

SUPERIOR COURT OF CALIFORNIA
CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL,)
) CASE NO. RG03079344
 Plaintiff,)
)
 vs.)
)
 MATTHEW CATE,)
)
 Defendant.)
 _____)

EIGHTTEENTH REPORT OF SPECIAL MASTER

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- Appendix B: Michael Gennaco, Expert to the Special Master, *Report of Site Visits to the California Department of Juvenile Justice Force Review Committees: Observations and Recommendations*. (March 4, 2011)
- Appendix C: DJJ *Use of Force Review Project Subcommittee Report*. (March 17, 2011)
- Appendix D: Letter from Bruce A. Monfross, Inspector General (A), to Special Master Nancy Campbell. (May 5, 2011)
- Appendix E: Barry Krisberg and Logan Hopper, *Use of Force in DJJ and Mental Health Youth, Supplemental Report*. (May 10, 2011)

I. INTRODUCTION

The Special Master submits for filing the Eighteenth Report of the Special Master. This report reviews the *Farrell* Sexual Behavior Treatment Expert, Dr. Barbara Schwartz's fourth comprehensive report, (site visits February 7, 2010 through September 22, 2010) and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation, Division of Juvenile Justice's (DJJ) compliance with the Sexual Behavior Treatment Program remedial plan. Also in this report, the Special Master analyzes an issue that is central to *Farrell v. Cate*, which is how staff responds to both positive and negative youth behaviors. Effective behavior management is central to the issues that constitute an integrated behavioral treatment plan. When and how force is used against youth as well as recurrent challenges at the Ventura Youth Correctional Facility (VYCF) are issues discussed in this report. Finally, the report reviews progress to date in the closure of the Preston Youth Correctional Facility (PYCF).

At the heart of *Farrell v. Cate* is the assumption that DJJ failed to deliver services that supported the rehabilitation of juvenile delinquents.¹ At the center of effective care, treatment and rehabilitation is behavioral management practices that reinforce the development of self-regulatory skills that help anti-social youth learn to control their behavior in appropriate pro-social, law abiding and productive ways. The staff practices that in part led to the lawsuit included those that exacerbated and supported anti-social behavior. Such practices range from seemingly insignificant acts such as not reinforcing

¹ Placing the burden of this issue solely at the organizational level of the Division of Juvenile Justice is neither accurate nor fair. Many of the challenges that impede progress in this area result directly from DJJ being so small in size compared to the parent agency and the inability of the adult agency to recognize and understand the differences in mission of adult and juvenile corrections agencies.

positive behavior to examples of excessive use of force against youth.² In short, DJJ relied and continues to rely too much on a punitive change model and not enough on a rehabilitative change model.

Delinquent, incarcerated youth are a very difficult population to work with. The volatility of their moods combined with the fact that adolescent brains are not fully developed, particularly in areas that allow for control of their behavior, can frustrate the most committed and dedicated staff members. Any parent of a teenager or young adult understands the challenges of teaching young people and that the diversity of personalities and unique individual needs of young people make the task extremely complex. Just as no parent is the perfect guide for a youth's individuation process, neither is any youth corrections system ever able to completely and fully meet the needs of all of its youth. There are, however, well-researched strategies that have proven to be more effective in managing delinquent behavior. DJJ has crafted an evidence-based approach to behavior management that will be reviewed in the section of the report on the Integrated Behavioral Treatment Model (IBTM). Creating a treatment and custodial staff that understand effective behavioral management strategies and skills is the challenge before DJJ.

Two areas of this report that clearly show the shift to a truly rehabilitative culture has not taken root in DJJ are the discussions of recurrent problems at VYCF including provision of mandated services, high levels of violence and when and how force is used. In both of these areas, DJJ has attempted to implement policies and procedures agreed

² This statement does not imply any violation of policy by staff. In many situations, staff abide by current policy but, as will be discussed later in the report, the current policy needs refinement to better address how to support pro-social behavior.

upon with the experts and the Plaintiff.³ Some of the proposed policies and changes have resulted in desired change while others have not yielded the desired results.⁴ For example, DJJ has tried to implement the use-of-force policy that was negotiated with the experts and the Plaintiff. In this implementation process, it has become clear that additional changes will be needed to improve the policy to support staff to reduce the level and type of force sometimes being used. Changing culture is a process and learning which policies, procedures and processes work and which do not is a healthy part of that process. The ability of the experts and DJJ to work together to evaluate their agreed upon options and decisions, and to modify them as needed, is a sign of progress, not failure.

There is, however, clear evidence of failure on the part of DJJ to adequately train, monitor and evaluate staff and systems to ensure that there is adherence to the intent of agency policy that is designed to support rehabilitation. Egregious examples exist of a failure to adequately train staff in why and how programs are to be implemented to ensure that rehabilitative and not punitive strategies are employed. As will be addressed below in the discussion of VYCF, this failure resulted in examples of youth being treated more harshly than California's *adult* inmates are treated. Similarly, there are examples of failure by senior management to monitor data that clearly indicated policies designed to not just protect but to support the development of youth were being violated.

³ Plaintiff indicates that while they did not block adoption of the current Use-of-Force Policy, they have clearly and consistently indicated that the Defendant needs a new policy based on engagement and problem-solving with youth and only using force as a last resort.

⁴ See OSM 17, March 11, 2011, pp.17-26. The current Use-of-Force Policy has resulted in a reduction of violence and fear. Both the Special Master and the Safety and Welfare Expert believe that without modification to the existing policy further reductions in violence and fear are unlikely.

Finally, the report reviews what has been a very successful process to close PYCF. The closure has not only been done well, it has provided examples of some of the best rehabilitative correctional practices. The staff of Preston has worked in the best interest of youth despite their own personal and professional challenges due to the facility closure.

II. VENTURA YOUTH CORRECTIONAL FACILITY

A. Chronology of Problems at VYCF

The closure of Hemen G. Stark Youth Correctional Facility (HGSYCF) resulted in the rapid transfer of youth from that facility to all facilities in DJJ. VYCF received the majority of HGSYCF's core population. The transition from a female population to a facility serving both female and male youth has been challenging. Concerns about the ability of the VYCF staff to respond effectively to this new and more challenging population has been on-going since the transfer began in November of 2009. The following is a chronology of concerns raised by the Plaintiff, experts and Special Master since the beginning of 2010. A more detailed analysis of specific issues follows the chronology.

During the March, 28, 2010 Case Management Conference, concerns were raised about education staffing at VYCF's Behavioral Treatment Program (BTP) units. As a result of this discussion and an array of on-going concerns shared by the Safety and Welfare Expert and the Plaintiff, a site visit by the parties, the Safety and Welfare Expert and the Special Master took place in April 2010. The parties, expert and the Special

Master met with senior managers and independently toured different units within the institution. Several issues were identified and solutions proposed.⁵

The central issue that resulted in the site visit was the perceived inability of the VYCF staff to effectively respond to a more aggressive and violent youth population. A major concern was the ability of senior management to integrate new staff transferred from other facilities, particularly HGSYCF. VYCF senior management openly discussed the challenges of integrating the very different philosophical approaches of the existing VYCF staff with the newly arrived HGSYCF staff. The VYCF staff was described as having a "treatment" philosophy while the HGSYCF staff was described as being more "punitive" in their approach. These are broad characterizations that cannot be applied to all staff but there is no question that HGSYCF and VYCF had very different behavioral management approaches. The transition from a small female facility to a larger, co-ed facility was made more difficult by having to combine staff with disparate behavioral management approaches. The lack of a unified approach to managing youth results in conflicting messages sent to youth. Effectively managing this type of youth population requires consistent messages that reinforce desired behavior. Conflicting messages to delinquent youth can promote anti-social behavior. Without a consistent behavioral management approach, the safety and security of both youth and staff are jeopardized.

The Defendant made the following commitments at the site visit to remedy identified deficiencies⁶:

⁵ See Ventura Site Visit April 20, 2010 Final. These minutes were reviewed and approved by the parties.

⁶ Special Master minutes of meeting at VYCF, April 20, 2011.

- Superintendent will audit to see if Program Service Day (PSD) is understood in each unit and whether there are sufficient structured activities in each unit consistent with DJJ policy.
- Requirements for a youth to move from a high core unit to a low core unit are written to be understandable to youth and posted
- Gather data regarding which youth receive the required educational hours, which do not and the reasons why not. DJJ was to provide short and long-term goals to get all youth in school for the required number of hours.
- Superintendent will review violence data for the school area to understand if this needs to be addressed and if so, how? The Superintendent will work with the staff and the youth to develop a plan to reduce violence in the school environment. Possible elements include: incentive system which includes how to reinforce lack of violence and a description of conflict resolution strategies that align with and reinforce what the treatment teams are trying to accomplish. Alternative Behavioral Learning Environment (ABLE) will be evaluated to determine if it is adequate for students who cannot receive education services in the school environment. *The same process would be used for the housing units.*
- The Superintendent will share his methods for ensuring that he and his management team define the new organizational culture.
- Train remaining staff in BTP protocol and practices and determine whether BPT model is being followed and if not, what is going to be done.

A year later, merely two of the agreed upon tasks appear to have been completed.

It is unclear whether other items agreed to and outlined above were initiated because the Special Master has only received feedback in two areas. First, the posting of clear steps for youth to move from high core units to low core units was completed and second, a system-wide audit of the program service day has resulted in improvement in documenting program service day activities. The Special Master has no data that indicates the VYCF Superintendent analyzed violence data or education hours. Nor has evidence of a plan to reduce violence in the school or housing units, train staff in the BTP protocol and practices, or to demonstrate efforts to create one organizational culture been provided to the Special Master, Safety and Welfare Expert or Plaintiff.

On February 25, 2011, the OSM discovered a discrepancy in the reporting of out-of-cell time on a high [risk] core unit. Specifically, it was reported in the WIN

mandated services log that the youth had received one hour out of his cell within the previous 24-hour period when he actually had been in his cell for 28 hours straight. The Special Master expressed her concerns to DJJ and Office of Audits and Court Compliance (OACC) about insufficient out-of-cell time (as well as inaccurate reporting of out-of-cell time) and questioned whether the same problem exists at other DJJ institutions.

In response to the Special Master's concerns, the OACC immediately launched an investigation into the Special Master's concerns. Among other findings, the OACC auditors determined that VYCF youth indeed were systematically not receiving even DJJ's established requirement of three hours out-of-cell time daily.⁷ In addition, the OACC auditors reported that the lack of out-of-cell time was reported to Central Office. Central Office would then send a memorandum to each facility identifying the percentage of time that youth did not receive at least three hours out of their cells. VYCF has had, at least since January 2011, the highest percentage. The Central Office memorandum instructed facility staff to correct deficiencies and report back to the Director of Facilities. The OACC auditor reported that Ventura did not follow-up with Central Office nor did Central Office or the Director of Facilities track its memorandum and the status of provision of mandated services at each facility. The fact that Central Office is now directing institutional staff to explain why youth were not let out of their cells indicates some attempt to fix the problem. Unfortunately, the Central Office memoranda are not

⁷ OACC Audit Report, VYCF, March 1, 2011. The three-hour out-of-cell time is an internal DJJ policy that requires a minimum of three hours out-of-cell time where youth are housed in individual cells rather than in open dorms. The Plaintiff has not endorsed this policy.

accompanied by offers of assistance or support, nor are they accompanied by Corrective Action Plans (CAPs) that ensure follow through to solutions at struggling facilities.⁸

In response to the OACC audit, on March 31, 2011, the Special Master sent a letter to the OACC Assistant Secretary, requesting answers to multiple questions that focused largely on, whether the VYCF was receiving any assistance from Central Office to ameliorate problems identified.⁹ Not having received a response, on April 21, 2011, the Special Master sent to DJJ a second letter, this time to the Chief Deputy Secretary requesting a response to the Special Master's first letter.¹⁰ On the same day, April 21, 2011, the Special Master received a response from the Chief Deputy Secretary indicating that she had deployed a team of Central Office staff to assist Ventura in determining, " . . . what systems have already been put in place to address the identified deficiencies. . . . identify the causes of deficiencies and . . . develop strategies to help to address the deficiencies."¹¹ The letter indicated that the Superintendent of VYCF issued an instructional memorandum to all staff to ensure that minimum of three hours out-of-cell time and the implementation of a daily reporting system are mandated services. The Chief Deputy Secretary also promised a formal response to the remaining issues in the Special Master's letter "as soon as possible." To date, the Special Master has not received a formal written response or briefing on outcomes from the support activities for VCYP.

On April 13-14th, the Special Master and Plaintiff toured VCYP. On April 12th, there had been a disturbance on the BTP unit that resulted in transfer of some youth to

⁸ *Id.* at p. 2.

⁹ *See* Letter, Special Master to Mike Brady, March 31, 2011.

¹⁰ *See* Letter, Special Master to Rachel Rios, April 21, 2011.

¹¹ *See* Letter, Rachel Rios to Special Master, April 21, 2011.

county jail. While on site, the Special Master and Deputy Special Master observed youth on VYCF's BTP who were shackled ankle to wrist, for every moment they were outside of their cells. Youth remained shackled while in the shower and one youth explained to the Special Master how he had to contort his body in order to clean himself while fully clothed, with ankle, waist chains and handcuffs.

In addition to the Special Master's concerns, the Plaintiff prepared a letter to the Special Master on May 4, 2011 expressing concerns about the lack of physical space to educate, program and treat youth. Plaintiff also expressed concern for deficiencies in out-of-cell time.¹² Based on the Plaintiff's letter, the other correspondence and memoranda discussed above and the OACC audit, the Special Master issued a formal request for information on several subject areas including out-of-cell time, the provision of educational services and medical care, the necessity of planned modular buildings as well as the provision of unique programming for young women. Young women's issues will be addressed in depth in the Special Master's 19th report.

As will be discussed in the remainder of this section, it is clear that the BTP at VCYF does not conform to DJJ BTP Operations Guide or the Safety and Welfare Remedial Plan.¹³ The reasons for these failures will be discussed in greater detail below.

B. Failure to Implement the Behavior Treatment Program

DJJ is clearly struggling in implementing the requirements outlined in the Safety and Welfare Remedial Plan, in the VCYF BTP, which calls for structured activities

¹² See Letter, Sara Norman to Special Master, May 4, 2011.

¹³ See BTP Operations Guide Draft, May 3, 2011 and. See Safety and Welfare Remedial Plan, p. 2.

codified in a Program Service Day schedule for each BTP that ensures youth are engaged in out of room activities for 40 to 70 percent of waking hours.¹⁴ Youth are to be engaged in education, treatment and recreation activities while out of their cells. DJJ fails to meet remedial plan as well as its own policy requirements in providing each youth a minimum of three hours out-of-cell time daily¹⁵ (The hours do not include required education, recreation and treatment activities).

The DJJ BTP Operations Guide describes the elements of a BTP program. It is a thoughtful description of a well organized and focused treatment intervention.¹⁶ It focuses on the use of a higher ratio of positive reinforcements to negative reinforcements in order to better achieve sustained behavioral change.¹⁷ The guide reiterates the BTP is a treatment program that provides treatment services. There is little evidence of treatment activities and ample evidence of negative reinforcement and punishment at the VCYF's BTP.

During a site visit by the parties and the Special Master on April 13-14, 2011, the Special Master learned that conditions for youth in VYCF's BTP units do not meet basic requirements of the Defendant's BTP guideline.¹⁸ At the time of the site visit, the staff

¹⁴ *Id.* at p. 51

¹⁵ It should be noted that this policy was not negotiated with and has not been approved by the Plaintiff.

¹⁶ See BTP Operations Guide Draft, May 3, 2011. While labeled a draft, the Special Master received confirmation from DJJ staff that the policy is final. See e-mail, re: BTP Operations Guide.

¹⁷ *Id.* at p. 4.

¹⁸ For example, there is no transition plan for youth, the referral process was not implemented accurately and cognitive behavioral treatment interventions are rarely used.

at VYCF's BTP unit had not been trained on the guidelines, which apparently was submitted on May 3, 2011 with a revision date of May 12, 2011.¹⁹

As a treatment program, the BTP is not to be utilized as a form of punishment, but may contain fewer privileges and involve more limited movements than core programs. The BTP utilizes motivational, cognitive and behavioral interventions, social learning, case management and family involvement to target aggressive behavior. Individualized treatment and case management are utilized to ensure the youth can successfully function in the least restrictive environment possible.²⁰

In observing conditions for youth on VYCF's BTP and other "High [risk] Core units, it is apparent that the majority of policy's language that is being consistently adhered to is, ". . .contain fewer privileges and involve more limited movements than core programs. . .ö The remaining treatment requirements of the policy such as cognitive behavioral interventions and using social learning and family involvement are not being implemented.²¹ Examples of punitive, negative behavior were found but few examples of treatment were found. Youth appear to be left in their cells for the large majority of the day, communicating by yelling, tapping, and sending small wads of paper ("kites") with writing on them through small openings under cell doors. Staff effort is focused largely on containing youth and not on assisting them to develop the positive behaviors needed to move up in levels and off the BTP.

C. Out-of-Cell Time

BTP Unit staff reported that it was impossible to provide each youth even with three hours out-of-cell time daily because the youth population is "so violent" and

¹⁹ A training on the BTP guidelines was scheduled for June, 2011.

²⁰ See BTP Operations Guide Draft, May 3, 2011, at p. 4.

²¹ Safety and Welfare Expert, Dr. Barry Krisberg recently interviewed youth in the VYCF BTP and discovered instances where youth who had approved visitation in units prior to transfer to the BTP, were denied such visits once in the BTP.

because they do not have an outdoor recreation area that can accommodate the high-escape-risk population.²² DJJ concedes that some youth do not receive the DJJ minimum required three hour out-of-room time each day. Administrators report that staff vacancies and lack of physical space require daily redirection of staff resources. Regarding physical space, in addition to lack of sufficient space to provide education services (discussed above) VYCF's youth assigned to the BTP are unable to recreate outside of the building because the large outdoor recreation area is not equipped with sufficient safeguards against escape. Consequently, facility staff is forced to utilize such space as the shower and a converted laundry room to provide education and recreation services. VYCF staff report that an upgrade of the current BTP yards, and the provision of the planned modular buildings, if accompanied by sufficient staff to operate and monitor them, would help VYCF recover from some of the deficits addressed here.

As reported in OSM 17, after years of negotiations, the Parties had negotiated a resolution to the space issues at VYCF and other facilities.

