the nurse, but said they did not see mental health staff.

- Instead of using individual forms for each youth, checks were documented for the entire hall on a single sheet (Challenger Camps, Camp Scott).

- Staff did not document the condition of the youth at the time of observation (e.g., sleeping, crying, eating, etc.) (Challenger Camps).

- The forms did not evidence any supervisory review (Challenger Camps, Camp Scott).

- The location (Dorm or Assessment Unit) was not marked (Camp Scott).

- The length of time in confinement indicated in the Observation Logs did not match the time in confinement indicated in the movement log (Camp Holton).

Apart from the serious issues evidenced in our review of the Observation Forms and Assessment Unit logs, at the Challenger Camps, we observed multiple additional troubling instances where staff failed to adequately supervise youth in the SHU, in direct contravention to Probation Department policies. For example, although Probation Department policy requires that the level of enhanced monitoring be gradually decreased over time as the youth's level of risk of self-harm decreases, we found three separate instances where youth were returned from the SHU to the general population without any gradual decrease in supervision. Moreover, direct care staff had placed one of these youth in a room providing only supervision by camera upon his entry to the SHU, in direct contravention of the policy prohibiting the camera room from substituting for direct care staff observation. Although the youth was later placed on one-to-one supervision after a mental health assessment, one-to-one supervision should have been the default level upon his placement in the SHU. In

another instance, a staff member providing one-to-one supervision to a youth did not have any information as to what behavior prompted the high level of supervision; the staff member reported being told only to make sure the youth's hands were visible at all times. Yet another staff member was performing one-to-one supervision while he had a novel on the chair next to him. It is inappropriate for staff to do anything other than observe a youth who is placed on one-to-one supervision. Such failures to supervise youth in the SHU put already vulnerable youth at risk of grave harm.

Finally, the Camps fail to adequately supervise youth at the outset of their placement in the SHU. At the Challenger Camps, although youth's general population clothes are shaken out and youth are required to put on a SHU uniform, youth are not routinely searched prior to placement in the SHU. Similarly, youth are not routinely searched prior to admission to Holton's SHU. A youth thus could conceal a weapon or other contraband on his or her person and bring it to the SHU. Indeed, at Camp Scott, a youth gave herself a tattoo while confined to that camp's assessment unit. This strongly suggests that search procedures prior to her admission were inadequate. Moreover, the Challenger Camps require a youth to search his own SHU room to ensure that the youth is not unfairly accused of property damage in the room. Staff - not youth - should be responsible for all searches so that the Camps can ensure that youth do not have access to contraband and potential self-harm items.

d. Lack of Preparedness for Suicide Attempts and Other Self Harm

Staff training in suicide prevention measures at the Camps also departs from generally accepted professional standards. Because the risk for suicide may be present at admission or may develop during incarceration, it is critical at each juncture that staff who interact with potentially suicidal youth be trained to detect, assess, and if necessary, intervene to prevent a suicide. The generally accepted practice is for all staff to receive suicide prevention training as part of both pre-service and annual training. The Camps fail in this regard, exposing youth to grave risk of harm.

The Camps' training statistics are alarming. Half of all staff at Camp Kilpatrick, and one-third or more of all staff at the Challenger Camps, Camp Holton, and Camp Scott have never received formal training in suicide prevention. Yet, these staff are responsible for the safety of vulnerable, potentially suicidal youth on a daily basis.

Annual suicide prevention training at the Camps is nearly non-existent. As of our visits in early 2007, since January 2006, no staff at Camp Holton had received refresher suicide prevention training; only 5% had received it at Camp Kilpatrick; just 18% had received such training at the Challenger Camps; and only 33% at Camp Scott. Even when the training statistics are expanded to encompass the entire course of a staff member's career, the numbers continue to paint a dismal picture: only an additional 33% of Scott staff had ever received suicide prevention training, only an additional 45% had received it at Camp Kilpatrick and the Challenger Camps, and just an additional 67% had received training at Camp Holton.

Based on the training statistics, it is not surprising that staff at all of the Camps lack knowledge and strategies for de-escalating youth who engage in self-harming behaviors. For example, at the Challenger Camps, even staff assigned to monitor youth on the highest level of suicide precautions have no guidance as to how to respond to youth who make statements indicating they are considering self harm. Indeed, Challenger staff gave widely conflicting accounts as to the Camps' policy and practice for safely managing youth who exhibit suicidal ideations. In one of the most egregious examples, one staff member stated that OC spray should be used to stop a suicide attempt in progress.

Additionally, at all of the Camps, many staff were frighteningly unaware of how to intervene appropriately in the event of an actual suicide attempt. For example, staff did not know how to relieve pressure on the neck in the event of a hanging or how to use the cut-down tool. In fact, at the Challenger Camps, although most staff were aware that cut-down tools had recently been placed in a lockbox in the control center of each dorm, none had received any training or instruction on how to use the tool. Indeed, when asked to open the box and remove the cut-down tool, the supervisor of the SHU was unable to do so; his key did not appear to fit the lock. At Camp Scott, staff also had received no formal training in the proper use of the cut-down tool.

Staff at Camp Holton also were unaware of any formal criteria used to determine the appropriate level of monitoring by staff (e.g., 15-minute checks versus constant observation), or even of any formal procedures for notifying mental health staff or anyone else in the event a youth expressed suicidality. Staff at Camp Scott likewise were unaware of procedures for monitoring youth who had expressed intent to harm themselves. In addition, at both Camp Scott and Camp Kilpatrick, staff lacked awareness of

the ways in which depression manifests itself in adolescents (e.g., fighting, failing to follow instructions, or letting others take advantage of them).

Finally, we found that emergency intervention measures at the Challenger Camps were wholly inadequate. For example, first aid kits and rescue tools (e.g., blades to cut ligature from around a hanging victim's neck) were not available. These failures to have emergency equipment readily available to trained staff can mean the difference between life and death to youth at the Camps.

2. Inadequate Mental Health Care

Because youth who have the most serious mental health needs are sent to the Challenger Camps, those camps are largely the focus of the mental health care deficiencies in this letter. Nonetheless, it is important to note that none of the Camps provides adequate mental health services to youth. The Camps' deficiencies include: (1) inadequate mental health screening and identification; (2) inadequate clinical assessment, treatment planning, and case management; (3) inadequate medication management practices; (4) inadequate mental health counseling and other rehabilitative services; and (5) inadequate quality assurance programs.

As an initial matter, many of the deficiencies described below are attributable to staffing shortages. Specifically, the Challenger Camps have only one full-time psychiatrist, and a new part-time psychiatrist. In addition, they have three full-time clinicians, two half-time clinicians and two interns (who are present on Fridays and Saturdays), along with two primarily administrative positions of Clinical Program Manager and Clinical Supervisor. Having only five and a half full-time equivalent clinicians for a population of more than 400 youth with serious mental health needs is clearly inadequate.

Of similar concern is the lack of adequate mental health staffing at Camp Kilpatrick. Camp Kilpatrick's licensed psychologist - the camp's only mental health professional - valiantly divides his time between Camp Kilpatrick and at least two other facilities. In doing so, he keeps no set schedule; rather, he sets his time at the facility based on staff referrals of youth to him. Indeed, none of the youth on the psychologist's caseload were self-referred, and he is not notified about youth placed in the Special Housing Unit in any systematic way. Moreover, he has not even been provided office space on site; consequently, he is forced to carry his notes and files with him

at all times and is at the mercy of other staff and the facility's schedule when he needs to find suitable private spaces where he can meet with youth. In the psychologist's professional opinion, the youth at Camp Kilpatrick are not being served properly with regard to mental health treatment. At Camp Kilpatrick (and at the Challenger Camps), interventions consist of "crisis management," where the psychologist acts more like a social worker than a psychologist. Camp Kilpatrick's psychologist sees individual youth for approximately eight hours per week, a length of time he believes is insufficient to meet their needs. He sees about 10 youth at the camp on a regular basis, but stated that, because of staffing constraints, he is unable to provide ongoing psychotherapy. He also is unable systematically to contact family members of youth to engage family in support of treatment. Although he has attempted to enlist the assistance of interns to expand mental health access at the camp, administrative obstacles have prevented him from being able to do so.

These staffing limitations inevitably affect the quality of mental health care and place these already vulnerable youth at significant risk of harm.

a. Inadequate Intake Screening and Identification

Generally accepted professional standards require that all youth entering secure facilities receive a reliable, valid, and confidential initial screening and assessment to identify psychiatric, medical, substance abuse, developmental, and learning disorders, as well as suicide risks as discussed above. The assessment should include assessment of suicide and homicide risk factors and past behaviors. Based on this screening and assessment, staff should refer youth for any required care. To do this, staff must gather available information, such as a youth's previous records from past admissions, and gather important information needed to care for and treat the youth. The information must be communicated to appropriate personnel so that each youth's needs are appropriately and timely addressed.

We find the efforts to identify youth with mental health disorders at the Challenger Camps significantly lacking. Not only do the Challenger Camps fail to screen youth for suicide risk, as described above, but they also fail to screen youth for other mental health issues at intake and fail to review youth's previous records. As with suicide risk screening, to the extent <u>any</u> mental health screening is performed, it is done only at the time the youth is admitted to the Juvenile Halls. Of additional concern, there is no protocol to ensure that mental health charts

and information are transmitted from the Juvenile Halls to the Challenger Camps. Thus, mental health screening information generated at the Juvenile Halls often does not follow a youth to the Challenger Camps. Consequently, the mental health team at the Challenger Camps often has no way of knowing a youth's mental health history and current medication needs or history. If documentation does not follow the youth to the Challenger Camps, and a current mental health screening is not performed upon a youth's arrival, it is impossible to identify and appropriately address a youth's mental health needs.

The intake process at the Challenger Camps consists merely of noting in a youth's medical chart those youth who come in on psychotropic medication and then scheduling a future appointment with the psychiatrist. Our observations, interviews with youth, and the facilities' own documentation indicate that a significant number of youth who manifest mental health disorders are not being identified, and thus are not being treated. These failures expose youth to significant risk of harm.

Moreover, the records provided to us reveal that the facilities have no reliable documentation system in place to actually identify youth who are receiving mental health services. At the time of our visit, the population roster listed 432 youth as living at the Challenger Camps. The mental health services roster of youth currently on the mental health caseload, however, indicated that 433 youth - a number one greater than the then-current population - were receiving mental health services. As reported to us, this suggested that every youth at the Challenger Camps was on the mental health caseload. When we cross-referenced the mental health services roster with the population roster, however, we discovered that only 192 names - fewer than half - matched. Even more disturbing, the mental health staff for the Challenger Camps identified 86 youth who were currently receiving psychotropic medications; of them, seven were not on the population roster and another eight were not on the mental health roster.

Based upon these conflicting figures, it is readily apparent that the Challenger Camps lack any uniform tracking system to identify youth currently at the facilities, youth receiving mental health services, and youth on psychotropic medications. If we rely upon the figures provided, it appears that only 46% of the total population at all of the Challenger Camps is receiving mental health treatment (192 youth plus the additional seven youth receiving psychotropic medications who are not on the mental health caseload). This statistic suggests that the facilities are not identifying and treating all the youth in need

of mental health services, particularly in light of the fact that all youth who have mental health needs are sent to the Challenger Camps and that, statistically, as many as 65-75% of youth in juvenile facilities have a diagnosable psychiatric disorder.[17] The failure of the Challenger Camps to adequately identify youth who have significant mental health disorders is a substantial departure from generally accepted professional standards.