DJJ has successfully negotiated the lease of surplus modulars from the public schools. The Department of General Services, DJJ and Prison Industries (DPIA) have negotiated for the purchase of 18 modular units to be placed at VYCF, Southern Youth Correctional Reception Center and Clinic (SYCRCC) and Northern California Youth Correctional Complex (NCYCC).²³ Twelve of the units will be placed at VYCF which has the greatest need for additional education and treatment space.²⁴

The agreement negotiated by the parties was reported on at the December 16, 2010 Case Management Conference. At the April 2011 parties meeting, the Defendant announced that the modulars that had been scheduled for placement by December of

²² Statements of VYCF staff to Deputy Special Master Cathleen Beltz, repeated during site visit, VYCF, April 13-14, 2011 and at DJJ Central Office.

²³ See Proof of Practice (PoP) #740. The total number of modulars has been reduced due to the closure of PYCF.

²⁴ See OSM 17, pp. 35-36.

2011 would be deferred until June of 2012.²⁵ The reason provided for this delay was that it appeared the possibility of complete elimination of DJJ existed and thus the purchase of the modulars was not necessary.

According to VYCF's Superintendent, VYCF's current facility staffing shortage of 12-15 Youth Correctional Counselors requires the "inversing" (forced overtime) of at least 15 shifts per day for an average overtime rate of \$250,000, as well as an exhausted youth correctional team. He further reports that staffing shortage and lack of physical space also result in the insufficient provision of services and to youth being confined to their rooms for extended periods of time. He reports, however, he is grossly under-resourced to remedy the situation.²⁶

VYCF's consistent inability to meet even DJJ's minimum three-hour requirement, let alone the BTP program and Safety and Welfare Remedial Plan requirements for months at a time, when combined with the violence data indicating consistent problems²⁷ should have resulted in recognition by DJJ management that there were problems at the VYCF facility that required immediate investigation and intervention. DJJ data systems clearly indicated problems with failure to meet mandated minimum services and violence rates that exceed other facilities. As well, Plaintiff's and Special Master's inquiries for over a year should have resulted in, at a minimum, some investigation of concerns. The lack of intervention resulted in a failure to provide even the most basic elements of

²⁵ See Parties Meeting Minutes, April 22, 2011.

²⁶ Statement, VYCF Superintendent to Special Master and Deputy Special Master during site visit, April 13-14, 2011.

²⁷ See OSM 17 section C., Reducing Fear and Violence, pp.17-26.

treatment in the BTP and in the deprivation of the most basic rights of youth.²⁸

DJJ has created a valuable information tool in the WIN mandated services logging system. If staff honestly report the provision or services, or lack thereof, and if Central Office and the Director of Facilities respond quickly and effectively to deficits reported, DJJ may be able to avoid the types of disturbances and violence experienced in recent months that have resulted in some of the desperate, excessive, and inappropriate uses of force discussed below.

D. Provision of Educational Services

Following the April 2010 site visit to VYCF, administrators were to identify the number of youth who were not receiving sufficient education services and develop short and long-term goals to remedy the problem. The Special Master was promised follow-up on the goals and planned remedies. She has received neither. The majority of information the Special Master has obtained about education services provided to youth at VYCF came from the education and other experts following their site visits to the facility. Both the education and safety and welfare experts shared with the Special Master their concerns that youth are not being provided with necessary (mandated education and out-of-cell time) services. DJJ reports that inadequate physical plant space and education staffing deficits result in DJJs continued failure to provide the minimum 240 minutes of educational services daily.

The Special Master received no feedback regarding the exact number of students not receiving education services as requested by the April 2010 agreement. According to

²⁸ While DJJ failed to use its own systems and data to identify and rectify problems at VYCF, the audit function of the OACC demonstrated the capacity for swift intervention. Concerns brought to the Special Master on March 1st, 2011 were investigated on March 3rd and 4th and reported immediately to the Special Master.

the education experts, however, the most significant deficits are occurring with special education students at Joanna Boss High School, N.A. Chaderjian High School and Mary B. Perry High School and youth in restricted housing and high core units at VYCF.

Education Experts, Dr. Robert Gordon and Dr. Thomas O'Rourke noted in their recent audit reports that youth in the three high schools listed above do not receive the full continuum of segments and services that are required in their Individual Educational Programs (IEP).²⁹ Failure to provide the required credentialed personnel to provide services to special education students has resulted in an inability to achieve substantial compliance in these audit requirements.³⁰ Hiring freezes have made it impossible for the schools to hire needed special education staff.

A failure to meet education requirements is particularly occurring at VYCF's BTP and for some youth in the high [risk] core units who are on temporary detention. There are several reasons for this failure.

First and foremost are the significant staffing challenges at Mary B. Perry High School. Despite constant efforts of the school Principal, the school does not have the level or type of staff required to address the unique and challenging needs of the special education or behaviorally challenging youth. The education experts noted that during their audit, the high school had 20 vacancies and that impending retirements and resignations indicated the situation would only get worse. At the time of the audit, the Principal had managed to fill vacancies with 19 substitute teachers. On May 16, 2011, there were 10 substitute teachers with long-term assignments and seven with short-term

²⁹ See Section V, Special Education, audit reports for Chad, Joanna Boss and Mary B. Perry.

³⁰ See audit requirements, Chad, Joanna Boss and Mary B. Perry audit reports.

assignments.³¹ Out of 32.5 teaching and specialist positions (FTE), vacancies of 20 positions are equivalent to a 62% vacancy rate.³²

The hiring freezes combined with organizational downsizing have made it almost impossible for the Principal to hire teachers despite the favorable market conditions. The hiring freeze required the Principal to use substitutes to replace retired teachers and to address the increase in the youth population.³³ The Special Master wrote a letter supporting DJJ's senior manager's request for a hiring exemption from freezes for education positions.

While the efforts of VYCF's school Principal to find substitute teachers are commendable, the impact on the youth at VYCF of not having a stable and consistent teaching staff is detrimental. Substitute teachers are often not equipped to work with such a challenging population.³⁴ The ability of substitute teachers to provide *effective* services with highly compliant students is challenging and more so with behaviorally challenged and anti-social youth. At the heart of the reform model is the ability of all staff to send consistent messages to youth regarding how to effectively manage their behavior. Educators are a key part of this process. They can be effective role models for youth. With staff shortages resulting in constant staff turnover, there is little chance for youth to

³¹ Statements during interview of Principal, Mary B. Perry High School, to Special Master, May 16, 2011.

³² The 32.5 FTE was provided by the Principal, Mary B. Perry High School, to Special Master Campbell during the same interview cited in footnote 32 above.

³³ *Ibid.*

³⁴ Exacerbating the staffing shortages is the time spent replacing the substitute teachers who quit because they are not able to work with the delinquent population.

bond with educators or for educators to effectively be part of the interdisciplinary treatment team which is at the heart of the reform model.³⁵

In December of 2010, an exemption from the hiring freeze resulted in approval to fill three positions. On May 24th, 2011, DJJ was granted exemptions to hire 34 education positions. Twenty of these positions are designated for VYCF. The Principal can now hire from lay-off lists within CDCR as well as hire any qualified substitute teachers for full-time positions.

Another impediment to providing the required 240 minutes of education to non-high school graduates is the lack of educational classroom space for the behaviorally challenging youth. VYCF is operating at almost maximum capacity. The facility lacks adequate classroom space³⁶ in several regards but the most challenging has been in the provision of education to those youth who are in Temporary Intervention Programs (TIP) on the high core units or who are in BTP units. Because these youth are restricted from attending classes in the school complex, the "alternative" education services are provided on the unit(s).

The rapidly fluctuating demand for services delivered on the units creates unique and challenging demands for education and custodial staff. The number of youth and type of educational services needed can and often does change every day. Services can sometimes be delivered in groups and other times must be individual. Without classroom space in the living units, facility staff have been creative in their attempts to deliver

³⁵ See Order Re: Integrated Behavior Treatment Model Report Summary and Implementation Outline May 27, 2010.

³⁶ An agreement was reached by the parties to provide modular units to VYCF to remedy this situation. The projected date for delivery of the units was June 2012. See Parties Meeting Minutes, April 22, 2011.

educational services. They are using closets, showers, storage rooms, kitchen and dining spaces to deliver services. Clearly some of these spaces are inappropriate and create education and security staffing challenges for the facility.

Presently, kitchen and dining spaces are being used to provide education services in the BTPs. There is no space in a BTP that is fully resourced for education services. Spaces where education services are currently delivered do not allow for efficient use of staff nor do they allow for effective teaching strategies. In a classroom, students can engage in different activities at one time. One can work individually while others work in a group. In the BTP this is somewhat possible in the dining room space but not in all areas. This means provision of education and custodial services must be provided serially and thus takes longer. In a time of fiscal constraint, this does not seem to be a wise use of resources. Typical educational tools that are available in classroom space are not available in living unit settings.

A final issue that is of concern is the lack of technology support for VYCF at Mary B. Perry High School. This is the only youth correctional facility without a half-time technology manager. The school pays from its own budget for this position but it is used as a regional coordinator that has many other responsibilities and as such, provides nominal support to the high school. The result is no staff to perform the following critical technology functions:

- Identify and order needed software
- Maintain the student network
- Maintain distance learning equipment
- Install SMART boards that sit in storage unused
- Project school technology needs
- Support teachers to incorporate technology into classroom teaching strategies

Educational staffing shortages combined with lack of classroom space and technology support have combined to create a situation where students with special needs are not receiving their full complement of educational services and those services received are sometimes substandard. Finally, severe staffing shortages at any high school compromise the ability of the entire facility to develop and effectively implement an integrated behavioral treatment model.

E. Provision of Medical Services

The medical experts report that high levels of institutional violence at VYCF has resulted in the cancellation of medical appointments and the failure to reschedule youth for medical treatment for several months with multiple rescheduling of appointments. The medical experts have noted multiple incidents of cancelled medical appointments that required several months of multiple appointment rescheduling. Custody staffing shortages exacerbate the problem, limiting facilities' ability to move youth to and from medical appointments and treatment.³⁷

The medical experts also express concerns about the hiring freeze, particularly if it extends to nursing staff. One *Farrell* medical expert notes:

Nurses handle almost all initial health complaints. Also, if the facility lost its clinical staffing for any reason (no psychiatrist or physician) it could be problematic. However, if they hired a doctor through a contract arrangement it would probably suffice based upon the current youth population.³⁸

³⁷ Defendant reports that many changes have been made to the medical services at VCYF to prevent delay in medical appointments. These changes include change in medical and custodial staffing schedules and addition of equipment in the medical clinic as well as creation of satellite medical units on the BTP and in the female living units to allow medical appointments to continue while post use-of-force evaluations and care are provided. While the Defendant attests to these changes, they have not been verified by the Medical Experts or the Special Master.

³⁸ Email, Madie LaMarre to Deputy Special Master Beltz, June 3, 2011.

III. USE OF FORCE

Under Section 3, *Reduce Violence and Fear*, the Safety and Welfare Remedial Plan states:

Reform is not possible if youth or staff fear for their safety. Unfortunately, this is a situation that prevails throughout much of DJJ. Reducing violence and fear in DJJ facilities is therefore the first step to reform. All other objectives, including the goals of gang integration and placing youth as close to their family and community as possible, must be subordinated to this objective. Once safety and order are returned, reform becomes possible and other objectives can be pursued.

The Safety and Welfare Remedial Plan components designed to reduce violence and fear include:

- A youth classification and reclassification system
- A force review model at each facility and at the Central Office
- Violence reduction committees at each facility
- Smaller living units, and
- A revised use-of-force policy

After three rounds of audits, the Safety and Welfare Expert, Dr. Barry Krisberg, has found the Defendant's compliance ratings with the standards and criteria related to Section 3 of the Safety and Welfare remedial plan to be 72% in substantial compliance, 23% in partial compliance, and 5% in beginning compliance.³⁹ Examples of standards found to be in substantial compliance include a youth classification system, a limit on the number of youth assigned to living units, a monthly review of use-of-force incident packages by each facility's Force Review Committee and the Division Force Review Committee, monthly meetings of each facility's Violence Reduction Committee, and a revision of the Use-of-Force Policy (Crisis Prevention and Management Policy) in February 2009. Examples of standards in partial compliance or beginning compliance include staff training and gang policy and gang/race integration training to appropriate staff.

³⁹ See Seventeenth Report of the Special Master, March 2011, p.19.

While progress is being made in implementing the remedial plans prescribed action steps, it is unclear whether sufficient progress has been made to reduce fear and violence to levels that support rehabilitative efforts. The level of youth-on-youth violence per 100 youth days declined from .50 in January 2008 to .43 (14%) in June 2010⁴⁰. Similarly, the use-of-force incident rate per 100 youth days declined from .44 to .35 (20%)⁴¹ over the same period. This is not a significant decline for such a period of time and especially in light of the small unit size.⁴²

Concerns have persisted by *Farrell* experts and the Plaintiff over the frequency of use-of-force incidents and the types of force deployed, particularly with incidents involving youth with mental health designations or who were identified as having developmental disabilities. At the request of the Plaintiff's counsel, a panel of *Farrell* experts consisting of Dr. Barry Krisberg, Logan Hopper, Dr. Terry Lee and Dr. Eric Trupin conducted a review of use of force and issued a report on April 26, 2010 which found that a disproportionately high number in force incidents occurred to youth in mental health living units and concluded the current use-of-force review process does not consider the unique needs of mentally ill or developmentally disabled youth, and that staff needed more training in how to de-escalate problematic situations with such delinquent youth.⁴³ At the time, the Court Experts made a series of 13 recommendations for short-term actions and intermediate-term actions.

⁴⁰ See Seventeenth Report of the Special Master (OSM 17), p. 20.

⁴¹ See Facility Safety Data January thru December 2008 and July 2009 thru June 2010.

⁴² See OSM 17, discussion of DJJ's initial progress toward reducing violence and use-of-force and the lack of progress made in the last two audit rounds.

⁴³ Appendix A, Use of Force in DJJ and Mental Health Youth: Preliminary Findings by Farrell Experts, Hopper, Krisberg, Lee and Trupin. The data for this report was derived from a review of 20 cases by each of the four experts. The methodology for review was

Short-term actions suggested include:

- Initiate a multi-disciplinary task force to more thoroughly examine this issue
- Revise policy to include additional provisions for staff interaction with mentally ill youth
- Revise the use-of-force review process, and
- Impose further restriction on use of chemical and mechanical restraints on youth with mental health disabilities.

Intermediate actions suggested include:

- More staff training on alternative dispute resolution
- Staff training on the behavior effect of psychotropic medication, and
- Staff training on behavior analysis and youth skill training with a emphasis on how to de-escalate conflict situations.

The Defendant acted on the first recommendation and created a multi-disciplinary task force to examine the issue. Rather than focusing only on youth in mental health units, the task force was expanded the inquiry's scope to use of force throughout the entire youth correctional system. Because of the breadth and depth of the study, the Office of Special Master was asked and agreed to participate in the process. The Task Force then formed a Use-of-Force Ad-hoc Workgroup to complete a study, and two of the Court Experts, Dr. Barry Krisberg and Logan Hopper, served as advisors to the ad-hoc work group.

The Office of the Inspector General was asked and agreed to participate in the study as an independent observer to ensure transparency and objectivity in the review process. In addition, Michael Gennaco, a use-of-force expert, was retained to observe and

not well defined in advance and with the exception of one expert, there was little or no written case analysis. The lack of written analysis of the case reviews by most of the experts made it impossible for the parties to assess the validity of the report. The Special Master encouraged the experts and the parties to engage in a process where both the methodology and underlying data was available for review.

provide comments on the Force Review Committee and the Division Force Review process.

On March 4, 2011, the Force Expert issued a report detailing his observations after attending force review committee meetings at VYCF and SYCRCC and at DJJ's Central Office.⁴⁴ The Force Expert found the committees functioned in ways that did not lend themselves to always achieve an in-depth review of each force incident and made a series of 25 recommendations to improve and enhance the current force review process. After completing a comprehensive study that involved a quantitative analysis of 245 cases⁴⁵ and a qualitative review of 100 force incident packages, the ad-hoc workgroup on March 17, 2011 submitted a draft report to the larger task force that contained a total of 28 observations and 99 recommendations. On April 19, 2011, Acting Chief Deputy Secretary Rachel Rios released the report after deletion of a statement in the report relating to progressive disciplinary action against staff in a particular living unit due to confidentiality concerns.⁴⁶

On May 5, 2011, Acting Inspector General Bruce Monfross released a letter commenting on the deliberative process engaged by the ad-hoc workgroup during the study. As an oversight agency, the Office of the Inspector General's role in the study was

⁴⁴ Appendix B, Report of Site Visits to California Department of Juvenile Justice Force Review Committees: Observations and Recommendations by Force Expert Michael Gennaco.

⁴⁵ The original sample size was a sample of 300 randomly selected cases from an estimated population of 1,800 cases to achieve a statistically valid sample. A random sample of 300 cases was identified by the Office of the Inspector General through a computerized program. As a result of some cases that were missing and DJJ's case numbering system, only 245 of the 300 cases have been located. While the sample size did not constitute a statistically valid sample for the purpose of extrapolating the sample results to the entire population, it was ample to provide a reasonable basis for making observations and reaching conclusions regarding practices at DJJ.

⁴⁶ Appendix C, DJJ Use-of-Force Subcommittee Report.

to serve as an independent observer to ensure transparency and objectivity in the review process. In his letter, Mr. Monfross found that "the casesø reviews conducted by the DJJ experts appeared thorough, critical, and objective. The expertsø discussions regarding the use-of-force incidents were robust and candid." ⁴⁷ As an independent observer of the review process, the Office of the Inspector General did not take a position on the DJJ internal report and Mr. Monfrossø letter noted that "The OIG did not review the report to validate the observations or comments, nor to offer an opinion as to whether any particular recommendation constitutes the best policy or practice for DJJ."

On May 10, 2011, the Safety and Welfare Expert, Dr. Barry Krisberg and Disability Expert, Logan Hopper issued a supplemental report to their original report of April 26, 2010. ⁴⁸ After having served as project advisors and then reviewing the ad-hoc workgroupø report in detail, the experts concurred with the observations in the report and concluded that the workgroup did an excellent job in describing current conditions. However, the experts did not "fully" endorse the report as they believe "more extensive changes and proactive policies" need to be implemented immediately to counteract the on-going trend of excessive use of force, both upon youth with mental health conditions and other disabilities and upon the general youth population. The experts made additional recommendations relative to use of chemical restraints, use of mechanical restraints, policy regarding immediate vs. controlled force, the force review processes, and the role of DJJ leadership.

⁴⁷ Appendix D, Letter from Bruce Monfross, Inspector General (A) to Special Master Nancy Campbell, May 5, 2011.