In short, the initial screening and assessment process fails to achieve all of its primary goals: the process does not identify youth who need immediate services, refer them for services in a timely manner, screen out youth who should be hospitalized rather than admitted to the Camps, or gather and disseminate necessary information to share with staff caring for the youth.

b. Inadequate Clinical Assessments, Treatment Plans, and Case Management

Generally accepted professional standards require timely specialized clinical assessments of youth who have potential mental health needs, development of treatment plans to guide youth's care, and implementation of those plans. The Challenger Camps fail to provide adequate clinical assessments, treatment plans, and case management.

i. Inadequate Clinical Assessments

Youth who are identified at intake as exhibiting behaviors associated with mental illness and/or substance abuse disorders must receive a timely assessment that includes the gathering of prior assessments, treatment history, and other information to confirm a diagnosis and determine an effective course of intervention. This process does not occur at the Challenger Camps, and the consequence for youth is haphazard, uncoordinated, and inadequate care.

As a result, some youth with serious immediate needs slip through the cracks and receive services far too late, or never, because of poor documentation and insufficient staffing levels.

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[17] Los Angeles County Juvenile Justice Coordinating Council, Comprehensive Multi-Agency Juvenile Justice Plan, at 57 (Mar. 20, 2001) (stating that both the National Mental Health Association and federal studies generally estimate that as many as 65-75% of incarcerated youth have a mental health disorder, and 20% have a severe disorder).

Other youth who are in need of an assessment are missed entirely because of the lack of screening. And, as described more fully in the medication management section below, even where youth are referred to mental health, they do not consistently receive an assessment.

Moreover, as a general practice at the facilities, it is our understanding that neither the psychiatrist nor any other member of the mental health staff reviews prior treatment records or contacts community therapists, parents, or probation officers for critical developmental and treatment histories. This is not acceptable.

ii. Inadequate Treatment Planning

In order for youth to receive adequate mental health treatment, they must be provided adequate treatment plans that guide their care. Treatment planning requires the identification of symptoms and behaviors that need intervention, and the development of strategies to address them. Such planning is a critical part of generally accepted professional standards and is critical for effective treatment of serious mental illness, ensuring that youth are receiving appropriate services, and allowing for the tracking of the youth’s progress.

The Challenger Camps lack any kind of formal treatment planning. Although recommendations for services are listed as part of initial assessments (to the extent such assessments occur at all), no treatment plans are identified. Although case workers write documents called “treatment plans,” these are, in reality, generally uniform sets of exercises designed to help youth develop insights about their delinquent acts, their behavior, and their future plans. They are wholly unrelated to mental health treatment planning.

Moreover, we found that, to the extent the Challenger Camps have any unofficial treatment planning, that planning fails to target specific symptoms or articulate meaningful strategies; does not involve important contributors, such as family members, previous therapists or psychiatrists, or any other system of care in which the youth may be treated; and fails to provide for measuring whether the plan is working. The treatment planning also rarely identifies co-occurring substance abuse disorders as primary goals of treatment, even though effective treatment of mentally ill youth with substance abuse disorders must address these issues simultaneously. Particularly troubling, the Challenger Camps have no substance abuse treatment programming, even though staff estimate that 70% of youth at the facilities

meet the criteria for a substance abuse disorder. The lack of such a treatment program grossly departs from generally accepted professional standards. In addition, the Challenger Camps have no system for establishing individual treatment plans or behavioral plans for youth frequently placed in the Special Housing Unit.

The Challenger Camps also fail to adequately involve families in any kind of treatment planning, despite the fact that families are an extremely important source of clinical information and that it is not possible to conduct an adequate overall functional mental health assessment without including current and historical information from families. Challenger staff reported that family meetings/therapy cannot be conducted on a regular basis because no clinicians are available on Sundays, which is the day families are permitted to visit. The resulting lack of assessment of family, social, and developmental history and the lack of family involvement can handicap clinicians in creating appropriate treatment plans.

iii. Inadequate Case Management

Case managers should communicate treatment plans for mentally ill youth to all staff involved in the management of youth in a juvenile justice facility, and should coordinate implementation of the plans. Although all youth at the Challenger Camps are assigned case workers in their residential units, these case workers have no mental health training, and serve as liaisons between the facilities and the probation officer, rather than coordinating care at the facilities for mentally ill youth. As described above, they write documents called “treatment plans,” but these documents have nothing to do with mental health treatment.

Moreover, staff who come in daily contact with youth must have sufficient information about youth’s mental health symptoms so that they can understand and respond appropriately when youth manifest such symptoms. Communication between mental health staff, health staff, custody staff, case managers, teachers, community probation officers, and parents regarding the treatment of youth at the Challenger Camps is grossly inadequate. Mental health staff do not share appropriate information with other personnel who need this information to supervise youth safely and meet their needs. For example, custody staff do not receive guidance about the behaviors that mentally ill youth display that stem from their mental illnesses. As a result, custody staff misconstrue psychiatric symptoms as intentional behaviors, and inappropriately apply ineffective discipline in an attempt to

reduce the troubling behavior. In addition, youth often target other youth who exhibit mental health problems, thereby exacerbating their symptoms.

Further, contrary to generally accepted professional standards of care, the Challenger Camps do not provide aftercare planning discharge summaries to facilitate treatment in future placements. Our review of 31 mental health records revealed that only seven contained some level of aftercare planning, and none were adequate. Although staff reported that aftercare planning is an important part of a youth's stay at the Challenger Camps and begins at the time of admission, we saw no evidence or documentation of such planning in the records we reviewed. The failure to communicate the goals, successes, and failures of treatments tried at the Camps may compromise future attempts at treatment for youth in other settings.

c. Inadequate Psychotropic Medication Management

Generally accepted professional standards include, where appropriate, the use of psychotropic medications to augment a mental health treatment plan. The care of youth on psychotropic medications requires proper assessment and management by a psychiatrist. Medications prescribed should have a known benefit to treat the symptoms identified, based on a valid diagnosis and understanding of the root causes of the illness, and medication changes should follow documented monitoring of the effects of previous medication choices and reasons for abandoning a previous approach. Youth and their parents or guardians should be informed about the benefits and risks of medications and give informed consent for their use. Careful monitoring through laboratory tests is necessary to ensure that youth do not experience harmful side effects of many psychotropic medications.