⁴⁸ Appendix E, Use of Force in DJJ and Mental Health Youth, Supplemental Report by Dr. Barry Krisberg and Logan Hopper, May 10, 2011.

In early May 2011, DJJ management appointed an implementation team to review the various observations and recommendations made by the Force Expert, the ad-hoc workgroup, and the experts. The implementation team is to release an implementation plan in June 2011.

The Special Master carefully reviewed the reports of the Force Expert, the ad-hoc workgroup, and the Safety and Welfare and Disability Experts. It is encouraging to note that the reports contain no disclosure of instances of misconduct or intentional abuse of youth on the part of staff. In fact, the ad-hoc workgroup found that staff in general made concerted efforts to adhere to existing policy, practice and training.⁴⁹ The problems with use of force appear to stem more from flawed policy and procedure than from an unwillingness of staff to adopt new methods of behavioral management. It appears that with clear policy enforced through training, mentoring, coaching, and positive reinforcement, the staff will respond favorably to proposed changes made regarding how and when force is used with youth.

The reports collectively present overwhelming data and evidence that suggest the Defendant's current use-of-force model is not effective in achieving the desired outcome that was envisioned in the Safety and Welfare Remedial Plan. The revised Crisis Prevention and Management Policy was adopted in February 2009 after review and comment by stakeholders including the Plaintiff's Counsel, *Farrell* experts, and the Special Master. The policy included all essential components identified in the Safety and Welfare Remedial Plan including:

- Adoption of a continuum of prevention, intervention, and de-escalation methods
- Smaller living units.

⁴⁹See DJJ Use-of-Force Subcommittee Report, p. 5.

- A use-of-force review model and processes.
- Staff training on force policy and on crisis prevention and management techniques.
- The establishment of violence reduction committees.

As evidenced by the most recent 72% substantial compliance rating, the Defendant has implemented many of the agreed upon standards and criteria of the Safety and Welfare Remedial Plan. Initially these efforts produced favorable reductions in violence and use of force. More recently there has been less progress and in some cases, a clear return to practices that not only do not support the rehabilitative intent of the reform effort but may violate constitutional protections for incarcerated youth.

It is the opinion of the Special Master that the challenges in achieving the purpose and intent of violence reduction as outlined in the Safety and Welfare Remedial Plan derive primarily from two things. First, the Defendant and the experts created a plan to see if the strategies in the plan would reduce violence and fear. Some of the strategies that were designed are proving to be successful while others are flawed. While labeled as failure by some, a necessary part of learning in the change process is to test strategies and tactics and to modify them based on the learning from the tests. The reassessment of initial strategies is part of the improvement process. Second, there continues to be a clear and profound lack of understanding by the Defendant of current correctional best practices and research findings. There continues to be fall back to a time when "treatment" was valued. While not doubting that the former California Youth Authority (CYA) had a different culture, many of the practices that were heralded as the "gold standard" have been proven to not be effective. This lack of understanding translates into direction to staff to "do things differently." From senior managers to youth correctional officers, staff are being told to change without concrete and clear direction about what to

change and why. A clearly articulated vision followed with well articulated guidelines for behavior is desperately needed.

In the following sections of the report, the Special Master discusses the key issues that need to be addressed to achieve the overarching goal of the Safety and Welfare Remedial Plan which is to create a safe and secure environment in DJJ institutions that supports the possibility of youth developing new pro-social behaviors. To achieve this, staff must practice behavior management strategies that support rehabilitative efforts. Key among such behavior management strategies is modeling how to effectively respond to confrontation. In some instances, staff models the same reactive behaviors youth engage in that escalate conflict. Learning from the implementation of agreed upon policies and strategies must be used to make revisions in those policies and strategies. Investment in coaching custodial and treatment line and management staff how to implement what they are learning in training must be made. The Defendant must be supported in their efforts to revise the plans that the experts and the court approved to accomplish these goals.

A. Staff Training and Skills in Addressing Youth Behavior Issues

Both the Safety and Welfare Remedial Plan and the Crisis Prevention and Management Policy prescribe measures to prevent the need to apply force. For example, the Crisis Prevention and Management Policy states:

Prevention is a critical step in dealing with the management of crisis situations and behavior. Prevention of violence begins with organized programs and staff who know and relate professionally with the youth population. Through these relationships, staff develop rapport and recognize behaviors and situations which have the potential of escalating and may lead to violent or acting out behavior.

Prevention techniques should be used prior, during, and after the point in which force measures become necessary. All Prevention and de-escalation measures, such as the use of Conflict Resolutions, Psychologists, Teachers, Interns, Clergy, Nurses, Recreation Therapists, ADA Coordinators, and other staff should be considered and utilized when

possible and practical. Reasonable effort to de-escalate and prevent force should be used.⁵⁰

DJJ officials maintain that, while not fully documented, an overwhelming number of incidents are avoided on a daily basis in the institutions as a result of effective staff intervention efforts. While this is likely to be true, the fact that the force incident rate has not declined significantly in two-and-a-half years raises questions regarding the effectiveness of both current policy and remedial training efforts.

The Special Master believes that the current use-of-force policy does not adequately address ways to prevent use of force. In reviewing the various "Case Snapshot" in the ad-hoc workgroups report that provide a detailed description of selected force incidents, it is clear that a large number of the incidents could and should have been avoided had staff taken more appropriate and proactive action to de-escalate the conflict. In its qualitative review of 100 cases, the ad-hoc work group found that only four cases included any indication that staff used alternative interventions or methods like a cool down period.⁵¹ In most instances, staff intervention consisted of unstructured dialogue that turned into power struggles with youth and ultimately led to force incidents. All staff members clearly are not adequately equipped to address challenging youth behavior.

The Safety and Welfare Remedial Plan requires direct care staff to be provided "Safe Crisis Management (SCM) training." DJJ provided the following description for the Safe Crisis Management Training: *"The focus of the Safe Crisis Management (SCM) training is to prevent incident and reduce use of force through the use of positive behavior interventions. It is a proactive approach and provides staff with an understanding of individual crisis behavior and the dynamics of escalation. The training*

⁵⁰ See Crisis Prevention and Management Policy, p. 14.

⁵¹ See DJJ Use-of-Force Subcommittee Report, p. 37.

includes proven de-escalation techniques that are applicable to a wide range of settings and situations and post intervention strategies that debrief, resolve, record, and restore individuals, their peers and their environment.” The length of this training is three days for peace officers and two days for non-peace officers.

Based on the course description, SCM training appears to be an essential tool for the direct care staff to learn how to address youth behavior issues effectively and to avoid conflict. After three audit rounds, none of the facilities have achieved a substantial compliance rating for this action step in the Safety and Welfare Remedial Plan. According to the defendant's training statistics, only 720 of the 1,877 staff (38%) who were required to complete SCM training had completed the course as of June 30, 2010. Of the 39 individuals in "administration" positions required to attend SCM training, only one had completed the course as of June 30, 2010 which, at least in appearance, sends a wrong signal to staff about management's commitment to this essential training course.⁵²

There is little evidence of a reversal of this trend. In the recent review of VYCF's compliance with the Safety and Welfare Remedial Plan, the OACC presented the following data regarding SCM training to direct care staff in the facility. Three of the four staff in "administration" positions did complete SCM training since June 30, 2010. However, of most concern is the low percentage of Youth Correctional Counselors (29%) and Youth Correctional Officers (36%) who have received the training. These are the front-line staff members with whom most youth interact and who typically are involved in force incidents. Clearly, they could benefit from SCM training. There apparently is no

⁵² See PoP #785, pp. 35-43.

immediate plan to provide SCM training on a more accelerated timeframe because of budgetary and staffing considerations⁵³.

SAFE CRISIS MANAGEMENT TRAINING For Remaining Direct Care Staff			
Area / Classification	# of Staff Required to Complete Training	# of Staff that Completed Training	% of Staff that Completed Training
Administration	4	3	75%
CWS	5	4	80%
Education	52	11	21%
Lieutenant	8	3	37%
Medical	12	0	0%
Mental Health	13	1	8%
Parole Agent	7	4	57%
SYCC	9	5	56%
Sergeant	4	1	25%
SCWS	3	1	33%
Support	52	0	0%
TTS	5	4	80%
YCC	127	37	29%
YCO	72	26	36%
TOTALS	373	100	27%

B. Controlled vs. Immediate Use of Force

The Safety and Welfare Remedial Plan called for the Defendant to establish a use-of-force review model that distinguishes between “immediate” and “controlled” use of force. An immediate use of force is necessary and appropriate when there are no options available except to subdue an attacker in order to defend oneself, prevent harm to another, or prevent escape. A controlled use of force is employed when time and circumstance permits a planned intervention. Controlled use of force requires that a deliberate, step-by-step implementation process be followed and that specific staff are present before controlled force is used. The revised Crisis Prevention and Management Policy in general is consistent with guidelines prescribed in the Safety and Welfare

⁵³ Statements of Tammy McGuire, Safety and Welfare and Youth with Disabilities Program Team Supervisor to Deputy Special Master, John Chen, May 19, 2011.

Remedial Plan. The ad-hoc workgroup found that, in actual practice, controlled force procedures were rarely implemented. In the quantitative analysis of 245 sample cases, 243 incidents (99%) involved immediate force and only two incidents (1%) involved controlled force.⁵⁴ Both controlled force incidents involved cell extractions where policy mandates application of control force procedures. During the period of July 2009 through June 2010, DJJ had a total of 1,637 uses of force incidents: 1,628 or 99% where immediate force was used and 9 or 1% where controlled force was used.⁵⁵

It is not surprising that staff rarely apply controlled force. For the 245 sample cases, 45 incidents (18%) involved applications of force against a single youth not engaged in assaultive behavior;⁵⁶ most instances involved youth refusing to follow staff orders, which later escalated into force incidents. Even though the youth apparently posed no immediate danger to others, staff applied immediate force because the Crisis Prevention and Management Plan contained a provision that allowed staff to apply immediate force when the action of the youth, in the judgment of a supervisor, significantly interrupted other youth's access to treatment, mandated services, or program activities. Virtually any disruption could be construed to constitute significant interruption of other youth's services or activities. Application of controlled force requires staff to follow often time-consuming approval and documentation protocol and procedures and provide special consideration in cases involving youth with known or identified mental health/disability issues. There are no incentives to use controlled force and there are many disincentives.

⁵⁴ See DJJ Use-of-Force Subcommittee Report, p.77.

⁵⁵ *Ibid.*

⁵⁶ *Id.* at p. 68.

In the sample of 100 qualitatively reviewed cases, the ad-hoc workgroup found 13 or 13% involved force due to a single youth being non-compliant. In all 13 cases, the ad-hoc work group judged that the youth did not demonstrate assaultive, destructive or self-injurious behaviors, commit suicide gestures or attempt to escape.⁵⁷ In all instances, the facility's Force Review Committees did not identify questions regarding whether or not controlled force should be applied during the force review processes. Clearly, the concept of controlled and immediate use of force has little relevance in the current force practice at DJJ facilities.

In their supplemental report, the Safety and Welfare and Disability Experts found the policy concerning immediate and controlled use of force to be too convoluted and opined that it is "the root cause for the majority of excessive use-of-force incidents." The experts recommended that the entire system of immediate force be suspended until appropriate safeguards can be effectively implemented to control current tendencies of staff to apply immediate force.⁵⁸

The Special Master agrees with the experts' assessment that the current policy, patterned after the California Department of Corrections and Rehabilitation adult model, is convoluted and unsuitable in a therapeutic environment for youth. However, suspension of immediate force altogether may not be viable in the absence of any other alternative besides controlled force. The Defendant should promptly revise the Crisis Prevention and Management Policy to show a continuum of interventions, and include immediate force as the most restrictive intervention method of intervention.

⁵⁷ See DJJ Use-of-Force Subcommittee Report, p.77.

⁵⁸ See Use-of-Force in DJJ Mental Health Youth Supplemental Report by Dr. Barry Krisberg and Logan Hopper, p. 5.

C. Force Incidents Involving Youth with Mental Health Designation and/or Disabilities

The Safety and Welfare Remedial Plan requires the Defendant to include special procedures and/or alternative interventions to accommodate youth with certain mental and physical conditions in a controlled use-of-force setting. Accordingly, the Crisis Prevention and Management Policy contains extensive procedures designed to ensure each youth with mental health/disability issues is clearly identified and assessed by the appropriate health care and mental health professional for accommodation and all employees are aware of the need for an accommodation during force incidents. Clearly these procedures require controlled use of force. These provisions appear to be meaningless as controlled use of force essentially does not exist at DJJ.

The ad-hoc workgroup study found most force incidents involved at least one youth with mental health designation and/or identified as youth with disabilities. In the quantitative analysis of 245 sample cases, it was found that 197 (80%) of the cases involved at least one youth with disability and/or mental health designation⁵⁹. The ad-hoc workgroup report contained little evidence to suggest that special consideration was provided to this group of youth during moments when youth presented behavioral management challenges. For example, the Crisis Prevention and Management Policy

⁵⁹ See DJJ Use-of-Force Subcommittee Report, p. 46. For clarification, this number does not suggest or imply that 80 percent of youth involved in force incidents were youth with a disability and/or mental health designation. This is the percentage of the cases in the 245 samples where one, two, or more youth were involved in an incident but at least one youth has a disability and/or mental health designation. In addition, DJJ's Office of Research conducted a separate analysis of the 245 cases and reported that a significant number of youth with a disability and or mental health designation were involved in multiple numbers of incidents. By counting multiple cases involving the same youth as one, the Office of Research calculated that 42 percent of the 245 cases involved youth with a disability and/or mental health designation.

provides for a Crisis Prevention Support Plan to identify key factors and effective strategies which staff can utilize for resolving crisis situations with youth. As the current policy does not require a Crisis Prevention Support Plan for every youth, the plans were developed at the discretion of facility staff members. Clearly youth with mental health and/or disability designations should be prioritized for Crisis Prevention Support Plans. However, there did not appear to be any pattern or criteria concerning the development of Crisis Prevention Support Plans for youth. Some youth assigned to core living units with no mental health or disability designation and history of violent behaviors were provided with a Crisis Prevention Support Plan⁶⁰. Meanwhile, in the sample of 245 cases, 60 of 123 youth (49%) involved in multiple force incidents had a mental health designation but were not provided with the Crisis Prevention Support Plan⁶¹. The ad-hoc workgroup further found that mental health professionals and custody staff did not partner effectively to de-escalate youth conflicts. In the total sample of 245 cases, 118 (48%) involved incidents that occurred outside of the typical working hours of mental health professionals.⁶² Of the 100 qualitatively reviewed cases, 76 cases involved at least one youth with a mental health designation, but only six case files contained evidence of involvement by mental health professional during force incidents⁶³. In the 100 cases, the ad-hoc workgroup found none of the cases contained evidence that staff members modified intervention strategies to meet the individual need of youth with a mental health designation.⁶⁴

⁶⁰ *Id.* at p.14.

⁶¹ *Ibid.*

⁶² *Id.* at p. 29.

⁶³ *Id.* at p. 30.

⁶⁴ *Id.* at p. 46.

In their study report of April 26, 2010, the Farrell experts found that the current use-of-force review process does not consider the unique needs of mentally ill or developmentally disabled youth and staff needed more training in how to de-escalate problematic situations with such delinquent youth. The ad-hoc workgroup's report presented overwhelming evidence to support the experts' findings and conclusions and demonstrated the need for much greater involvement by mental health professionals in force incidents. The fact that the experts' report was released more than a year ago provides additional sense of urgency for the Defendant to take action immediately to address this issue.

D. Force Review Committees

DJJ's current force committee review model is outlined in the Safety and Welfare Remedial Plan. It calls for a facility Force Review Committee (FRC) to conduct a mandatory review of all force incidents using a structured and consistent process supported by *comprehensive documentation and training*. A second level of Divisional Force Review Committee (DFRC) is to meet monthly and select and review at least 10% of use-of-force incidents. In addition, each facility is to establish a Violence Reduction Committee (VRC) to review, map and evaluate all incidents of violence quarterly. DJJ policy calls for the VRC to meet on a monthly basis. The role of VRC was examined and discussed in the Seventeenth Report of the Special Master.⁶⁵

The design of the force review process is excellent. Unlike more limited paper processes, the model includes in-person meetings designed to include the treatment and custodial staff that have the professional expertise to discern if a youth(s) behavior was

⁶⁵ See Seventeenth Report of the Special Master, pp. 24-25.

responded to both according to DJJ policy and best correctional practice. The policy specifically encourages a focus on the steps or actions that led to the use of force which is key to a goal of the process which is to learn how to avoid unnecessary force and to model appropriate conflict resolution strategies for youth who need to learn new conflict resolution skills.⁶⁶ The problem with the process is one of implementation and not design. The process has been implemented in a way that it achieves little more than a clerical review of documentation and does not result in a critical analysis of whether the actions taken in a situation where force was used were appropriate or congruent with the therapeutic goals of the youth.

The current use-of-force review model focuses primarily on ensuring that the *documentation* requirements of the remedial plan are met but not the *training* requirements. Feedback given to staff about use-of-force incidents is primarily about the accuracy with which they completed their paperwork. There is almost no evidence that at either the institution or headquarters meetings there are discussions that focus on if use of force could have been avoided and/or what alternative methods could have been used to de-escalate or prevent the need for use of force. Similarly, there is little evidence that staff are provided feedback regarding the level and type of force they use. The process is rarely used to provide staff with information that tells them if they employ force too often, for the wrong reasons or if alternative methods of conflict resolution or prevention could have been employed. Similarly, the process is not used to compare individual levels of use of force compared to unit and facility levels of use of force. In short, the

⁶⁶ Appendix B, Report of Site Visits to the California Department of Juvenile Justice Force Review Committees: Observations and Recommendations by Force Expert Michael Gennaco.

process is not used to assess the effectiveness of staff actions to address youth behavior issues.

In the qualitative review of 100 cases, two peace officer members of the ad-hoc workgroup independently found 31 cases to be "egregious" using criteria that include whether force could have been avoided, appropriateness of staff actions prior to and after force, type and amount of force, extent of documentation deficiencies, and quality of review at all levels.⁶⁷ In reviewing the "Case Snapshot" for some of these cases, the Special Master concurs these cases indeed were egregious. Yet, in all 31 cases, the FRC review did not disclose any substantive issues other than procedural matters, which raised serious questions about the effectiveness of the current force review model.