Based on our review, the Challenger Camps have serious deficiencies in these areas, exposing youth to risk of grave harm. First, we noted lengthy delays in the initial psychiatric review of youth on psychotropic medications. For example:

- A youth arrived on 11/24/06 with a notation in his chart that he had been taking medications prior to his arrival at the Challenger Camps, and an "ASAP" request for a psychiatric evaluation. No response was noted in his chart. Two more requests for a psychiatric evaluation followed on 12/7/06 and 12/18/06, both also marked "ASAP," and both had no response noted. The psychiatrist did not see the youth until 12/29/06 - more than a month after the youth arrived at the camp.

- Another youth arrived at a Challenger camp on 1/3/07, and a request for medication evaluation for him was similarly marked “ASAP.” Again, no response was noted. Shortly thereafter, the youth’s mental health services were terminated as a result of his “asking for things and getting angry.” Ironically, it appears that the youth was denied mental health treatment because he was exhibiting possible signs of a mental health disorder.

Instead of promptly evaluating youth who have been prescribed psychotropic medications prior to their admission, the mental health staff at the Challenger Camps automatically continue youth on those medications until they are seen by a facility psychiatrist. This means that rather than verifying the medication and obtaining a verbal order from the camps’ psychiatrist (thus sanctioning the use of the medication until the youth can be seen for an in-person evaluation), medical staff assume that the youth is taking the medication pursuant to a valid prescription, and that the medication is being prescribed for the appropriate reasons. This practice is particularly dangerous because, as discussed above, in many cases, the mental health records do not accompany the youth to the Challenger Camps. We saw many cases where admitted youth had a history of taking psychotropic medications, but had no records to document diagnosis, side effects, or past efficacy of treatment efforts. These youth nonetheless were continued on their medications. Moreover, as described above, we identified seven youth who were prescribed psychotropic medications but were not being seen by mental health staff because they did not appear on the mental health caseload.

For youth who did not enter the facilities already on psychotropic medications, the provision of such medications to youth at the Challenger Camps who need them is inconsistent at best. Some youth are prescribed psychotropic medications without the benefit of appropriate evaluations or systematic physiological monitoring. Other youth are not provided with medications to treat their symptoms at all. Still other youth are referred for psychiatric evaluation for “urgent” medication evaluations because of side effects from the medications or other mental health concerns and either are never seen by the psychiatrist or are seen weeks after the request for referral.

Moreover, where youth are placed or continued on psychotropic medications, the Challenger Camps have no protocols for providing monitoring or periodic reassessment. Specifically, although many of the medications youth at the Challenger Camps are taking require laboratory tests prior to and during the

course of the treatment, we found no protocols for the administration of appropriate tests to monitor the efficacy and side effects of psychotropic medications in accordance with professional medical standards. Additionally, the frequency of psychiatric follow-up depends, in many cases, upon when the psychiatrist has time to evaluate the youth. Often, such evaluation does not occur for months after the youth's arrival. We found a wide range of follow-up frequency, from several weeks to more than 60 days. For example:

- One youth's chart contained an "ASAP" request for medication evaluation dated 1/20/07, as well as a second request on 2/3/07. Despite these repeated urgent requests, as of our tour on 3/7/07, the youth's chart contained no documentation indicating that a psychiatric evaluation had occurred.

- Another youth was referred from another camp on 9/26/06 for an "urgent" medication evaluation because he had been having "severe headaches" and was "very irritable" since stopping his medications. Although he denied suicidal ideation, he made the statement, "I can't make it." He was housed in the Special Housing Unit pending a psychiatric evaluation, which he did not receive for more than a week.

In addition, although the case files reviewed all included signed consent forms for treatment, it does not appear that the Challenger Camps involve families in youth's therapy and treatment, including when the treatment includes psychotropic medications. Families should be involved, where possible.

Finally, as discussed above, youth at the Challenger Camps are discharged from the facilities without aftercare planning, including medication or prescriptions, thus making it likely that their medications will be discontinued precipitously. This can be dangerous. See, e.g., Wakefield v. Thompson, 177 F.3d 1160, 1164 (9th Cir. 1999) (in the context of a prisoner who was receiving psychotropic medication while incarcerated, holding that the State "must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply.").

d. Inadequate Mental Health Counseling and Other Rehabilitative Services

Generally accepted professional standards require that mental health counseling be provided frequently and consistently enough to provide meaningful interventions for youth. Treatment should utilize approaches that generally accepted practices have determined are effective. Youth with mental illness should receive treatment in settings appropriate to their needs.

We have noted previously the lack of adequate mental health counseling and rehabilitative treatment at Camp Kilpatrick. At the Challenger Camps, mental health counseling is also inadequate to meet the needs of mentally ill youth both in frequency and in content. The limited counseling records that exist do not evidence adequate use of effective treatment strategies. Despite the presence of some caring, dedicated counselors, interventions are not structured toward specific goals and do not adequately involve approaches accepted as effective. As discussed above, many youth are prescribed psychotropic medications to manage their behavior, but receive no counseling whatsoever. Indeed, as noted above, the youth with mental health needs are housed at the Challenger Camps; yet, as the Director of Mental Health Services at the Challenger Camps explained to us, mental health services at the Challenger Camps consist of “mostly crisis intervention.”

Troublingly, the Challenger Camps fail to provide adequate individual and group therapies. Both types of therapy are critical to effective treatment in detention settings and are required by generally accepted professional standards of practice.

Of equal concern is the lack of a substance abuse treatment program. Staff generally do not examine individual patterns of use, abuse, addiction, or motivation, nor do they instruct youth in alternative stress management or abstinence support techniques. We found similar deficiencies in this area at Camp Holton, as well.