The Special Master is also concerned about a disclosure in the ad-hoc workgroup report concerning missing force incident packages. The DFRC apparently did not have a system or process in place to ensure every force incident package was properly and timely accounted for and thus, it only reviewed the incident packages received. It was found that some facilities did not submit any packages for an entire month. In the ad-hoc workgroup's original sample of 300 cases, 100 force incident packages were not found in the files of the DFRC. Some of the missing cases were accounted for as some of the original sample of 300 contained behavior reports from the same force incident. While some facilities eventually provided additional incident packages, some incident packages remained missing. The most notable exception is SYCRCC. Of the original sample 300 cases, 39 were related to force incidents that occurred at SYCRCC. After repeated requests, the SYCRCC staff still could not properly account for 19 of the 39 (49%) force

⁶⁷ See DJJ Use-of-Force Subcommittee Report, p 7.

incident packages.⁶⁸ Whether resulting from inadvertent oversight or intentional omission, these missing cases raised serious concerns over the adequacy of system control and accountability and compromised the integrity of the Defendant's force review process.

In addition, the Ad-Hoc Workgroups report raised questions about the accuracy and reliability of use-of-force data in the Defendant's Computer Statistic (CompStat) database. It was found that staff at each of the five DJJ facilities employed a different methodology in compiling use-of-force data and no backup documentation was maintained to link the data to the behavior report or use-of-force reports.⁶⁹ Thus, there is no audit trail to provide assurance that the data is reliable or complete for analysis and decision-making by DJJ management. In his report, the Force Expert identified processing inefficiencies and quality control issues throughout the force review processes. The Force Expert suggested that the force review committees placed too much focus on procedural matters such as report writing and deadlines rather than more substantive issues of identifying means to prevent avoidable future force incidents. The Special Master accompanied the Force Expert on his visit to SYCRCC, and the observations of the Force Expert are entirely consistent with the conclusions reached by the Special Master during her site visit. While the current process serves important administrative purposes, it is not as effective as a management and teaching tool to prevent and reduce force incidents. Moreover, it is the opinion of the Special Master that the current review process that focuses almost exclusively on narrow and non-substantive matters adds little value to the goal of reducing violence and fear at DJJ facilities.

⁶⁸ Compiled from data in the DJJ Use-of-Force Subcommittee Report, p. 137.

⁶⁹ See DJJ Use-of-Force Subcommittee Report, p. 138.

The Force Expert presented 25 recommendations to improve efficiency in the force review processes, improve learning by staff and management to reduce force incidents, and promote accountability before, during, and after the force incidents. Some of the key recommendations include the following:

- Encourage participation by ensuring each participant in the committee understands his or her role and provide each attendee the opportunity to review the incident package before the committee meeting; the committee chair should spur dialogue by identifying issues and seek input from committee members instead of reading the reports.
- Spend more of the committee's time evaluating the effectiveness of force deployed and identifying ways to reduce future incidents and use the information to provide meaningful feedback to staff.
- Develop a formal action plan to ensure proper training to individuals and the facility as a whole with mechanism for feedback to the committee about the effectiveness of the action plan.
- Obtain the input of youth involved in the force incident as well as other youth who observed the incident.
- Develop a database to track staff performance on use of force, report writing, and documentation issues.

The Special Master finds the Force Expert's recommendations to be thorough and thoughtful and, if properly implemented, will improve efficiency and effectiveness of the force review processes.

Some of the failure to implement the force review process in a way that supports reduction of unnecessary force and encourages teaching of alternative conflict resolution skills to staff may be the perceived role and purpose of the Violence Reduction Committees (VRC). The remedial plan specifies that the VRC is to review, map, and evaluate all incidents of violence quarterly and develop local violence reduction plans to reduce youth-on-youth and youth-on-staff violence. Many creative and interesting ideas

have been developed at the VRCs but it is possible that having this group focus on violence has resulted in not having discussions at the FRC and DFRC about reductions of force and violence. While there may have been a reasonable rationale for the original design of two committees, it does not appear to be an efficient use of staff time and may be part of the reason that the FRC and DFRC have become largely a clerical review process.

E. Use of Chemical Agents

The appropriateness of using chemical agents on youth, especially those with mental or disability designation, has been an issue of long and contentious debate between the Defendant and its stakeholders. Notwithstanding the fact that only a handful of jurisdictions that participate in PbS allow use of chemical agents⁷⁰, the Defendant strongly believes use of chemical agents is necessary and effective in minimizing injuries to staff and youth during force incident. However, it does not have data to support this supposition as PbS does not track staff and youth injury resulting from force incidents separately. On the other hand, there are real medical risks and complications in applying chemical agents to individuals with severe asthma, chronic heart conditions, or who are seizure prone. The Special Master has not been able to locate reliable research data on the lasting effect of chemical agents. Of equal concern is the message that the use of chemical sends to youth about how to resolve conflict. Clearly it is not desirable to teach youth to resolve conflicts by using chemicals.

⁷⁰ Email exchange between Alex Mora, DJJ PbS Manager and Deputy Special Master John Chen on May 31, 2011. There were a total of 111 "correctional sites" that participated in PbS during the April 2010 collection cycle. Of the 111 correctional sites, 12 reported use of chemicals, six of which were from California (DJJ).

The Crisis Prevention and Management Policy prohibits the use of chemical agents on a youth prescribed psychotropic medications and imposes other requirements for applying chemical agents on youth with certain mental and physical disabilities in a controlled force setting. These provisions are rather meaningless since control procedures are rarely implemented in DJJ facilities.

The Special Master finds the observations of the ad-hoc work group's report presented a compelling case for a need to at least curtail chemical agent use in DJJ facilities. The report identified cases where chemical agents were applied to a single youth not engaged in assaultive behavior, applied to youth repeatedly when not effective, and applied when physical strength and hold was viable and perhaps more effective.⁷¹ Despite the fact that the Crisis Prevention and Management Policy specifies that chemical agents shall not be used as a daily management tool, the prevalent practice raises questions about staff over-reliance on chemical agents and thus compromise the DJJ's core mission of providing treatment services to youth.

The ad-hoc workgroup recommended the Defendant amend the Crisis Prevention and Management Policy to prohibit use of chemical agents against a single non-compliant youth. The Special Master agrees with this recommendation. In the sample of 245 quantitatively analyzed cases, 45 incidents (18%) involved a single youth not engaged in assaultive behavior. DJJ staff clearly recognized that chemical agents were not necessary in most single youth incidents as chemical agents were used in only 8 of the 45 incidents (18%). In the 100 qualitatively reviewed cases, 25 incidents involved a single youth and

⁷¹ See DJJ Use-of-Force Subcommittee Report, pp. 72-76 and pp. 87-99.

chemical agents were used in six of the 25 (24%) incidents.⁷² The ad-hoc workgroup found chemical agents were unnecessary as in all six cases the single youth did not pose any immediate danger to others. In three of the six cases, chemical agents were repeatedly used against a single youth.

In their supplemental report, the Safety and Welfare and Disability experts recommended elimination of all chemical agents against female youth housed within DJJ. The Special Master agrees with this recommendation. In the sample of 245 quantitatively analyzed cases, 30 incidents (12%) cases involved female youth which appears to be disproportionately high as female youth constitutes less than 5% of the Defendant's youth population. For the 30 cases, 21 (70%) involved single youth incidents where youth either refused to follow staff orders or engaged in self-injurious behaviors.⁷³ Eight of the nine remaining cases involved youth engaged in one-on-one fights without weapons and the last case involved one youth assaulting another without weapon. These data do not support need for use of chemical agents against female youth.

IV. INTEGRATED BEHAVIORAL TREATMENT MODEL (IBTM)

The Special Master previously reported,

Being safe, healthy and accessing equitable services are all prerequisites to achieving behavior change in youth but, by themselves, cannot achieve the ultimate goal of a pro-social youth. The parties wisely agreed to the need for an Integrated Behavioral Treatment Model (IBTM) that overarches all the remedial plan goals and ensures that all aspects of a youth's incarceration support the development of pro-social behavior.⁷⁴

⁷² *Id.* at p. 68.

⁷³ Data compiled by the Office of the Special Master using a matrix developed by the DJJ Use-of-Force Subcommittee.

⁷⁴ *See* OSM 16, p.13.

The Defendant successfully completed Phase I (0 through 6 months) deliverables as outlined in the IBTM Implementation outline.⁷⁵ In October of 2010, DJJ established a multidisciplinary implementation headquarters team, as well as 4 subcommittees: *1) Assessment and Case Planning; 2) Treatment/ Scheduling; 3) Behavior Management; and 4) Quality Assurance.* The subcommittees were comprised of headquarter and facility staff. All committee chairs completed all tasks by April 1, 2011. Examples of completed tasks include:

- Integration of assessment and case planning functions to include integration of assessment functions into the WIN system to avoid duplicate entry. This integration benefits the entire DJJ system.
- Developing a schedule and method for consistent delivery of core cognitive behavioral programs
- Development of group observation methods to ensure fidelity to the program.

As will be seen in the next section of this report, the Defendant has and continues to make progress in many remedial plans. However, it appears there remains a fundamental lack of understanding of the central role that appropriate behavioral management is to the centerpiece of the reform effort, the behavioral treatment process. Ultimately both treatment and custodial staff must be trained to reinforce behaviors that support a pro-social lifestyle. While the external environment continues to create challenges for the Defendant to implement the necessary activities to support staff in understanding and developing behavioral management strategies that support pro-social behavior, many challenges also reside with the Defendant. This can be seen in the implementation of the IBTM.

⁷⁵ See Order Re: Integrated Behavior Treatment Model Report Summary and Implementation Outline May 27, 2010 and PoP #821.

After years of painful negotiations and court actions, the parties reached agreement on both the model and the process for implementation of the IBTM. In its simplest terms, the model requires the elimination of unproven treatment approaches⁷⁶ and youth change strategies, focuses on a limited cadre of cognitive behavioral treatment programs that must be implemented with exact fidelity to the model(s), and requires that all staff learn a core set of basic behavioral management skills that address a youth's development of interpersonal, stress management, self-regulation, self-monitoring and cognitive/thinking skills. To teach youth how to extinguish anti-social behavior, the cognitive behavioral training courses in combination with consistent reinforcement of what is taught in them and where needed, supplemented by mental health therapy that is also cognitive-behavioral in approach is required. The challenge for all youth correctional systems is training staff how to change their responses to youth that actually impede skill development. To do this requires exposing staff to the research or the "why" these changes make sense and work. All adults have been exposed to some ineffective behavior management practices in their own youth and without accurate information, unknowingly or knowingly exhibit these practices to the youth in their care. As such, most adults have to learn at least some different behavioral management strategies.

There is little evidence that the senior headquarters and senior facility staff fully understand what constitutes the behavioral management strategies that support the development in youth of effective intrapersonal and interpersonal skills. Few of the

⁷⁶ It is always difficult for staff to stop engaging in practices that in fact are ineffective but because they have done them for so long or were once trained in them create the belief that they are good practices. Senior level managers are as challenged as line staff with this issue.

senior staff has been exposed to sufficient training to understand the concepts and almost none have visited or experienced a system that daily implements effective behavioral management. This makes it difficult for system leaders to help staff understand how their behavior is or is not congruent with reform efforts.

There are several excellent psychologists and case managers that do understand these concepts and are excellent teachers and coaches.⁷⁷ Those staff who received the training for dialectical behavior therapy received training in the cognitive behavioral skill sets as well as those trained in the various cognitive behavioral programs understand the concepts. There is a notable absence of headquarters staff in trainings ranging from Safe Crisis Management, Motivational Interviewing or the Cognitive Behavioral Primer all of which are central to understanding the overall direction of the integrated behavioral treatment model.⁷⁸ The lack of exposure by senior managers in headquarters and the institutions to the fundamentals of the Integrated Behavioral Treatment Model may delay progress in its implementation.

The consultant team from the University of Cincinnati raises two notable examples of the lack of engagement by senior leaders. They note in their April 30th Quarterly Report that even after extensive training, the pilot sites struggled to adhere to the treatment group schedule. Groups were cancelled for a wide range of issues.⁷⁹ Also noted is that some staff appear resistant to facilitating the groups. For example, of the

⁷⁷ Unfortunately, it is also true that many psychologists and staff do not understand behavioral management reinforcers.

⁷⁸ For example, see PoP #785. Sixteen of 80 Central Office staff attended Safe Crisis Management Training, 19 of 65 attended Motivational Interviewing and none of DJJ's Central Office staff were scheduled to attend the Cognitive Behavioral Primer.

⁷⁹ A solution to group cancellation has been crafted. In essence, it requires getting approval for cancellations higher up the chain of command. See PoP #828.

three psychologists scheduled to attend aggression replacement training, none attended. The IBTM committee members have done their work but do not appear to be receiving the full support of senior managers at headquarters and in the facilities to implement the program. While reasons for the lack of demonstrated support by senior managers is unclear, it is more difficult to garner support when the senior managers have not been adequately trained to understand the program. Additional training targeted for mid-level and senior leaders is needed.

Another critical issue is the training of Youth Correctional Officers (YCO) in the IBTM and core supplemental training such as the Cognitive Behavioral Primer. Appropriately treatment and case management staff have been prioritized for these trainings. It is time to include the YCO staff in the training. They are central to effective reinforcement of desired behavior by youth.

The success of the pilot hinges on the level of support that it receives from management. In addition, learning from the pilot could be useful to the challenges discussed in this report regarding failure to implement the BTP model and needed revisions in how force is used throughout institutions. A key component of the IBTM is the development of an effective behavior management system that is central to the challenges DJJ is experiencing in these areas.

V. SEXUAL BEHAVIOR TREATMENT PROGRAM

Dr. Barbara Schwartz, *Farrell* Sexual Behavior Treatment Program Expert has completed her "Sexual Behavior Treatment Program Fourth Round Comprehensive Report" dated March 31, 2011. Since the Special Master last reported on DJJ's Sexual Behavior Treatment Program (SBTP) in December, 2009 DJJ has made substantial

improvements in multiple areas of SBTP implementation.⁸⁰

DJJ's Quarterly Report, March 15, 2011 indicates decreases in compliance ratings compared to the same measures from previous rounds. This round's compliance measures are based on criteria from an entirely *new audit tool* that was created in conjunction with the new SBTP Program Guide, adopted in September 2010. That DJJ has received a combined 70 percent rating in substantial and partial compliance is excellent for the first monitoring process/audit using a new measuring tool.

DJJ has made good progress from the Expert's last audit round to this round. DJJ has implemented a program guide and has almost completed program guide training in preparation for implementation. DJJ achieved a high number of "Substantial Compliance" ratings at the Central Office level, which indicates the action plan to implement the curricula and other required program elements is being effectively planned and prepared for implementation in the facilities. Dr. Schwartz and the Special Master are pleased with the continued progress in implementing the standards and criteria for the Sexual Behavior Treatment Remedial Plan. The Defendant's efforts and, in particular, efforts made by the SBTP Coordinator, Dr. Heather Bowlds, are to be commended.

Much of DJJ's SBTP success in this round is due directly to the collaborative style of the SBTP teams and the SBTP Coordinator. Dr. Schwartz notes multiple areas of improvement throughout her report, as well as identifies areas needing still more improvement. Among DJJ's most noteworthy successes is the appointment of a Full-Time Sexual Behavior Treatment Program Coordinator (SBTP Coordinator). The SBTP Coordinator had held an "acting" position since 2008. Her official appointment in

⁸⁰ See Twelfth Report of the Special Master (December 2009).

October 2010 has afforded her a measure of autonomy and authority in policy development and staff training and implementation decisions that are consistent with her knowledge of DJJ's program, her expertise in the field and her clinical acumen. Under Dr. Bowlds's leadership, the Defendant has made significant progress in achieving the standards and criteria of the Sexual Behavior Treatment Remedial Plan.

A. Organizational Structure

Dr. Schwartz recommends amendments to the DJJ SBTP Organizational Chart so that it clearly delineates the SBTP Task Force's oversight authority of the SBTP programs. Dr. Schwartz questions why the most recent organizational chart provided reflects the SBTP Coordinator position, but does not link the position to the SBTP Task force, which is the instrument by which the Coordinator oversees the programs at the various sites.⁸¹ It is Dr. Schwartz's opinion that absent the coordinator's clearly designated supervisory authority, site staff may be unsure to whom they must turn when issues or questions arise. The SBTP Coordinator reports that she is confident that any and all problems reach her personally and that she and the various teams work together to resolve them. Matrix management that provides for leadership of others over whom one does not have direct supervisory authority can be a successful model for this type of situation. The Defendant is reviewing Dr. Schwartz's proposed model.

B. Staff Qualifications

DJJ has successfully hired or retained staff that meets the SBTP job qualifications. She reports, however, that "right sizing" of all DJJ staff has resulted in well intentioned, yet untrained staff persons being assigned to treat youth on the SBTP

⁸¹ *Id.* at p.1

without sufficient qualifications.

Secondary to the staffing issue raised above, there exist on the SBTP units a great many counseling staff whom through experience on the unit(s) and/or desire and motivation to treat youth, have gone to great lengths to develop or utilize curricula that they feel reflect best practices. The staff is to be commended for their effort but Dr. Schwartz reports that those providing treatment on the SBTP units must adhere to an evidence-based curriculum. The formal SBTP curriculum is being written as of this filing. The calendar for the writing and implementation of the SBTP Curriculum is as follows:

June-November 2011: Development of curriculum

Dec 2011: Submit completed draft for review

Jan 2012: Complete revisions based on feedback

Jan-Feb 2012: Develop training manuals and training curriculum

March 2012: Train staff for pilot

March-April 2012: Pilot redesign

May 2012: Finalize and submit completed curriculum

June 2012: Statewide training

July 2012: Implement new curriculum

The SBTP Coordinator assures the Special Master that, as yet, the curriculum schedule is on track.⁸²

C. Staff Training and Program Adequacy

Dr. Schwartz reports that with very few exceptions, staff on all SBTPs were

⁸² Statement of SBTP Coordinator to Deputy Special Master Beltz, June 3, 2011.

trained (or are completing training) from the Program Guide that was filed in September 2010. Again, the SBTP expert emphasizes the importance of a singular *evidence-based* curriculum from which all treatment, custody and other service providers must follow.⁸³

The SBTP Residential Program Operating Guide is implemented in three facilities and is operating successfully on five living units. Unfortunately, the Healthy Living Curriculum, at the time of the site visit, was not being implemented on non-SBTP living units, despite youth on those units being in need of SBTP treatment. The Healthy Living Curriculum is being used effectively, however, not with the youth for whom it is intended. The Curriculum was intended for use with youth who have committed sexual offenses but who do not necessarily reside on in-patient units. In fact, Dr. Schwartz states that the Healthy Living Curriculum could be appropriate for all youth in DJJ, which might solve the dilemma of implementing a sexual behavior curriculum to only certain youth who may be singled out for their offenses. She states that a way to deliver the Healthy Living Curriculum services must be devised. This suggestion should be examined in the context of the IBTM and as such, should be reviewed by the IBTM oversight committee, the IBTM consultant team and Dr. Schwartz.

D. Treatment

The SBTP Expert reports that the required number of treatment hours is not being met. There appear to be multiple intervening factors that curtail sufficient SBTP treatment hours. Anecdotal explanations range from insufficient treatment space, insufficient custody staff to transfer youth to treatment, youth refusal of treatment, and

⁸³ See Sexual Behavior Treatment Program Fourth Round Comprehensive Report, March 31, 2011, pp.2-4.

that the Program Service Day does not allow for it.⁸⁴ The SBTP Expert has not received a comprehensive response to the question about insufficient treatment hours. The Administrative Taskforce has been discussing this issue. The audit data from this round will be analyzed to determine the cause(s) of this and solutions for individual unit and/or system problems will be proposed.

E. Criteria (Audit Item 4.10) and Welfare and Institutions Code §1800

Dr. Schwartz addresses issues involving the Welfare and Institutions Code § 1800 (WIC §1800) as it relates directly to and impacts the release or to the extension of a DJJ youth's sentence. Dr. Schwartz paraphrases the purpose of WIC § 1800: "It is intended to provide for the continued confinement of youths whose behavior presents an immediate danger to the public."⁸⁵

Dr. Schwartz reviewed three DJJ cases that had been petitioned successfully under WIC § 1800 for extensions to youths' sentences. In Dr. Schwartz's opinion, only one of the three petitions was rightly granted. She reports that one youth's recommendation and extension appeared to have been appropriate because of the youth's *current* acting out behavior. A second youth who presented with a WIC § 1800 petition was deemed inappropriate by DJJ medical professionals, but was approved upon referral to the Parole Board for re-evaluation. The final case Dr. Schwartz reviewed involved a youth whose §1800 petition was approved by DJJ's Chief Psychiatrist. Dr. Schwartz is particularly concerned with the second two cases in which WIC § 1800 petitions were granted based solely on non-completion of all phases of the Sexual Behavior Treatment

⁸⁴ Statements to Dr. Schwartz and Deputy Special Master Cathleen Beltz during an administrative meeting.

⁸⁵ See Sexual Behavior Treatment Program Fourth Round Comprehensive Report, March 31, 2011, p. 7

Program. Neither youth appeared to pose an immediate threat if released.

Training on the WIC § 1800 process was provided for staff in the NCYCC on May 17, 2011 and training for VYCF and SRCYCC has been postponed due to the travel freeze imposed by the Governor.

VI. UPDATE ON THE CLOSURE OF PRESTON YOUTH CORRECTIONAL FACILITY

The closure of PYCF has been timely, orderly and problem free. Staff engaged in the process demonstrated excellent project management skills as well as behavioral management skills. DJJ senior headquarters managers engaged the *Farrell* experts in the process soliciting their feedback and suggestions and kept the experts informed of progress periodically throughout the transition.

On May 6, 2011, a conference call with experts, Plaintiff, Special Master and DJJ took place where the Defendant once again updated the experts and Plaintiff regarding closure status. At that time all youth had been transferred to other facilities without incident except for a small group of low core youth who remained to help with final closing activities.⁸⁶ Efforts taken to assist youth with the transition included having gang members transferring into other facilities meet with their rival gangs to discuss strategies to avoid conflict.⁸⁷ School enrollment, orientation packets and meetings with treatment teams and a free entry phone call helped to ease the transition of youth between facilities.

Organizational changes including the transfer of the reception functions, revising of units at the O. H. Close Youth Correctional Facility (OHCYCF) and N. A. Chaderjian

⁸⁶ At the time of the call, 18 youth remained at PYCF. Some of these youth were projected to parole prior to transfer and any remaining youth would transfer before closing. As of this writing there are 12 remaining youth.

⁸⁷ Assistant Superintendent, Rob Pennington, shared this strategy with the Special Master during a site visit to O.H. Close Youth Correctional Facility on March 10, 2011.

Youth Correctional Facility (NACYCF), and training staff at OHCYCF how to operate a BTP were successfully completed by the end of May 2011.⁸⁸

The Defendant is to be congratulated for the orderly, thoughtful and professional manner in which such a difficult and complex process is being implemented.

VII. RECOMMENDATIONS

The recommendations made by the Special Master to the Court in this section of the report may require modifications to the Safety and Welfare Remedial Plan. The Safety and Welfare expert has indicated a willingness to do this but the parties will need to meet and confer on any recommended changes.⁸⁹ Recommendations in most areas enforce the existing requirements of remedial plans. The Special Master recommends that the Court order the Defendant to do the following:

1. Revise the Crisis Prevention and Management Policy to show a continuum of interventions, and include immediate force as the most restrictive intervention method.
2. Revise the Crisis Prevention and Management Policy to ensure that a Crisis Prevention Plan is completed for all youth with 60 days of arrival at a facility.
3. Complete a Crisis Prevention Support Plan for all youth designated mentally ill and/or disabled within 90 days and all remaining youth within 180 days.
4. Revise the use-of-force review process to focus on training staff to reduce their reliance on force and to learn how to de-escalate and prevent use of force through cognitive behavioral management practices.
5. The Use-of-Force-Implementation Committee and IBTM staff adopt a recommendation for behavioral management training that teaches how to de-escalate and prevent the need for force. The recommended training should be

⁸⁸ See Proposed Transition Timeline PYCF.

⁸⁹ Dr. Krisberg and the Special Master have had several conversations about desired changes to the Safety and Welfare plan. Some of the proposed changes have also been discussed with the Defendant.

provided to all direct care staff, within 180 days. Scheduling preference should be given to staff at VYCF.

6. Immediately issue a directive to stop using chemical agents on single youth or female youth who do not engage in assaultive behaviors or pose an imminent danger to self or others.
7. Conduct a pilot project that reduces the use of chemical agents on a mental health unit and substitutes the behavioral management strategies.
8. Design and provide training and coaching in the behavior management skills as identified in the Integrated Behavioral Treatment Model (based on knowledge acquired through recent Dialectical Behavior Therapy (DBT) pilot projects).
9. Examine the role of mental health professionals and explore means to increase their involvement in force incidents involving youth with a disability and/or mental health designation.
10. Provide DJJ Education Services with an exemption from the hiring freeze so that youth in all of DJJ's facilities will receive at least the mandated 240 minutes of education services per day, including youth on the BTP's high core units and youth on Temporary Detention and Temporary Intervention Programs.
11. Provide immediately training to all staff on VYCF's BTP units, VYCF's managers and administrators and all staff on other facilities' BTP units so that the facilities' BTP units operate consistently with the rehabilitative intent of the BTP policy
12. Negotiated placement of planned modular buildings at VYCF and other sites, which will afford education staff additional instruction space, and unit staff additional program treatment and/or group space must be completed no later than January 2012.
13. Provide training regarding the IBTM to senior headquarters and institution staff as well include Youth Correctional Officers in IBTM training and Cognitive Behavioral Primer.

Implementation of these recommendations should be considered within the context of other reform efforts such as the IBTM and other treatment programs to assist staff in addressing youth behavior issues. The Special Master recognizes that recommendation number eight is related to the IBTM. As such, the Defendant may argue

that the time frames should be tied to agreements between the parties regarding its implementation.

Finally, as a result of the issues identified in the use of force reports and matters that recently surfaced at VYCF, the Special Master is concerned about the effectiveness of the audit instrument for the Safety and Welfare Remedial Plan. The current audit approach places heavy emphasis on literal compliance with specific provisions of the remedial plan and not enough focus on whether the purpose, intent, and objectives of the plan had been accomplished. The Special Master plans to work with the parties and the Safety and Welfare Expert in exploring ways to improve the effectiveness of the current audit process.

VIII. CONCLUSION

There is one issue in the *Farrell v. Cate* litigation that is central to all the outstanding issues in the case and that is developing effective behavioral management strategies that support rehabilitative efforts. Problems with use of force and at VCYP stem directly from the failure to have an integrated behavioral treatment model that explicitly and concretely guides custodial, treatment and all other staff how to most effectively support the development of pro-social behaviors in the youth in their care. Clearly, without a deeper understanding of effective behavioral management strategies, there will continue to be vast discrepancies between how programs such as a BTP are implemented compared to how they are designed.

Senior management must be better educated so that they can lead and support staff in what for some will be difficult changes in their behavior and patterns. Senior staff must also become more engaged in the IBTM pilot and learning from the pilot must be

explored as refinements are made to the use-of-force processes and revisions in programs such as the VCYP BTP. DJJ does not need to wait until the conclusion of the IBTM pilot to integrate changes in behavioral management practices. DJJ should ensure staff are trained in the existing courses that focus on crisis management and learning the foundational underpinning of cognitive behavioral approaches. Using some of the highly trained and skilled staff who understand cognitive behavioral approaches to coach and mentor staff while they work in living units and interact with youth is one of the most effective and least expensive methods of helping staff develop new skills. Talented field staff need to be empowered to provide needed leadership to the change effort.

DJJ staff is talented and caring. They suffer from not having a clear direction and, in some cases, support regarding how best to influence youth. Too often the messages they receive are mixed and unclear which is a prescription for a failed change effort.

The Special Master respectfully submits this report.

Dated: July 1, 2011

Nancy M. Campbell
Special Master

Use of Force in DJJ and Mental Health Youth: Preliminary Findings

**Reported by
Barry Krisberg, Logan Hopper, Terry Lee and Eric Trupin**

Purpose of this review

A panel of Court experts consisting of Barry Krisberg, Terry Lee, Eric Trupin and Logan Hopper were asked by Plaintiffs attorney to examine whether there were any problems in the current use of force on youth on the mental health caseload in DJJ. This group was ably assisted by Zack Schwartz of the Office of Special Master (OSM). This group held a number of phone conferences and requested that the OSM pull together the last trend data on use of force (UOF) with mental health youths. It was decided that the Court Experts would review a sample of cases involving UOF with youth who were residing in mental health units.

This report is a first cut at our observations and lists our basic recommendations. We believe that the next step must involve an active engagement with DJJ management and institutional staff to fashion remedial actions as required. These findings have not been discussed with DJJ staff.

Methodology

Working with DJJ, Zack Schwartz, OSM, assembled a random sample of 80 UOF reviews and incident reports that occurred in the first six months of 2009. While these reports did indeed occur some time ago, subsequent and on-going UOF and file reviews indicated that similar conditions still exist.

Each of the Court experts independently examined 20 cases.¹This review covered all DJJ facilities with mental health units. Our examination sought to identify patterns in the UOF. Further, we looked at the quality and the thoroughness of the UOF review process. The group also examined more detailed files for two DJJ youth that had been subject to extensive UOF and DDMS processing. The names of the youth were suggested to us by the Prison Law Office and the Los Angeles County Public Defender. The Court Expert panel also reviewed pertinent UOF policies with respect to mental health cases.

Overview

The aggregate data on UOF in mental health units is alarming. Data from Compstat from 2007-2009 show a consistent pattern in which the rate of UOF in mental health units (number of incidents per 100 youth residing in those units) is 4 to 5 times greater than in non-mental health units. Even as UOF in the DJJ has declined somewhat over the past two years, the rates of UOF in MH units are still more than three times those in non-mental health unit. For example, in 2009 there were almost 533 incidents of UOF in DJJ mental health units that held an average of 215 youth on a typical day – a rate of 62 per

100 youth. By contrast the UOF rate for DJJ non mental health units in 2009 was 20 per 100 youth.

UOF rates in mental health units varied across DJJ facilities with a rate of almost 80 per hundred in Chad; 65 per 100 in Ventura as compared with UOF rates per 100 of 48, 45, and 45 in SYCRCC, OHC and HGS, respectively.

These UOF data are surprising since the living unit size of most mental health units is somewhat smaller than in other units and there are higher staffing ratios. Moreover, the staff assigned to mental health units are presumed to have received special training in managing emotionally troubled young people. Further, the mental health units possess on-site clinical staff to assist the youth corrections counselors and custody staff in managing difficult youth. DJJ policies direct staff to minimize the UOF with mentally ill youth. The next step of this data analysis should be to examine these UOF trends for individual mental health living units. We are requesting these data from DJJ.

General Considerations

The Court Experts note that counting the total number of youth in DJJ who are suffering from significant mental health challenges is problematic. There is not a central listing of all youth in DJJ who are developmentally disabled and DJJ only recently (date) implemented a uniform definition for youth on the mental health caseload. This means that there are certainly some such youth who were residing in regular housing units who were subject to UOF incidents. The MH and Disability Experts are working to help the DJJ establish a consistent and uniform definition by which these youth could be identified or tracked. For this preliminary study, we could only gather data on UOF that involved youths who were residing in a mental health unit. It will be worth determining if mental health youth who live in regular units fare better or worse than those in designated mental health units.

We also note that existing DJJ review process is limited to deciding if the UOF incident was consistent with policy. These reports lack much detail on the circumstances leading up to the UOF or the preventive measures taken to avoid UOF. Likewise, the behavior reports submitted by staff have minimal content. There are often multiple reports by involved staff that repeat the same details of the incident. The behavior reports rarely, if ever, describe the context of the incident that led to the force, or any analysis of how the situation could be handled differently. The vast majority of this review finds that the staff members were following policy. In a very few instances in which the review identified problems, these tended to be “technical” concerns such as the lack of signatures, the omission of medical exams, or other examples of insufficient report writing. These reports rarely mention that the youth was residing in a mental health unit, and they do not contain input from clinical staff

Discussion Points from Case Reviews

As noted earlier, the Court experts reviewed UOF cases each that were selected randomly by DJJ staff from all such incidents that occurred in the first six months of 2009. The Experts each looked at 20 cases. These reviews were intended to get a qualitative picture of the behavior of youth and staff in these situations. Each of the Experts came up with roughly the same conclusions. These are listed below:

1. Almost half of the incidents involved a single youth who was defying staff instructions; typically the staff response would escalate as the youth became more agitated by these confrontations with staff. Incidents included conflicts over giving up old clothing, taking showers, staff requiring that youth move to another location, youth not permitting room searches, contraband or prohibited possession of a range of property items, or the youth covering his room window with paper or towels. An extreme, unfortunate example of not engaging a youth and instead escalating a situation involved a youth with an extensive history of mental health problems, necessitating multiple admissions to licensed mental health facilities while youth was serving his DJJ sentence. During one episode of acute psychiatric decompensation, admission to the CTC was deemed necessary for this youth. When the youth expressed that he did not wish to be transferred to the CTC, he was handled roughly and involuntarily injected with a large dose of sedating medication. When he awoke in the CTC more than a day later, he had no idea what had happened and thought that the CTC staff had caused the multiple bruises he observed on his body. Had the referring facility staff spent more time in dialogue, rather than quickly turning to coercive means—youth was not actively engaged in harm to self or others just prior to the use of force—physical harm to the youth could have been avoided.
2. Almost as many cases involved one-on-fights between that usually did not involve weapons other than fists. In these cases the staff would instruct the youth to stop fighting, and if the youth did not immediately desist, the staff would use chemical restraints on the youth
3. There were occasional cases that involved group disturbances or self-injurious behavior, but these were much less frequent in UOF incidents than the situations just described.
4. The dominant method of force involved chemical restraints. It did appear that staff members were more likely to use physical restraints or takedowns with females as compared with the males.
5. The incident reports rarely contained information about alternative de-escalation resolution approaches that were used by DJJ staff. Of course, the Experts looked at incidents UOF occurred and not events which UOF was averted by staff.
6. The UOF reports suggest that chemical restraints often involved spraying the youth in the face with pepper spray from a distance of 3-6 feet. There are several reports in which staff report that the pepper sprays are ineffective, leading to an escalation to the strength of the chemicals utilized or the use of other non-lethal weaponry such as rubber bullets.

7. There are few mentions of involvement of mental health staff prior to, during or after these UOF incidents.
8. The reports rarely mention that the youth is in a MH unit, and it appears that staff respond similarly to behavior by mentally ill and non-mental health cases.
9. Often the UOF incident results in the youth being seen by a nurse, receiving a shower, and returning to their room. It is unclear how often these cases result in write-ups or more serious DDMS sanctions.

Conclusions and Preliminary Recommendations

The aggregate data suggest that there is a significant problem in the UOF with youth who are in MH units. The lower living unit sizes and enhanced staffing, combined with quality training should be reducing the rates of UOF in these locales. The current UOF review process does not appear to consider the special issues posed by mentally ill and developmentally disabled youth. Staff appears to need much higher levels of training on how to preclude and defuse situations with mentally ill youth that escalate to UOF. The most important recommendations that should be implemented immediately are following:

Short Term Actions

Proposed Policy and Procedure Changes

1. DJJ should initiate a multi-disciplinary task force that would include the appropriate Court experts to more thoroughly examine this issue and propose remedies – the efforts to look at the issue previously at Ventura that were headed up by Bob Moore and Dr. Telander are a good model for this approach. It is essential that DJJ management make this issue a top priority and carefully monitor implementation of needed reforms.
2. UOF policies must dictate the use of the less restrictive restraint options and staff must justify escalation of force. UOF policies should specifically review the circumstances in which more patience with mentally ill youth or not responding to less serious misconduct is the preferred staff response.
3. UOF policies should specifically review the circumstances in which more patience with mentally ill youth or not responding to less serious misconduct is the preferred staff response. The role of mental health staff to be engaged in the situations should be defined in DJJ policy and training.
4. All incidents of youth engaging in self-injurious behavior should be immediately referred to a psychological counselor for intervention.
5. All staff in mental health units should work as treatment team and be familiar with each youths individual vulnerabilities and trained in a variety of individualized responses to youth misconduct
6. Supplemental UOF reports should be developed that report on mental health or medical interventions that occur immediately after the incident.

**Report of Site Visits to the California Department
of Juvenile Justice Force Review Committees:
Observations and Recommendations**

By: Michael Gennaco
Expert to the Special Master
March 4, 2011

This writer was requested by Nancy Campbell, Special Master in Farrell v. Cate to observe a sample of the California Department of Juvenile Justice's ("DJJ") Use of Force Committees. Accordingly, this writer traveled to the Ventura Youth Correctional Center on December 21, 2010 and the Southern Youth Correctional Reception Center and Clinic on January 21, 2011 and observed a force review committee meeting at each location. In addition, this writer traveled to DJJ Headquarters on January 13, 2011, to observe the Department Force Review Committee review use of force cases submitted from the various facilities throughout the state. On each occasion, this writer was afforded the opportunity to review the reports for each use of force prior to their presentation to the Committee. During each site visit, this writer was well accommodated and afforded the ability to ask questions about the work of the Committees both during the site visit and afterward. Without the helpful cooperation and insight provided by the participants, the observations and recommendations submitted below would not have been possible.