Recordkeeping also is inadequate. Mental health staff must keep records in a manner that allows both mental health and non-mental health staff at the facility, as well as future providers, to track treatment previously provided. Records of prior interventions are critical to guide staff regarding effective methods of crisis intervention. Counseling records at the Challenger Camps are incomplete, as evidenced by the failure to document follow-up to mental health referrals, including those involving requests for treatment, medication side effects,

discontinuation of psychotropic medications, and suicidal thoughts.

The lack of family involvement in treatment is concerning. Counseling staff fail to adequately involve youth's families in therapy and treatment interventions, thus reducing the effectiveness of any attempt at rehabilitation for youth who plan to return to their families following detention.

Additionally, generally accepted professional standards require juvenile facilities to provide opportunities for rehabilitation that include effective behavior management systems. Effective behavior management systems generally involve incentive-based programs for promoting appropriate behaviors throughout the day, and clearly defined guidelines that are consistently applied across each institution. For youth identified as having behavioral health problems, behavior management programs need to be coordinated with a treatment plan. Appropriate rehabilitative programs for youth confined in juvenile justice facilities include programs that address family conflict, substance abuse, anger management, gang affiliation, and other issues youth in a juvenile justice system typically face.

Contrary to these generally accepted professional standards, the Challenger Camps do not have an adequate behavioral management system in place. As a result, the goals of custody staff and mental health providers are not coordinated, and youth do not benefit from the little mental health treatment that is provided.

e. Inadequate Quality Assurance Program

Generally accepted professional standards require juvenile facilities to establish a quality assurance program to continuously evaluate the processes and efficacy of mental health treatment. The Challenger Camps lack any such program. Indeed, they do not even conduct internal audits; at most, the Los Angeles County Department of Mental Health conducts yearly audits. The risk of inadequate treatment without accountability or oversight is extremely high. The lapses in care discussed above should not have to be discovered by outside auditors or agencies. And, they would be less likely to occur in the first instance if adequate internal review processes were in place.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of the youth confined at the Camps, the County should implement, at a minimum, the following measures:

A. Protection of Youth From Harm

1. Ensure that youth are adequately protected from staff abuse and abusive institutional practices such as “slamming,” or “assuming the bob sled position.”

2. Develop and implement a use of force policy that provides clear guidelines and appropriate limits on the use of force, including OC spray. Ensure that OC spray is used only where there is an imminent risk of serious bodily harm and no other less intrusive restraint is available, and that policies regarding disqualifying conditions for use of OC spray are developed and followed. Ensure that all uses of OC spray or chemical restraints are well-documented and reviewed in a timely manner by senior administrators.

3. Ensure that staff neither threaten or intimidate youth from reporting abuse or mistreatment, nor maintain or

4. Ensure that the facilities maintain sufficient levels of adequately trained direct care staff to supervise youth safely. Provide sufficient staff supervision to keep youth safe from youth-on-youth violence and allow rehabilitative activities to occur successfully in accordance with generally accepted professional standards.

5. Improve orientation to communicate important information to new residents, such as how to access the grievance system, medical care, and mental health services.

6. Ensure that there is an adequate, appropriate, and effective behavior management system in place, and that the system is regularly reviewed and modified in accordance with evidence-based principles.

7. Provide adequate training and supervision to staff in all areas necessary for the safe and effective

performance of job duties, including training in child abuse reporting and training in the safe and appropriate use of force and physical restraint, the use of force continuum, and de-escalation techniques. Routinely provide refresher training as required by generally accepted standards.

8. Ensure that all allegations of child abuse and mistreatment are promptly referred to the appropriate authorities.

9. Ensure that serious incidents, allegations of abuse, and allegations of staff misconduct are adequately and timely investigated.

10. Ensure that the facilities provide adequate protections for youth once abuse has been reported, and safe avenues through which youth may report mistreatment.

11. Ensure that the facilities develop and implement an adequate objective housing classification system to ensure safe and appropriate housing assignments.

12. Ensure that the facilities develop and maintain an adequate youth grievance system that ensures youth access to a functional and responsive grievance process.

B. Suicide Prevention and Mental Health Care

1. Develop and implement an adequate formal suicide prevention policy, procedure, and protocol.

2. Develop policies and procedures to reduce the risk of self harm and suicidal behaviors, to include adequate suicide risk assessments in accordance with generally accepted professional standards.

3. Develop and adhere to specific protocols for mental health involvement for all youth identified as being at risk of suicide.

4. Adequately and effectively monitor all youth who are placed on suicide precautions in accordance with generally accepted professional standards in order to reduce the risk of self harm, and accurately document the frequency of all safety checks.

5. Create and implement a procedure for enacting suicide precautions pending transfer to another facility for assessment.

6. Provide staff with adequate training to identify and supervise youth at risk for suicide, including training on suicide prevention measures such as the proper use of cut down tools, and re-train staff annually to refresh their skills and knowledge of suicide prevention procedures.

7. Provide and maintain adequate mental health care staffing.

8. Provide an adequate, comprehensive, reliable mental health screening and assessment at intake.

9. Develop and implement policies, practices, and procedures for identifying youth receiving mental health services and youth on psychotropic medications.

10. Maintain accurate and complete mental health records; ensure that all relevant records are forwarded from the Juvenile Halls in a timely manner.

11. Provide ongoing training, proper supervision, and reasonable accountability for mental health clinicians in accordance with generally accepted professional standards.

12. Provide timely evaluations to youth referred for mental health services.

13. Establish and maintain adequate formal treatment planning in accordance with generally accepted professional standards.

14. Establish and maintain adequate mental health programming, including substance abuse programming, and the case management thereof.

15. Establish and maintain protocols to monitor youth who are on psychotropic medications in accordance with generally accepted professional standards.

16. Provide aftercare planning discharge summaries to

17. Establish and maintain an effective quality assurance program consisting of established policies and procedures by which to judge the quality and success of treatment.

* * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until 10 calendar days from the date of this letter.

The collaborative approach the parties have taken thus far has been productive. We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns with regard to the Camps. Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical, technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at prompt remediation.

We are obligated by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you.

Accordingly, the lawyers assigned to this matter will be contacting your attorney to discuss next steps in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General

cc: Robert Taylor
Chief Probation Officer

Raymond G. Fortner, Jr.
County Counsel

Gordon Trask
Principal Deputy County Counsel
Law Enforcement Services Division

Leon Bass, Director
Camp Clinton B. Afflerbaugh

Edward Anhalt, Director
Camp David Gonzales

Lynn Duke, Director
Camp Karl Holton

Harold Soloman, Director
Camp Gregory Jarvis

Craig Levy, Director
Camp Vernon Kilpatrick

Mike Varela, Director
Dorothy Kirby Center

Luis Domiguez, Director
Camp Ronald McNair

Gary Thomas, Director
Camp William Mendenhall

Alex Williams, Director
Camp Fred Miller

Daniel Moreno, Director
Camp John Munz

Randy Herbon, Director
Camp Joseph Paige

Trenier Woodland, Director
Camp Judith Resnick

Eduardo Silva, Director
Camp Glenn Rockey

Charlie Trask, Director
Camp Louis Routh

Jennifer Owen, Director
Camp Scott

Walter Mann, Director
Camp Francis Scobee

Michelle Guybon, Director
Camp Kenyon Scudder

Walter Mann, Director
Camp Michael Smith

The Honorable Thomas P. O’Brien
United States Attorney for the
Central District of California

Audit finds continuing problems at LA County juvenile halls 2013

Audit finds continuing problems at LA County juvenile halls

By Christina Villacorte, Los Angeles Daily News

POSTED: 12/24/13, 2:28 PM PST | UPDATED: ON 12/24/2013 1 COMMENT

The Los Angeles County Probation Department is stumbling in its implementation of reforms demanded by the U.S. Justice Department at juvenile halls, according to a recent audit.

In a report to the county Board of Supervisors, Auditor-Controller Wendy Watanabe explained her office continued monitoring the juvenile halls after the DOJ concluded in 2009 that the department had already completed the reforms listed in a consent decree.

After an audit early last year, she noted, “Probation was not always complying with all the settlement agreement requirements.”

Follow-up audits — one at the beginning of this year, and another conducted recently — tracked the problems and found they had not been corrected.

“Overall, Probation has not made significant progress,” Watanabe wrote in her report.

Probation deputy chief Sharon Harada said the department strives to fulfill the consent decree as much as possible.

“We do internal checks but it’s a daily process and we have three shifts in every juvenile hall,” Harada said.

“We do the best we can,” she added. “We always want to be in compliance. Sometimes, we are not always 100 percent, but we are definitely trying.”

The audit found that juvenile hall staff sometimes abandoned minors who required “enhanced supervision,” and pepper sprayed minors despite risks to their health.

It also noted that supervisors did not always properly review incidents of staff resorting to force against minors.

“Probation management needs to continue to ensure that supervisors conduct timely and thorough reviews of use of force incidents (i.e. involving soft restraints, chemical restraints, or physical interventions),” the audit said. “Probation management also needs to ensure that staff members do not leave their assigned post, or leave minors unattended while on enhanced supervision status.”

The audit found an instance where a staffer left 10 minors unattended. There were also cases where staffers left one or two minors without supervision.

Staff at the juvenile halls are supposed to list the names of minors who cannot be subjected to pepper spray because they’re on psychotrophic medication or have fragile medical conditions, such as heart disease and asthma.

The audit, however, found that six of the 48 minors pepper sprayed from December 2012 through February 2013 were on that “do not spray” list.

In a letter to Watanabe, Probation Chief Jerry Powers explained three of the minors were involved in a gang fight, two others were trying to escape, and one minor was assaulting staff, making the use of pepper spray “acceptable under the circumstances.”

He acknowledged, however, that staff should have immediately reported their use of pepper spray, and referred the minors to mental health consultation afterwards.

Not all of the staff had the required pepper spray canisters. During the audit, two had to retrieve theirs from their car and their locker, another admitted having left hers at home, while another said his had been stolen over a month ago.

One staffer's canister was missing nine bursts of pepper spray. She said it was because she had dropped it at home a month before, causing it to discharge.

Powers agreed with the findings of the audit, and said "corrective action" is underway.

"Additionally," he added, "Probation's internal audit team has conducted random audits at the juvenile halls to identify deficiencies in staffing, specifically in the supervision of minors who have been placed on enhanced supervision status."

Powers said staffers have been provided written instructions on proper procedure. In at least one case, disciplinary action is being considered.

On the plus side, the audit found that Probation has been able to implement strategies for reducing youth-on-youth violence, including training staff in behavior management and response to gang dynamics.

Understaffing in Alameda JH- pepper spray

THE BLOG 08/21/2015 07:27 pm ET Updated Aug 21, 2016 Huffington Post

Unlocked: The Understaffing of Juvenile Hall

By Youth Radio — Youth Media International

2015-08-21-1440198228-1815088-photoB.jpg

By: Brett Myers

Reported over four months, Unlocked is a three-part investigation into alternatives to juvenile incarceration-both model programs and cases that raise serious concerns. From Alameda County in San Francisco's East Bay, to Wayne County, Michigan, Youth Radio reveals how moves away from juvenile incarceration are affecting youth and the system.

In 2007, Alameda County, California, built a new Juvenile Justice Center, a $176 million complex of courtrooms, law offices, and a huge, 360-bed incarceration facility — juvenile hall. This May, I visited the hall, where Superintendent Christian Muñoz showed me around. He told me he'd been having trouble keeping the facility staffed.

"We survive on overtime," he said. "It's that bad."

Across the country, there are efforts to close outdated and dangerous juvenile incarceration facilities. But even in places with so-called "model" juvenile halls, counties often struggle to meet the minimum standards. Alameda County's facility, based in San Leandro, receives generally high marks, but faces some major challenges.

The inmate headcount here is the lowest it's been in five years. Yet, overtime for guards is more than double what it was five years ago, according to public salary reports. Just minutes into showing me around, an announcement squawked across Muñoz's walkie talkie:

"If you're interested or available to work, please give me a call in the junior-seniors office."