Observations Regarding the Work of the Committees

It has been this writer's experience that the large majority of prisons, jails, and correctional institutions in both California and the nation review uses of force by staff exclusively through a paper review. Written reports of varying quality are prepared and a mid level supervisor merely "signs off" on the vast majority of force incidents. To DJJ's credit, it has created a committee structure to review force that has the potential for a more robust, systemic, and meaningful result than any paper review could achieve. In addition, the framework created by the committees through which to review force requires "findings" about whether the actions that led up to the force, the force itself, and the actions subsequent to the use of force were within policy. Many use of force review protocols focus solely on the use of force itself and disregard the actions (or non-actions) that may have contributed to the use of force or whether reporting requirements after the force occurred were met. DJJ recognizes that a review of just the propriety of the force itself is too narrow a prism with which to review force incidents and has developed a structural framework that requires consideration and review of the acts prior to and subsequent to the event.

That being said, the committees functioned in ways that did not lend themselves to always achieve an in-depth review of each force incident. Following are some observations that may have contributed to not achieving the ideal in each force case reviewed:

It was not clear from the interaction of the committees whether each participant had a clear understanding of their roles. It appeared that while some attendees regularly attended the meetings, most did not. For those that did attend, very few had been presented the opportunity to

review the incidents prior to the meeting. As a result, a majority of the meeting consisted of the chair or the use of force coordinator reading part of the reports to the other committee members.¹ This type of structure did not lend itself to much dialogue or participation by the committee members who were not regular attendees and did not have prior access to the incident reports.

The committees had a heavy docket of incidents to review. As a result, the committee meetings took several hours and even with that commitment of time, most incidents received relatively short shrift.

Not every facility has a designated use of force coordinator. It appears that the process was streamlined at the committee phase for institutions that had in place a designated use of force coordinator.

The majority of the discussion regarding the incidents focused on issues involving the quality and timing of report writing and the report review process. While admirable that the use of force coordinator and/or the chair (or other report reviewers) had identified gaps in reporting or failures to meet writing and review deadlines, it did not appear particularly efficacious to have those issues considered by and presented to the other committee members. It seemed inefficient to have the other committee members present and simply listening when the litany of report writing issues and failures to meet deadlines was reported out by the chair.

In some cases, staff was instructed by the committee to send the incident back so that additional reports or clarification could be obtained. However, rather than wait until the presumably important information was returned to the committee, there was often a finding at the same meeting that the force was in policy, despite the committee having incomplete information.

While most of the committee's time was being informed by the chair of defects in report writing and deadlines not being met, there seemed to be little discussion to whether any learning was possible from the incident to reduce the likelihood of force occurring in the future, either on a micro (individual) or macro (systemic) basis. While there was some discussion at one facility about the unpredictability of youth programming and the resultant fights that required force to break up and in another instance, discussion about whether staff should use force to stop contraband from being secreted, even in these instances there was little apparent remedial action taken to address these issues. It was suggested that the more comprehensive review of preventive measures is taken up at each facility by the Violence Reduction Committee.

It is apparent that emanating from the committees are written advisories to staff alerting them of issues in report writing. However, these advisories apparently consist of a written memorandum issued to staff setting out the issue. There was some discussion of certain staff being ordered to attend training on report writing and/or DJJ's use of force policy, but it was not clear that a remedial plan carefully tailored to the issue(s) identified was routinely devised. No apparent robust "action" plan was developed detailing any remedial measures that might be used

¹Interestingly, the only time that raw data was actually presented to committee members was when the ward had been asked to provide a videotaped statement.

to address issues identified.

There did not appear to be any mechanism by which the committee could receive formal feedback from facility supervisors whether remedial plans were, in fact, implemented. There was also no apparent device through which the committee could learn the effectiveness of any remedial measures.

There were isolated times in which an incident was discussed and positive comments were made regarding the quality of the report writing or actions taken by staff in responding to the incident. However, there did not appear to be any systemized way in which such observations were meaningfully communicated back to facility staff. It appears, rather, that the majority of feedback received from staff consisted of advisory memoranda about defects in report writing while feedback regarding “jobs well done” was not evident.

The use of chemical agents was prominent in the uses of force reviewed. In some cases, the reports indicated that the use of the chemical agent had proved ineffectual. However, there was no discussion at the committee level about why the tool had been ineffective. As a result, helpful feedback to staff regarding the failure of the tool in that circumstance did not occur. In addition, there is no apparent uniformity to the type of chemical agent to be deployed, likely resulting in disparate results in their effectiveness.

While there was discussion of current policy, with one exception, there was no discussion at the force review committees regarding whether policy needed to be changed or reevaluated.

At the DFRC, incidents were reviewed from four facilities however the committee did not review any incidents at three facilities since those facilities had apparently not forwarded incident reports during the requisite time frame.

Potential External Barriers to Effective Committee Review

DJJ lacks a facile way for supervisors to access prior staff conduct. For example, to learn how many times a particular employee has used force over a period of time, the use of force reports written during that time frame must be reviewed by hand to determine how many times the employee showed up as using force. There is no tracking database that captures uses of force by each employee or whether there were issues with the use of force or subsequent report writing. As a result, patterns of past behavior are not readily available for the committees’ use or for that matter, for any DJJ supervisory or training use.

Except in limited circumstances, the committee was not presented with the ward’s version of what transpired. This is in large part due to the fact that the ward is usually not interviewed as part of the force review. While the ward would be interviewed as part of any subsequent disciplinary process, his or her statements are not obtained for purposes of the force review. The same is true for ward witnesses to the use of force incident. As a result, in most cases the committee only has for its consideration the version of the event put forward by staff.

In some instances certain staff was not interviewed or asked to write a report. For

example, in one case, the reports indicated that a supervisor responded to a force incident and instructed the staff person who had used force to leave the area. However, this supervisor was not asked to explain why he did so.

The force packages contain much duplication. Review of the packages becomes more time consuming than necessary as a result of having to sort through redundant and duplicative reports.

There appears to be little systemic effort to examine facility cameras to learn whether the incident has been captured on videotape. Several facilities do not have cameras or the staff to monitor them.

There is apparent confusion about whether unresisted handcuffing needs to be documented as a use of force. To categorize such an event as a use of force is inconsistent with current DJJ policy. Even if the policy were changed to include unresisted handcuffing as a use of force, it does not naturally follow that such incidents need to be reviewed by the Force Review Committees. An unintended consequence of categorizing such events as a use of force might be to provide a disincentive to handcuff wards, even in instances where for staff and ward safety reasons, the application of handcuffs is advisable.

Each facility has an entirely different way of case numbering the use of force incidents. Such non uniformity causes potential difficulties in comparing use of force issues between the various facilities. The lack of a uniform case numbering system also provides unnecessary challenges to the DFRC which reviews uses of force from all facilities.

As noted above, the bulk of the committees' discussions concerned ambiguous or incomplete report writing. This fact is suggestive that there may not be enough attention to the review of reports at the time they are first written and submitted. With a more exacting review of the reports at the time of submission, ambiguities and missing information could be captured in real time, when the memories of staff are fresh. More attention to the reports at the front end would also lessen the need for the committees to send reports back for clarification or further work.

The current time frames for each stage of the report review stage are more often breached than met. As a result, current time frames are relatively meaningless with regard to DJJ expectations.

Recommendations for Consideration

The following recommendations are offered for consideration:

1. Ensure that each participant in the committee has a clear understanding of his or her roles. Regularize attendees and provide advance notice of the committee meeting. Learn several days ahead of time the individuals who will be in attendance.

2. Provide each attendee the opportunity to review the incident reports prior to the committee meeting with expectations that each will afford themselves of that opportunity.
3. Instead of reading reports, the chair should spur dialogue by identifying issues and asking for input from individuals representing various disciplines.
4. Consider triaging use of force reports so that a manageable quantity of incidents can be meaningfully discussed. Consider having cases that do not raise significant issues to be reviewed by a smaller subset of individuals such as the Superintendent, the Chief of Security, Training, and the Use of Force Coordinator.
5. Have issues involving report writing handled off line by the Superintendent and Use of Force Coordinator.
6. Have each facility designate an individual as a Use of Force Coordinator.
7. If reports are sent back for clarification or for more information, do not determine whether the force was in policy until the additional information is returned for consideration.
8. Spend more of the committee's time considering whether learning was possible from the incident to reduce the likelihood of future uses of force.
9. If the learning needs to be directed to a set of individuals involved in the incident, designate an individual to effectively convey that learning experience back to involved staff through face to face briefing and/or training rather than advisory bulletins.
10. If the learning is more systemic, designate an individual to effectively convey that learning experience back to the institution as a whole through training bulletins, in-service training and/or briefings.
11. Develop a formal action plan to ensure that effective individualized and/or systemic teaching tools are devised.
12. Develop a feedback loop to ensure that the committee is informed about the effectiveness and results of any action plan developed.
13. Develop mechanisms by which quality performance is meaningfully communicated back to involved staff.
14. When a force option proves to be ineffectual, provide the opportunity for community discussion to gain insight on why the force option was not effective. Consider regularizing and limiting the types of chemical agents permitted to be deployed.
15. Regularly ask the question of committee attendees about whether each event requires refinement of current policies, protocols, procedures or training curricula.

16. Ensure that each facility sends its force reports to DFRC on a regular and timely basis.
17. Develop a data base that would track staff performance on use of force and report writing issues.
18. Consider obtaining the ward's version of what had transpired as well as any ward witnesses to the event for purposes of the force review.
19. Devise ways to streamline the use of force report packages to avoid duplication.
20. If an event may have been captured by facility cameras, ensure that the cameras are reviewed and any evidence of the incident is collected. In facilities which do not have cameras, continue to push for installation of cameras and the staff to monitor them.
21. Clarify whether unresisted handcuffing needs to be documented as a use of force and whether it needs to be reviewed by the force review committees.
22. Devise uniformity in case numbering and report preparation among facilities.
23. Emphasize more exacting review by first level supervisors of report writing at the time the reports are submitted. Hold first level supervisors accountable should the review be less than exacting.
24. Either commit to honoring current time frames or develop realistic time frames that can be reasonably met.
25. Ensure during committee review that all witnesses to the event have, in fact, been asked to write reports or be interviewed.

OFFICE OF THE CHIEF DEPUTY SECRETARY

4241 Williamsborough Drive, Suite 227
Sacramento, CA 95823



April 19, 2011

Nancy Campbell
Special Master
56 East Road
Tacoma, WA 98406

Dear Ms. Campbell:

Attached is the sub-committee report on Use of Force. As you are aware the Division of Juvenile Justice (DJJ) convened a multi-disciplinary committee which included staff from the Office of the Special Master, Experts, Office of Inspector General and DJJ staff. The committee was charged with looking at use of force incidents within the DJJ to determine if policy was followed. More importantly, the committee was to identify additional steps that DJJ could take to reduce the number of force incidents, especially with mentally ill youth. The full committee assigned the quantitative and qualitative review of the force incidents to a sub-committee, which provided us their report on March 17, 2011.

I would like to thank and acknowledge the members of the subcommittee for their hard work and commitment to the Use of Force review project. After much discussion, we are releasing the March 17th report produced by the subcommittee.

The original process included an opportunity for the full Use of Force committee to review and have input into the final report. The full committee met last week and discussed the report. However, it became apparent that the process was getting sidetracked on details of the report. This delay would cause us to lose focus on the important issue at hand. Therefore, in an effort to move us closer to working on solutions for this issue, we are releasing the subcommittee's work. The only change made was the deletion of the specific living unit and facility identification when reporting progressive disciplinary actions of staff.

While DJJ does not endorse the report, we find the information to be valuable in assisting us with our next steps. As you know with any report we need to validate the findings and research will continue their work in doing so. We are committed to moving forward and have already met with you and the experts to review the recommendations for consideration of adoption. In the next few days I will be forming an implementation team who will be reviewing the recommendations of the sub-committee. The implementation team will develop a plan within 30 days that

identifies labor, and fiscal implications as well as immediate, short term and long term strategies for addressing this issue.

We are anxious to move forward with the important work of decreasing force within DJJ and look forward to discussing this with our partners.

Sincerely,



RACHEL R. RIOS
Chief Deputy Secretary (A)
Division of Juvenile Justice

Cc: Michael Brady
Don Spector
Barry Krisberg
Logan Hopper
William Kwong
Van Kamberian
Julie Bole

**Use of Force
Review
Project**

**Sub-Committee
Report**

**Date Submitted:
March 17, 2011**

Use of Force Review Project

DIVISION MISSION

As described in Section 1700 of the *Welfare and Institutions Code*, the mission of the *Division of Juvenile Justice* is to protect the public from criminal activity by:

- Providing youthful offenders with a range of training and treatment services;
- Directing youthful offenders to participate in community and victim restoration;
- Assisting local justice agencies in controlling crime and delinquency; and
- Encouraging development of state and local programs that prevent crime and delinquency.

Use of Force Review Project

USE OF FORCE REVIEW PROJECT TASK FORCE

Steve Kruse, Chairperson
Deputy Director, Juvenile Facilities

Bob Moore, Co-Chairperson
Major(R), Administration and Operations

Sandra Youngen
Director, Juvenile Facilities

Dorene Nylund
Chief, Court Compliance

Ed Morales, M.D.
Chief Psychiatrist, Mental Health Services

Jeff Plunkett
Major, Juvenile Facilities

SUB-COMMITTEE

John Chen, Project Leader, Ad-hoc Workgroup
Farrell Deputy Special Master

Barry Krisberg, Ph.D. Advisor, Ad-hoc Workgroup
Farrell Court Expert, Safety & Welfare Remedial Plan

Logan Hopper, Advisor, Ad-hoc Workgroup
Farrell Court Expert, Ward with Disabilities Remedial Plan

Suzanne Gostovich, J.D. Monitor, Ad-hoc Workgroup
Special Assistant Inspector General, Bureau of Independent Review

Brian Trott, Technical Support, Ad-hoc Workgroup
Deputy Inspector General, Senior, Bureau of Independent Review

Ken Willis, Technical Support, Ad-hoc Workgroup
Deputy Inspector General, Bureau of Independent Review

Eric Umeda, Ad-hoc Workgroup Member
Program Administrator(R), Program Operations

Amy VanBoven, Ph.D. Ad-hoc Workgroup Member
Staff Psychologist, Mental Health Services

Rick Flynn, M.S.W. Ad-hoc Workgroup Member
Supervising Casework Specialist, Juvenile Facilities

Susan Sonoyama, M.S. Ad-hoc Workgroup Member
Staff Services Manager II, Administration and Operations

Use of Force Review Project

INTRODUCTION

Purpose

Background

Division Executive Management Team

Use of Force Task Force and Ad-hoc Workgroup

Office of the Inspector General

Use of Force Review Project

INTRODUCTION

Purpose

The purpose of the study was for an interdisciplinary team to examine force practices from multiple perspectives and to deliberately reach consensus on identifying ways to reduce the frequency of force incidents. An additional purpose of the study was to identify the extent to which chemical agents had been used in force incidents and assess whether alternative options might have been viable. Comprehensive, special attention was afforded force incidents that involved Youth with a *Mental Health Designation* or an identified disability. The purpose for the study was not to identify specific staff members who were out of compliance. In fact, the study found that, in general, staff members made concerted efforts to adhere to existing policy, procedures and training.

Background

The Attorney for the Plaintiffs in the *Farrell v. Cate* litigation requested that a panel of Court Experts examine force issues related to Youth with *Mental Health Designations*. In response, with the support of the *Office of Special Master*, the Court Experts conducted a review and concluded that significant force issues existed with Youth residing on Mental Health Units. After the review, the Court Experts made a variety of recommendations, including:

“DJJ should initiate a multi-disciplinary task force that would include the appropriate Court experts to more thoroughly examine this issue and propose remedies – the efforts to look at the issue previously at Ventura that were headed up by Bob Moore and Dr. Telander are a good model for this approach. It is essential that DJJ management make this issue a top priority and carefully monitor implementation of needed reforms.”

Division Executive Management Team

After careful consideration of the recommendations the Court Experts issued, the *Executive Management Team* expanded the scope of work by forming a multi-disciplinary task force to examine use of force throughout the entire Youth Correctional System. Because of the breadth and depth of the study, the *Office of Special Master* was asked and agreed to participate in the process and subsequently, John Chen, Deputy Special Master, was appointed to the task force.

Use of Force Task Force and Ad-hoc Workgroup

Steve Kruse, Deputy Director, Juvenile Facilities, chaired, and Bob Moore, Major, Retired, co-chaired the *Use of Force Task Force*. The Task Force represented multiple disciplines and consisted of managers and supervisors from across the organization. To complete the *Use of Force Study*, a *Use of Force Ad-hoc Workgroup* was formed.

Office of the Inspector General

In addition, the *Office of the Inspector General* was asked to participate in the study as an independent monitor. As a result, Suzann Gostovich, Special Assistant Inspector General, was appointed to the ad-hoc workgroup. In addition, Brian Trott, Deputy Inspector General, Senior, and Ken Willis, Deputy Inspector General, provided computer and technical support. Lisa Seaton, Staff Services Manager I, developed a *Force Incident Review Process Flowchart* [Exhibit I].

Use of Force Review Project

SCOPE AND METHODOLOGY

Use of Force Study

Quantitative Analysis

Qualitative Review

Egregious Cases

Expert to the Farrell Special Master

Youth Interviews

Sampling Selection

Use of Force Review Project

SCOPE AND METHODOLOGY

Use of Force Study

The scope of the study encompassed force incidents that occurred from March 2009 through May 2010 in five of six existing facilities. March 2009 was selected to begin the study because the *Crisis Prevention and Management Policy* became effective in February 2009. To ensure that force incidents had been subjected to the entire review process, May 2010 was selected as the month to conclude the study. Because the facility closed during the study period, force incidents that occurred at *Heman G. Stark* were excluded.

Quantitative Analysis

The *Office of the Inspector General* was provided over 6000 identification numbers from the *Division Use of Force Database*, each corresponding to a Behavior Report that was generated during the specified time period. From the 6000 identification numbers, the *Office of the Inspector General* randomly selected 300 through a computerized program. *Due to complications with the sampling selection, 245 rather than 300 force incidents were analyzed. The ad-hoc workgroup developed a *Use of Force Matrix* to capture relevant data, including, time of the force incident, any *Mental Health Designation* and/or identified disability for each Youth, type of force used, any injuries that Youth or Staff members sustained, as well as conclusions the *Institutional Force Review Committee* reached. The matrix data was analyzed for trends and patterns, which were subsequently used to support the study observations and recommendations. [See Attachment A for a summary of the *Use of Force Matrix*.]

**See the Sampling Selection Section.*

Qualitative Review

From the quantitatively analyzed cases, 100 were selected for qualitative review. The 100 cases selected were compared to those in the original sample and no significant differences were identified. The qualitative review involved each member of the ad-hoc workgroup independently reviewing the entire case and then meeting to discuss the incident from multiple perspectives. The results of the qualitative review, supported by the data from the quantitative analysis, formed the basis for the study observations and recommendations. [See Attachment B for a summary of the *Use of Force Matrix* for the 100 qualitatively reviewed cases.]

Egregious Cases

Two trained and competent Correctional Peace Officers independently examined the 100 qualitatively reviewed cases using criteria that included whether force could have been avoided, appropriateness of staff actions prior to and after force, type and amount of force, extent of documentation deficiencies and quality of review at all levels. The cases that the Correctional Peace Officers identified were thereafter referred to as the 31 most egregious cases and were used to provide additional support for the study observations and recommendations.

Expert to the Special Master

Mike Gennaco, Force Expert, was retained to observe and provide comments on the *Institution Force Review Committee* and the *Division Force Review Committee* process. [See Attachment C for report from Mike Gennaco.]

Use of Force Review Project

SCOPE AND METHODOLOGY [Continued]

Youth Interviews

The Youth were considered a major stakeholder in the study. Thus, exploratory interviews were conducted with 20 Youth who had been involved in force incidents. During one of the interviews, an allegation of staff misconduct surfaced; this was reported through the chain of command and a request for an investigation was submitted to the *Office of Internal Affairs*. [See Attachment D for *Youth Interview* results.]

Sampling Selection

An estimated 2,000 force incidents occurred during the study period of March 2009 through May 2010. Thus, a random sample of 300 would permit extrapolation at a 95 percent confidence level, the range of error being plus or minus 5 percent. Regarding sample selection, originally, the force incidents were to be selected from the *Division Compstat Database*. However, this approach was not viable as Compstat only contains summary data on force incidents, as reported by the staff members at the facilities. The database does not contain individual data on force incidents. So, the *Office of the Inspector General* assisted and, using a computerized program, provided a random sample of 300 identification numbers that corresponded to Behavior Reports generated during the study period. Nevertheless, for the following reasons, the random sample of 300 resulted in only 245 force incidents being analyzed:

1. The majority of force incidents involved multiple *Behavior Reports*. Thus, some of the 300 identification numbers corresponded to the same force incident.
2. Some Behavior Reports did not include use of force.
3. Not all of the *Force Incident Packages* were found. After *Institutional Force Review Committees* convene, the facilities submit packages to the *Division Force Review Committee*. Initially, 100 of the 300 incident packages randomly selected had not been submitted to the *Division Force Review Committee*. Requests were made to the staff members at the facilities to submit the missing packages but some could not be located. In total, 25 packages, including 19 from the *Southern Youth Correctional Reception Center and Clinic*, were not located and thus, not accounted for in the *Use of Force Matrix*. This issue is further discussed in Section VIII *Tracking System*; Observation 8.1 *Missing Use of Force Reports*.

Despite the complications, the ad-hoc workgroup believes the force incidents selected fairly represent use of force practices within the Division. Two ad-hoc workgroup members, Eric Umeda and Rick Flynn, have extensive experience with force incidents and have concurred that the 100 qualitatively reviewed cases are representative of incidents encountered in the past. Since facility staff members were only able to locate 18 of the 37 *Force Incident Packages* requested, a remaining concern is that force practices at the *Southern Youth Correctional Reception Center and Clinic* may not have been adequately represented.

Use of Force Review Project

USE OF FORCE TRENDS

Division Use of Force Trends January 2008 through June 30, 2010

Use of Force Incidents Rate per 100 Youth Days – All Facilities

Use of Force Incidents – All Facilities

Use of Force Incidents Involved Chemical – All Facilities

Percentage of Force Incidents Involved Chemical – All Facilities

Use of Force Review Project

USE OF FORCE TRENDS

Division Use of Force Trends January 2008 through June 30, 2010

Based on Compstat data, the following two tables provide the overall rate and number of force incidents within the Division from January 2008 through June 30, 2010. The monthly average of force incidents declined from 206 in 2008 to 132 in 2009 or by 36%. The monthly average of force incident rates declined from .38 to .29 or by 24% per 100 Youth days, as the Youth population declined during that period.

Due to the closure of *Heman G. Stark* that necessitated the transferring of Youth to other facilities, the monthly average number of force incidents increased from 132 in 2009 to 144 during the first 6 months of 2010 or by 9%. The monthly average of force incident rates spiked from .29 to .38 or by 24% per 100 Youth days, as the Youth population continued to decline from 2009 to 2010.

Use of Force Incidents Rate per 100 Youth Days – All Facilities

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
2008	.44	.41	.39	.42	.43	.33	.36	.30	.33	.42	.36	.35
2009	.36	.29	.32	.30	.28	.28	.23	.28	.33	.25	.35	.26
2010	.33	.40	.39	.38	.40	.35						

Use of Force Incidents – All Facilities

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
2008	286	243	239	219	234	173	191	159	168	217	177	170
2009	174	121	141	130	128	122	111	133	150	114	149	112
2010	137	146	154	145	155	131						

The following two tables provide Compstat data on the number of force incidents where chemical agents were applied. Application rates of chemical agents remained fairly consistent over the years: 74% of incidents in 2008, 69% of incidents in 2009, and 73% of incidents for the first 6 months of 2010. In the total sample of 245 incidents in the study, chemical agents were applied in 183 or 75%.

Use of Force Incidents Involved Chemical – All Facilities

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
2008	236	186	157	173	168	116	146	125	127	134	122	138
2009	120	92	107	87	90	92	78	82	100	70	90	89
2010	111	126	113	93	106	82						

Percentage of Force Incidents Involved Chemical – All Facilities

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
2008	83%	77%	66%	79%	72%	67%	76%	79%	76%	62%	69%	81%
2009	69%	76%	76%	67%	70%	75%	70%	62%	67%	61%	60%	79%
2010	81%	86%	73%	64%	68%	63%						

Use of Force Review Project

OBSERVATIONS AND RECOMMENDATIONS

Observations and recommendations are presented in the following sections of the report. The ad-hoc committee examined force practices from multiple perspectives and reached concurrence throughout the process via critical, robust and ongoing discussions. The recommendations impact staff members across disciplines, including custody, mental health, and medical, ranging from broad to specific. Implementation of the recommendations should be considered within the context of other reform efforts.

Use of Force Review Project

OBSERVATIONS AND RECOMMENDATIONS

SN	Section	ON	Observation
I.	<i>Prevention</i>	1.1	Crisis Prevention Support Plans
		1.2	Antecedent and Proximate Events
		1.3	Visual Obstruction
II.	<i>Inter-disciplinary Treatment Team</i>	2.1	Role of the Mental Health Clinician
III.	<i>Intervention</i>	3.1	Conflict Resolution Sessions
		3.2	Alternatives to Unstructured Dialogue
		3.3	Gang Management
		3.4	Youth with Disabilities and Mental Health Issues
		3.5	Transitional Events, Transfers and Movements
		3.6	Reintegration
IV.	<i>Use of Force</i>	4.1	Youth Covering Windows
		4.2	Single Youth
		4.3	Repeated Use of Chemical Agents
		4.4	Controlled versus Immediate Force
		4.5	Viable Alternative Force Option
V.	<i>Health Care Services</i>	5.1	Youth Injury
		5.2	Self-injurious Behaviors
VI.	<i>Documentation</i>	6.1	Use of Force Reports
VII.	<i>Debriefing</i>	7.1	Dissemination of Information Post Incident
VIII.	<i>Tracking System</i>	8.1	Missing Use of Force Reports
IX.	<i>Quality Assurance</i>	9.1	Force Review Process
		9.2	Institution Force Review Committee
		9.3	Quarterly Qualitative Force Reviews
X.	<i>Accountability</i>	10.1	Continuous Improvement
		10.2	Progressive Discipline
XI.	<i>Staffing</i>	11.1	Shifting Staff Members
		11.2	Mental Health Coverage

Use of Force Review Project

PREVENTION

1.1 Crisis Prevention Support Plans were not required for every Youth, easily accessed, routinely updated, or relied upon before, during, or following incidents.

1.2 Staff members did not consistently identify warning signs and intervene when Youth behavior was escalating.

1.3 Female Youth hid behind vertical shelves in rooms which precluded visual observation.

Use of Force Review Project

I. Prevention

Observation One: Crisis Prevention Support Plans

1.1 Crisis Prevention Support Plans were not required for every Youth, easily accessed, routinely updated, or relied upon before, during, or following incidents.

Authority

According to the Crisis Prevention and Management Policy:

Assessing Youth Behavior

When crisis behavior is observed by staff, it is best, whenever possible, to assess the behavior to better determine how to resolve the situation. Some ways to resolve crisis behavior include, but are not limited to:

Crisis Prevention Support Guide

This is a plan created in advance of any crisis situation by the Treatment Team and individuals familiar with a Youth. It is continually modified as staff become more familiar with a Youth. The plan identifies key factors and effective strategies which staff can utilize for resolving crisis situations. Some of the factors might be:

- *Potential medical and mental health risks*
- *Youth history – Past events, trauma's, anxieties, or other issues which might impact crisis behavior*
- *Youth response to force interventions, and which interventions have been most successful*
- *Successful resources: individuals or resources which might help avert the escalation of force*

Quantitative Analysis

The data collected during quantitative review suggested that *Crisis Prevention Support Plans* were developed at the discretion of facility staff members. Of the 561 Youth involved in the 245 sample cases, only 144 or 26% had a *Crisis Prevention Support Plan* on file. No apparent pattern emerged through quantitative analysis showing that preparation of *Crisis Prevention Support Plans* was risk driven.

- The sample identified 173 Youth involved in multiple incidents; one (1) Youth was involved in nine (9) incidents.
- Of the 173, 122 or 71% had no *Crisis Prevention Support Plan*. Sixty (60) of the 123 Youth had a *Mental Health Designation*.
- One (1) Youth residing on a *Mental Health Living Unit* and had an identified disability had no *Crisis Prevention Support Plan* but was involved in 5 incidents.
- The sample identified 388 Youth involved in only one incident. Of the 388, 92 had a *Crisis Prevention Support Plan*. Forty-six (46) of 92 or 50% of the Youth were assigned to core living units.

Use of Force Review Project

I. Prevention

Observation One: Crisis Prevention Support Plans

1.1 Crisis Prevention Support Plans were not required for every Youth, easily accessed, routinely updated, or relied upon before, during, or following incidents.

Qualitative Analysis

1. During the qualitative review process, *Crisis Prevention Support Plans* were not considered by staff members before, during or following the force incidents analyzed. As the plans are maintained electronically in the *Ward Information Network*, it was unclear whether staff members were aware when a plan existed for a particular Youth.
2. There was no evidence that the information contained in a *Crisis Prevention Support Plan* was being discussed during *Institution Force Review Committee* meetings as a way to reduce future incidents.

Case Snapshots

Two case snapshots follow that describe incidents where staff members failed to use critical information contained in a *Crisis Prevention Support Plan* during a force incident.

[Additional case examples where a Crisis Prevention Support plan was not in place: 16, 27, 36, 67, 70, 75, 76, 81, 87, 88, 94, 96 and 98]

Case 1

In Case 1, a male Youth, 18 years; 10 months, and a male Youth, 19 years; 6 months, who resided at *N.A. Chaderjian on Kern Living Unit*, were involved in a one-on-one fight. Chemical agents were used to gain compliance and effect custody.

Mental Health and Disability Status

On the date of the incident, neither Youth had a *Mental Health Designation* or an identified disability.

Crisis Prevention Support Plan-Youth A

Youth A did not have a *Crisis Prevention Support Plan* in place.

Use of Force Review Project

I. Prevention

Observation One: Crisis Prevention Support Plans

1.1 Crisis Prevention Support Plans were not required for every Youth, easily accessed, routinely updated, or relied upon before, during, or following incidents.

Crisis Prevention Support Plan-Youth B

1. Youth B had a *Crisis Prevention Support Plan* in place.
2. During the incident, the plan for Youth B was not utilized.
3. According to the plan:
 - The Youth had been placed on *Temporary Detention* for a *Group Battery on Youth without a Weapon*; the case had been referred for prosecution.
 - When confronted by staff members, the Youth had a tendency to be verbally abusive. The Youth was described as having a long history of violence toward other Youth. The plan suggested that it was better to speak with the Youth individually rather than in a large group setting.
 - To prevent crisis situations the plan reiterated that speaking with the Youth on a one-to-one basis worked best. The plan suggested that the Youth did not handle situations well when confronted in front of his peers. The plan indicated that a telephone call to an Aunt would be helpful.

Prevention

If any of the four staff members involved in the incident had intervened using alternative methods, possibly, this force incident could have been prevented. In the *Crisis Prevention Support Plan*, Youth B was described as having a long history of violence toward other Youth. Prior to the one-on-one fight, obvious warning signs occurred indicating an incident was likely to happen. Speaking with Youth B individually, away from his peers might have de-escalated the situation.

Case 4

In Case 4, a female Youth, 17 years; 4 months, who resided at *Ventura* on *Alborado Living Unit*, refused to comply with a lawful order, assaulted two officers and subsequently tied a piece of her tee-shirt around her neck. Physical strengths and holds as well as mechanical restraints were used to effect custody.

Mental Health and Disability Status

On the date of the incident, the Youth had a *Mental Health Designation* but was not identified with a disability.

Use of Force Review Project

I. Prevention

Observation One: Crisis Prevention Support Plans

1.1 Crisis Prevention Support Plans were not required for every Youth, easily accessed, routinely updated, or relied upon before, during, or following incidents.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place. During the incident, the plan for the Youth was not utilized. According to the plan:

Youth Behavior

The Youth had an extensive history of self-injurious and suicidal behavior. The Youth could become unpredictable and violent. The Youth had numerous incidents where she acted out impulsively causing harm to herself, staff members and peers. In crisis situations, the Youth had bitten, kicked and spat on staff members. When provoked, incited by other Youth or upset at staff members, the Youth was known to damage or deface state property. The Youth was described as embarrassing easily and acting out impulsively as a means to express her frustration. Many times, the behavior of the Youth was described as due to her *Mental Health* needs and was not viewed as behavioral. When addressed in a punitive manner, her agitation was known to increase. When others were around, the Youth was described as more defensive and defiant. The Youth was known to work more cooperatively in one-on-one situations.

Successful Prevention and Intervention Techniques

- Have a staff member who has rapport with the Youth calmly engage in dialogue.
- Approach in a non-threatening manner.
- Decrease the audience size, the less Youth and staff members around the better.
- Utilize staff members like the Psychologist, Casework Specialist, Recreation Therapist or Licensed Psychiatric Technician.
- Check-in with the Youth at the beginning of the shift. If the Youth is withdrawn or agitated, take her aside and give positive feedback using a strength-based approach.
- Know what positively influences the Youth. [For example, her niece was described as a huge motivator.]

Considerations in a Crisis

- When booked for the day, the Youth becomes upset and more likely to act out later in the evening.
- When the Youth is in a high state of aggression and at-risk to self, staff members should approach with extreme caution and wear long sleeves for their own safety.
- Avoid mentioning the *Camera Room*. [The *Camera Room* was viewed as a huge trigger for the Youth.]
- Remain impartial and refrain from antagonizing.

Use of Force Review Project

I. Prevention

Observation One: Crisis Prevention Support Plans

1.1 Crisis Prevention Support Plans were not required for every Youth, easily accessed, routinely updated, or relied upon before, during, or following incidents.

Policy, Practice and Training Recommendations

1. Within 30 days, develop a *Crisis Prevention Support Plan* for every Youth with a *Mental Health Designation* or an identified disability; at a minimum, review and update plan every 30 days.
2. Within 60 days, develop a *Crisis Prevention Support Plan* for every Youth; at a minimum, review and update plan every 30 days.
3. Within 6 months, implement a standardized *Crisis Prevention Support Plan Policy* state-wide. At a minimum, ensure the policy includes provisions for the following:
 - Expected content and format for each plan.
 - Development of a plan for every Youth.
 - Review during each *Case Conference* and after each force incident.
 - Involvement of the Youth in drafting and updating the plan.
 - Description of any required accommodations for a Youth with a *Mental Health Designation* or an identified disability.
 - Stated concerns regarding specific types of force for individual Youth, including prohibition of chemical agents with pregnant females.
 - Review and approval of the plan by the Senior Psychologist.
 - Easy accessibility to each plan on every living unit and in designated areas.
 - Formulation of a dissemination and communication strategy.

4. Regardless of whether the techniques actually de-escalate the conflict, reinforce and reward staff members for attempting to use effective strategies identified in the *Crisis Prevention Support Plan* developed for a Youth.

Use of Force Review Project

I. Prevention

Observation Two: Antecedent and Proximate Events

1.2 Staff members did not consistently identify warning signs and intervene when Youth behavior was escalating.

Authority

According to the *Crisis Prevention and Management Policy*:

Prevention is a critical step in dealing with the management of crisis situations and behavior. Prevention of violence begins with organized programs and staff who know how to relate professionally with the Youth population. Through these relationships, staff develop rapport and recognize behaviors and situations which have the potential of escalating and may lead to violent or acting out behavior.

Prevention techniques should be used prior, during, and after the point in which force measures become necessary. All prevention and de-escalation measures, such as the use of Conflict Resolution Teams, Psychologists, Teachers, Interns, Clergy, Nurses, Recreation Therapists, ADA Coordinators, and other staff should be considered and utilized when possible and practical. Reasonable efforts to de-escalate and prevent force should be made.

Qualitative Analysis

During the qualitative review process, in the sample of *31 cases identified as especially egregious, 6 or 19% involved incidents where staff members failed to recognize behaviors or situations that had the potential of escalating into violent or acting out behavior. In each of the 6 incidents, when reasonable efforts to de-escalate and prevent force should have been made, appropriate interventions were not utilized.

**Based upon the judgment of two objective, trained and competent Correctional Peace Officers serving as Subject Matter Experts.*

Case Snapshots

Two case snapshots follow that describe behaviors or situations where staff members did not intervene when Youth behavior was escalating.