The evening shift was starting in less than an hour and Muñoz was short six people. He told me this happens all the time. There are lots of reasons for the staffing shortage: guards retiring, moving over to the adult system, or filing for workers comp. Across the state, hiring into the juvenile system is a challenge. Background checks often eliminate candidates because of past criminal activity or even for having stains on their credit history.

"It's difficult to run a lemonade stand like that," Muñoz said.

"Any time you're talking about supervising human lives it's an enormous amount of responsibility," he said, "and a liability for us as well."

2015-08-21-1440195743-6200399-photoD.jpg

We kept moving throughout the facility, eventually pausing in the section called Unit One. It's two stories high with 15 cells on each level. From where we stood, I could hear the sound of running water from the showers nearby.

On this particular day, there were three guards are on duty — two of them working the upper and lower decks, shuffling kids back and forth from their cells to the showers. The guards were also doing room checks, looking for contraband like food, cell phones or weapons.

Suddenly, a commotion broke out. A teen named Rudy had just returned to his cell to discover that the cookies and snacks he had stashed away had been confiscated. As punishment for having food in his cell, he had also been docked 15 minutes of rec time. He was upset — yelling, and refusing to go back inside his cell.

A female voice rang out across the unit: "Rudy!" It was Bonnie Lacy, one of the guards working Unit One. "Wait a minute," she told another guard, "let me go get him."

She walked toward Rudy, making eye contact as she addressed him. "Fifteen minutes for me" she said, emphasizing the "me." It wasn't a command exactly — her voice was flavored with warmth as well as firmness. The words had their desired effect on Rudy. He turned around, stepped into his cell, and closed the door.

Afterward, the superintendent and several guards told me they prefer to talk through conflicts like this with kids. But incidents can escalate quickly. According to county records obtained by Youth Radio — guards at Alameda County's Juvenile Hall used pepper spray 147 times last year.

Ninety percent of state-run juvenile correctional agencies don't allow guards to carry pepper spray at all.

But here, with guards working an average of 30 hours of overtime per week, there has been an increase in the use of force on juvenile inmates — like guards performing take-downs or handcuffing detainees. The department calls these acts "use of physical and mechanical restraints," and that number has nearly tripled in the last five years.

Understaffing is a big part of the issue. "You know you've got a couple of staff watching a number of kids, and things happen," said Ray Colón, a Supervisor at Alameda County's Juvenile Hall who has been working there for 25 years.

2015-08-21-1440195905-2884746-infographic.jpg

During waking hours, the state mandates a minimum of one guard for every ten kids in detention. But Colón added:

"The kids don't always get the services they should get, because we're running short," he said. "They spend more time in their room, which is unfortunate, but it's the reality of not having the staff to complete the duties we need to do."

When they're short on guards, supervisors sometimes run what they call split recs — basically dividing recreation, exercise, and dinner time in half. Fifteen kids come out while the other 15 remain in their cells.

18-year-old Malik spent more than four months incarcerated in Alameda County Juvenile Hall. He says when young people are locked in their cells with the rec time they expect, tensions flare.

“Man, more fights more attitudes,” he said. “Kicking and banging. You know it’s just angry. They want to be out of their rooms. That’s why I used to kick and bang. If I know that I have a guaranteed hour of P.E. each day no matter what, I’m going to be angry if I can’t get that.”

While conditions for both the inmates and the guards have gone down, the costs have not. On average, there are only about 150 kids at Alameda County Juvenile Hall at any given time.

It costs 48 million dollars a year to detain them.

Youth Radio/Youth Media International (YMI) is youth-driven converged media production company that delivers the best youth news, culture and undiscovered talent to a cross section of audiences. To read more youth news from around the globe and explore high-quality audio and video features, visit Youthradio.org.

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Fresno County Local 521 SEIU – complaint on understaffing 2016

Fresno County Local 521 SEIU

Memo re Fresno County Unit 2 – Juvenile Correctional Officers (for June 9, 2016 meeting)

http://www.seiu521.org/workplace/region4/fresno/cofresno/unit2-juvenile-hall/

Directed Overtime: Management's Poor Decisions on Directed Overtime is Hurting JJC Staff

Click here to view flyer: Directed Overtime Flyer 4.26.16 (PDF)

Prior to its implementation, JJC staff held a Meet and Confer with management to discuss the impact of the new directed overtime policy. We objected, because it:

- Increased directed overtime but lacked options
- Failed to consider severe understaffing at JJC
- Would quickly lead to staff burnout
- Further lower morale

"Directed overtime compromises safety, security, and morale. It creates a stressful work environment, and takes a toll on every employee's home life. Never knowing if you get to go home is brutal." – Bob Winebrenner, JCO II

"Working 16 hour shifts multiple times a week is draining on every aspect of our lives. We need management to show us they care by making adjustments that will relieve us from the burden of under-staffing in this department." – Kevin Lee, Sr. JCO

We're now seeing the consequences of management's decision to ignore our issues. A large number of JJC staff are overworked, burnt out and this policy is negatively effecting their families and personal lives.

At a Labor Management Meeting on Wednesday, April 20, JJC staff once again raised concerns, but management responded that "everything will continue status quo until decisions are made on the Chief position".

This is not an acceptable response. We're disappointed and JJC staff is coming together to develop a plan to address management's poor decisions. In the coming week, we will be reaching out to JJC staff to further discuss the issue in more detail, and to highlight the impact this policy is having on us as employees, and our families.

Stay tuned for more details. If you have questions, please contact the union office at (559) 447-2560.

Make Officer Safety a Priority

In the past year, members have continuously addressed the issue of mandatory over time and short staffing with management. Yet management continues to drag their feet. It is our job to protect the community and it's management's job to protect us. Send a clear message to management that we are sticking together and officer safety has to be the County's priority.

Click here to view flyer: JJC Make Officer Safety a Priority Flyer 3.23.16 (PDF)

NPJS Minimum Direct Care Staff Ratio in Juvenile Detention and Correctional Facilities

MINIMUM DIRECT CARE STAFF RATIO IN JUVENILE DETENTION AND CORRECTIONAL FACILITIES

Adopted by NPJS Board of Directors October 21,2013

STATEMENT OF THE ISSUE

Juveniles require adequate adult guidance and direction to ensure their healthy development. The typical population of juveniles held in detention or correctional facilities requires greater support and supervision than non-confined juveniles. It is important to supervise the juvenile's actions, statements, and developing relationships through meaningful interaction with staff.

To be effective, supervision of juveniles requires a sufficient number of trained and competent staff members, in a sufficient staff-to-juvenile ratio. Confined juveniles are sometimes being housed in facilities that are overcrowded and understaffed.

NATURE OF THE ISSUE

Juvenile detention and correctional facilities face constant pressure to reduce budgets. As staffing accounts for 70 to 90% of the total fiscal operations, many administrators are pressured to reduce staff or house additional juveniles to achieve a lower per diem rate.

- Some juvenile facilities utilize modern design and technology features as an intended substitute for appropriate levels of direct care staffing and associated costs.
- In times of population crisis and regardless of design, all facilities may experience periods when they have insufficient staff-to-juvenile ratios due to exigent circumstances.
- An adequate number of direct care staff is necessary to monitor the behavior of juveniles and to engage them in helpful programs and services without reliance on segregation of misbehaving juveniles.
- Juvenile detention centers generally do not control their admissions or releases and their staff-to-juvenile ratios can increase quickly. Therefore, those facilities must have a system for enhancing the direct care staff-to-juvenile ratio accordingly.
- Unique juvenile facility populations, such has those with mental health diagnoses, sex offenders or others requiring specialized services, may require a larger staff-to-youth ratio to safely and effectively be served.
- The OJJDP Conditions of Confinement: Juvenile Detention and Corrections Facilities

Research Report states, “One important element of security is staffing levels. Without sufficient staff, juveniles are more likely to be able to harm each other, staff, or themselves. In addition, lack of staff causes low staff morale and higher levels of stress for staff.” When the staff to juvenile ratio exceeds national standards, programming effectiveness will diminish, which increases the likelihood of physical intervention occurring.

DEFINITION

Direct Care Staff ~ Employees whose exclusive responsibility is the direct and continuous supervision of juveniles. Direct care staff must be in the same room, trained and responsible to ensure a safe environment for juveniles.

POSITION STATEMENT

The National Partnership for Juvenile Services advocates that regulation, policy, procedure and practice ensure a minimum ratio of one direct care staff to no more than eight (1:8) juveniles during waking hours, and a ratio of one direct care staff member to no more than sixteen (1:16) juveniles during sleeping hours, with a minimum of two direct care staff on duty at all times regardless of population. At least one direct care staff of the same gender as residents served shall be on duty at all times. Further, if the design of a facility limits direct care staff members’ direct interaction with residents or if a facility’s population has specialized characteristics or needs, that facility should increase the number of direct care staff beyond minimum recommended ratios. Monitoring technology may be used as a supervisory enhancement but shall not be a substitute for direct supervision of youth.

National Institute of Corrections – Desktop Guide – Staffing Adequacy

NATIONAL INSTITUTE OF CORRECTIONS

Desktop Guide to Quality Practice for Working with Youth in Confinement (Published on Desktop Guide - https://info.nicic.gov/dtg)

Excerpt from Ch.8 Management and Facility Administration

Staffing Adequacy

Confinement facilities are unique organizations in that they never close; they must be staffed by trained, competent staff 24 hours a day, seven days a week. This makes the need to develop individual leaders—as well as leadership capacity in all employees—even more important. Facilities must have assigned leader decision-makers on duty at all times, and, if the facility has a system for developing them, leaders will be available to make decisions on a routine basis or in unusual, critical situations. In addition to recognized leaders, the facility must also have a sufficient number of qualified line staff who have received training in an accepted juvenile justice curriculum and in facility-specific expectations. The staffing plan must meet accepted staff-to-youth ratios. Those ratios may be based on a variety of factors, which the Prison Rape Elimination Act Standards (PREA) delineate specifically:

(a) The agency shall ensure that each facility it operates shall, develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staff levels and determining the needs for video monitoring, facilities shall take into consideration:

(1) Generally accepted juvenile detention and correctional/secure residential practices;

(2) Any judicial findings of inadequacy;

(3) Any findings of inadequacy from Federal investigative agencies;

(4) Any findings of inadequacy from internal or external oversight bodies;

(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);

(6) The composition of the resident population;

(7) The number and placement of supervisory staff;

(8) Institutional programs occurring on a particular shift;

(9) Any applicable State or local laws, regulations, or standards;

(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and

(11) Any other relevant factors.

(b) The agency shall comply with the staffing plan except during limited and discreet exigent circumstances, and shall fully document deviations from the plan during such circumstances.

(c) Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete circumstances, which shall be fully documented. Only security staff shall be included in these ratios."[7]

PREA Standards serve as a useful tool in clearly enumerating a range of factors to consider in establishing a staffing plan. PREA Standards must be adhered to; however, to ensure safety and security of both staff and youth while delivering specific treatment programs, a facility may need to exceed those standards. For example, a facility that serves sex offenders may need to increase staffing to provide adequate supervision and programming. A juvenile correctional facility that has a robust treatment component may need a staffing plan that includes a strong clinical staff in addition to the security staff outlined in the PREA requirements.

Long before PREA Standards were finalized, the NJDA promulgated a position statement on staffing adequacy by supporting “regulation, policy, procedure and practice ensure a minimum ratio of one staff to no more than eight (1:8) juveniles during the day, and a ratio of one staff member to no more than sixteen (1:16) juveniles during the night.”[8]That position statement intentionally emphasized the need for those ratios to reflect minimal numbers to ensure the safety and security of the facility and the provision of necessary programming for juveniles.