[Additional case examples included: 7, 36, 67 and 91]

Use of Force Review Project

I. Prevention

Observation Two: Antecedent and Proximate Events

1.2 Staff members did not consistently identify warning signs and intervene when Youth behavior was escalating.

Case 1

In Case 1, a male Youth, 18 years; 10 months, and a male Youth, 19 years; 6 months, who resided at *N.A. Chaderjian on Kern Living Unit*, were involved in a one-on-one fight. Chemical agents were used to gain compliance and effect custody.

Mental Health and Disability Status

On the date of the incident, neither Youth had a *Mental Health Designation* or an identified disability.

Crisis Prevention Support Plan

On the date of the incident, Youth A did not have a *Crisis Prevention Support Plan*. However, Youth B did have a *Crisis Prevention Support Plan* in place. [See Section I; Observation 1.1]

Prevention

If any of the four officers involved in the incident had been more proactive and intervened using alternative methods, possibly, this force incident could have been prevented. The initial intervention employed was chemical agents. Clearly, the use of chemical agents proved less than effective.

Warning Signs

Obvious signs that an incident was about to occur were observed:

1. To gain better traction on the floor during the subsequent fight, three Youth Correctional Counselors, as well as the Lieutenant observed a Youth switch his shower shoes for tennis shoes with another Youth.
2. To safeguard his shirt during the subsequent fight, three Youth Correctional Counselors observed the same Youth walk to his room and hang his shirt on the door handle.
3. Prior to the fight, one of the Youth Correctional Counselors warned the Lieutenant and another Youth Correctional Counselor that there might be an issue with the Youth who had exchanged his shoes and removed his shirt.

Training

After reviewing the incident, training on Warning Signs, Alternative Interventions, and/or the *Crisis Prevention and Management Policy* was not recommended by the Chief of Security, Superintendent or the *Institutional Force Review Committee*.

Use of Force Review Project

I. Prevention

Observation Two: Antecedent and Proximate Events

1.2 Staff members did not consistently identify warning signs and intervene when Youth behavior was escalating.

Case 2

In Case 2, a female Youth, 20 years; 1 month, who resided at *Ventura* on *Alborado Living Unit* refused to comply with a lawful order. Physical strengths and holds as well as mechanical restraints were used to effect custody.

Mental Health and Disability Status

The Youth had a *Mental Health Designation*. There is evidence that interventions were adjusted to accommodate the individual needs of the Youth in crisis, including the involvement of a Mental Health Clinician. The Youth did not have an identified disability.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place, some of which was utilized during the incident. According to the plan, the Youth experienced manic episodes, was prescribed psychotropic medication that needed to be taken regularly and worked herself up emotionally when she perceived she had nothing to lose. Additionally, the Youth was known to cover her window. Effective crisis prevention and de-escalation strategies for staff members working with the Youth included speaking slowly, interacting with her one-on-one, remaining calm, explaining the situation and possible consequences, placement in her room at the beginning of a crisis or moving her to another room away from a crisis. Other suggestions included limiting the number of staff members involved with the Youth. As the Youth reacted aggressively to touch, the plan recommended using physical force as a last resort.

Temporary Detention

On the day of the incident, the Youth was released from the *Temporary Detention Program*. Prior to release, the Youth gave a commitment to be on good behavior.

Warning Signs

1. While on school movement, the Youth requested to speak with a staff member before “going off on a certain someone standing behind her.” The “certain someone standing behind her,” was a Youth Correctional Counselor from her assigned living unit.
2. There is no indication that staff members followed-up on the comment the Youth made during school movement. If staff members had intervened, the force incident that occurred later in the day on the living unit might have been prevented.
3. One Youth Correctional Counselor reported that the Youth had been escalating her behavior throughout the day. Notwithstanding, staff members did not encourage the Youth to use effective coping strategies.

Training

After reviewing the incident, training on *Warning Signs*, *Alternative Interventions*, and/or *Controlled Force* was not recommended by the Watch Commander, Chief of Security, Assistant Superintendent or the *Institution Force Review Committee*.

Use of Force Review Project

I. Prevention

Observation Two: Antecedent and Proximate Events

1.2 Staff members did not consistently identify warning signs and intervene when Youth behavior was escalating.

Policy, Practice and Training Recommendations

1. Within 90 days, implement specific procedures for identifying warning signs and employing de-escalation techniques among Youth with a *Mental Health Designation* or an identified disability. At a minimum, ensure the procedures include:

- Training and coaching for staff members.
- Consultation with a Mental Health Clinician.
- Recognition of effects of trauma, including possible triggers.
- Extended time periods for interventions.

2. Identify employees effective in identifying warning signs and employing de-escalation techniques; use designated staff members as role models and mentors.
3. Train and coach staff members on identifying warning signs, events that precipitate force and how to effectively intervene.
4. Train and coach staff members on crisis intervention, with priority given to those staff members assigned to living units that target Youth with behavior challenges.

Use of Force Review Project

I. Prevention

Observation Three: Visual Obstruction

1.3 Female Youth hid behind vertical shelves in rooms which precluded visual observation.

Authority

According to the Suicide Prevention and Assessment and Response Policy:

1:1 Observation

Staff assigned to 1:1 Observation shall remain as close to the Youth as required to immediately respond to any attempt at self-injurious behavior. Staff shall maintain clear visual and auditory contact with the Youth.

1:1 Observation is the sole responsibility of staff assigned to this task.

Facility Staff shall be contacted as soon as possible to provide constant 1:1 Observation. Youth shall remain on Suicide Intervention until seen for a face-to-face evaluation by a mental health clinician and until written documentation indicates that a different level of observation is required. The Youth may be placed on Suicide Watch or Suicide Precaution or may be removed from SRR if clinically indicated.

Clinician Contacts

Face-to-Face Evaluation:

- 1. During normal business hours during the week, a face-to-face evaluation by a mental health clinician shall begin within one (1) hour of initiation of Suicide Intervention.*
- 2. Youth placed on Suicide Intervention after 5 p.m. on weekdays, on weekends or on holidays shall be seen by a mental health clinician starting at 10 a.m. the following day.*
- 3. On weekends and holidays, the mental health clinician on-call for suicide evaluations shall contact the Duty Sergeant, or designee, by 8 a.m. to determine the need for evaluations. If contact is not initiated by 8:30 a.m., the Duty Sergeant shall contact the on-call mental health clinician. The Chief Psychologist, or designee, shall be informed by the Duty Sergeant of the need to contact the Psychologist.*

According to Section 1815 of the Institutions and Camps Policy Manual:

Expectation Regarding 30 minute Room Checks

Physical Count Expectations require "a visual count conducted by staff of each Youth assigned to their immediate supervision. When counting Youth, staff will observe skin, check for breathing, movements, and other signs of life. Staff will positively identify each Youth, call the count into the control Sergeant and document the count in the unit log."

Use of Force Review Project

I. Prevention

Observation Three: Visual Obstruction

1.3 Female Youth hid behind vertical shelves in rooms which precluded visual observation.

Qualitative Analysis

1. During the qualitative review process, in the sample of *31 cases identified as especially egregious, 4 or 13% involved incidents where a Youth hid behind vertical shelves in her room. Two (2) of the 4 incidents involved the same Youth; the incident dates were six days apart.
2. During the qualitative review process, in the sample of *31 cases identified as especially egregious, in 4 of 4 or 100% of the incidents involving self-injury, a Youth hid behind a vertical shelf at *Ventura*.

**Based upon the judgment of two objective, trained and competent Correctional Peace Officers serving as Subject Matter Experts.*

Case Snapshots

The case snapshots that follow describe two incidents where a Youth hid behind vertical shelves during a crisis situation.

[Additional case examples included: 59 and 82]

Case 34

In Case 34, a female Youth, 16 years; 11 months, who resided at *Ventura* on *Alborada Living Unit*, was involved in self-injurious behavior. Physical strengths and holds were used to overcome resistance.

Mental Health and Disability Status

On the date of the incident, the Youth was assigned to a *Mental Health Unit*, was on *Suicide Watch* status and prescribed psychotropic medication. The Youth had an identified disability; however no accommodations were cited on the *Youth with Disabilities List*.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place. According to the plan, when unable to deal with a situation, the Youth liked to self-mutilate and therefore needed to be watched closely when in her room. The Youth presented with a history of violent behavior and clenching her fists when angry. When angry, the plan suggested giving firm, clear instructions and removing the Youth from the area. When in crisis, the plan recommended encouraging the Youth to use positive coping skills. Prevention strategies included reminding the Youth of her goals like stepping down to a lower level of care, maintaining “B” phase workability status or talking with her one-on-one. The Youth also responded positively when asked to talk about what was bothering her, when receiving positive feedback or when dialoguing, especially if her sister was mentioned. Speaking in a firm tone, counseling and redirecting were seen as valuable de-escalation strategies. Also, allowing space when she did not want to speak and addressing the Youth using slow, calm speech while addressing different options were viewed as valuable strategies to defuse crises. Dialogue was seen as the least restrictive intervention and chemical agents as the most restrictive force option.

Use of Force Review Project

I. Prevention

Observation Three: Visual Obstruction

1.3 Female Youth hid behind vertical shelves in rooms which precluded visual observation.

Summary

Youth Correctional Counselor One was called to B hallway to assist Youth Correctional Officer One who was supervising a Youth on *1:1 Suicide Watch*. The Youth was in the standing position behind her shelf, not visible or responsive to staff members. Counselor One then stepped into the doorway to acquire a clear visual of the Youth. Once Counselor One could see the Youth, she attempted to reason with her about the importance of staff members being able to see her. The Youth told Counselor One to get out; Counselor One agreed to do so as long as staff members could see the Youth. The Youth then began to bang her head very hard, face forward, against her shelf. Counselor One urged the Youth to stop, sit down or at least move to where she could be seen. The Youth then stood on her bed and began to slam her fist into the window screen. At this point, Counselor One stepped out of the room because the Youth could be seen. Almost immediately after Counselor One exited the room, the Youth began to again hide behind her shelf. At this time Counselor Two arrived at the scene and witnessed the Youth hiding, so he entered the room and attempted dialogue. The Youth yelled, "Leave me alone." The Youth then communicated that she would be using the metal fixture supporting the shelf ledge to bang her head. In response, Counselor One told the Youth that everyone would leave if she would sit and stop hurting herself. At this point, the Youth attempted to flee the room.

Case 81

In Case 81, a female Youth, 21 years; 5 months, who resided at *Ventura* on *Alborada Living Unit*, was involved in self-injurious behavior. Physical strengths and holds were used to gain compliance with a lawful order.

Mental Health and Disability Status

On the date of the incident, the Youth was assigned to a *Mental Health Unit* and prescribed medication by a Psychiatrist. The Youth had an identified disability; however no accommodations were cited on the *Youth with Disabilities List*.

Crisis Prevention Support Plan

On the date of the incident, the Youth did not have a *Crisis Prevention Support Plan* in place.

Summary

The Youth was physically extracted from a safe room and placed in another room after refusing to follow instructions to move from behind the cabinet where she could not be completely seen. The Youth was observed with blood on her arms; blood was on the floor area. The Youth was non-responsive to staff instructions. The Lieutenant called for an emergency extraction. Youth Correctional Officer One held the shield; Officer Two held the chemical agents and Officer Three keyed the door. Officers Four and Five assisted. Officer One then entered the room with the shield and observed the Youth in a crouched position behind the cabinet.

Use of Force Review Project

I. Prevention

Observation Three: Visual Obstruction

1.3 Female Youth hid behind vertical shelves in rooms which precluded visual observation.

Policy, Practice and Training Recommendation

Within 30 days, issue an official statement requiring that any Youth who is at risk of suicidal or self-injurious behavior and who has a documented or demonstrated history of hiding behind vertical shelving is placed in a room without any visual obstruction.

Use of Force Review Project

INTER-DISCIPLINARY TREATMENT TEAM

2.1 Mental Health Clinicians and custody staff members did not partner effectively to de-escalate and manage Youth conflicts.

Use of Force Review Project

II. Inter-disciplinary Treatment Team

Observation One: Role of Mental Health Clinicians

2.1 Mental Health Clinicians and custody staff members did not partner effectively to de-escalate and manage Youth conflicts.

Authority

According to the Crisis Prevention and Management Policy:

Prevention techniques should be used prior, during, and after the point in which force measures become necessary. All prevention and de-escalation measures, such as the use of Conflict Resolution Teams, Psychologists, Teachers, Interns, Clergy, Nurses, Recreation Therapists, ADA Coordinators, and other staff should be considered and utilized when possible and practical. Reasonable efforts to de-escalate and prevent force should be made.

Follow-up or Debriefing Strategies

The following strategies, when used correctly, can assist staff in reducing the re-occurrence of a crisis situation. Staff should consider using the strategies listed below following a crisis situation:

...Communication with the Youth's Treatment Team...

Controlled Use of Force: Special Considerations for Youth with Known or Identified Mental Health/Disability Issues

In a controlled use of force situation, if the time needed does not create an additional safety and security issue or significantly interfere with the operations of the facility, Correctional Peace Officers shall consult with a licensed Health Care/Mental Health Professional regarding the mental and physical impairments of a Youth with disabilities prior to using force.

Principles of Mental Health Assessment and Treatment Policy [In process]

Use of Force Review Project

II. Inter-disciplinary Treatment Team

Observation One: Role of Mental Health Clinicians

2.1 Mental Health Clinicians and custody staff members did not partner effectively to de-escalate and manage Youth conflicts.

Quantitative Analysis

1. In the sample of 245 cases, 177 or 72% involved at least one (1) Youth with a *Mental Health Designation*.*
2. Out of those 177 cases identified above, 96 or 54% involved at least one (1) Youth residing on a *Mental Health Living Unit*, while 81 or 46% involved Youth who did not reside on a *Mental Health Living Unit*.
3. In the total sample of 245 cases, 118 or 48% involved incidents that occurred outside of the typical working hours for Mental Health Clinicians which are Monday through Friday, 0800 to 1800.
4. In the total sample of 245 cases, 173 of 561, or 31% of the *Youth with Individual Needs*** were involved in multiple incidents.

Youth with Individual Needs

- Ninety-six (96) or 55 % were involved in two (2) incidents.
- Forty-four (44) or 25% were involved in three (3) incidents.
- Twenty-one (21) or 12 % were involved in four (4) incidents.
- Nine (9) or 5 % were involved in five (5) incidents.
- One (1) or less than 1% was involved in six (6) incidents.
- One (1) or less than 1 % was involved in seven (7) incidents.
- One (1) or less than 1 % was involved in nine (9) incidents.

**Mental Health Designation*

The criteria for a Mental Health Designation: Residence on a Mental Health Living Unit, Prescribed Psychotropic Medication, Placement on Suicide Watch / Suicide Risk Reduction Status, Receiving Outpatient Mental Health Services

***Youth with Individual Needs*

The criteria for a Youth with Individual Needs: A Youth with Disability or a Mental Health Designation requiring accommodations.

Use of Force Review Project

II. Inter-disciplinary Treatment Team

Observation One: Role of Mental Health Clinicians

2.1 Mental Health Clinicians and custody staff members did not partner effectively to de-escalate and manage Youth conflicts.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, the evidence for involvement of Mental Health Clinicians in force incidents was limited to 6 or 6%.
2. In the sample of 100 qualitatively reviewed cases, 76 or 76% involved at least one Youth with a *Mental Health Designation*.
3. According to the *Force Review Committee Review and Analysis Form* (DJJ 8.443) that was included in each *Force Incident Packet*, a Mental Health Clinician attended some but not all *Force Review Committee* meetings. Nevertheless, in the sample of 100 qualitatively reviewed cases, 0 or 0% included documented contributions from a Mental Health Clinician.
4. The *Force Review Committee Review and Analysis Form* (DJJ 8.443) and the *Use of Force Incident Review Form* (DJJ 8.440) did not contain any provisions for contributions from a Mental Health Clinician.

Case Snapshot

The following case snapshot describes an incident in which Mental Health Clinicians and Correctional Peace Officers did not partner effectively to de-escalate and manage a Youth in conflict.

[Additional case examples included: 2, 66, 81, 82, 86 and 88.]

Case 62

A female Youth, 18 years of age, who resided at *Ventura* on the *Buena Ventura Living Unit*, refused to go to her room after lunch. Physical force and mechanical restraints were used to overcome resistance and gain compliance with a lawful order.

Mental Health and Disability Status

The Youth had a *Mental Health Designation*. The Youth had an identified disability; however no accommodations were identified on the *Youth with Disabilities List*. The evidence suggested that during the incident interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place that was not utilized during the incident. According to the plan, the Youth had past suicidal behavior and ideation, hallucinations, irritable mood, gang involvement and assaultive behavior. Effective crisis prevention and de-escalation strategies for the Youth included speaking one-on-one with a trusted staff member, taking a “cool down” period and limiting involvement with others.

Use of Force Review Project

II. Inter-disciplinary Treatment Team

Observation One: Role of Mental Health Clinicians

2.1 Mental Health Clinicians and custody staff members did not partner effectively to de-escalate and manage Youth conflicts.

Custody Response

The Youth refused to go to her room after lunch. The Youth threw her lunch across the dayroom. A Youth Correctional Counselor pressed his alarm and called a code via his radio. The Youth threw a trashcan. Four Youth Correctional Officers and a Case Manager responded. The Case Manager attempted to dialogue with the Youth for ten to fifteen minutes. The Youth continued to refuse to go to her room. The behavior of the Youth was identified as interfering with the operation of the living unit. To overcome resistance and gain compliance, two Youth Correctional Officers used physical force and attempted to apply mechanical restraints. The Youth pulled away. A Youth Correctional Officer used physical force to transition the Youth to a prone position. Another Youth Correctional Officer used physical force and applied mechanical restraints. The Youth was escorted to a *Safe Room*. The Youth refused to kneel down for mechanical restraints to be removed. Two Youth Correctional Officers used physical force to transition the Youth to a prone position on the bed and remove mechanical restraints. The *Safe Room* door was secured.

Mental Health Response

No Mental Health Clinician intervened before, during or following the force incident. The force incident involved a series of power struggles; at no point was the safety of anyone threatened. Possibly, the power struggles could have been de-escalated and managed via an effective partnership between the Mental Health Clinicians and the Correctional Peace Officers. Specifically, power struggles are about emotional needs. A Mental Health Clinician could have intervened and/or guided custody staff members in intervening to meet the individual needs of the Youth in alternative ways that avoided power struggles. Moreover, effective crisis prevention and de-escalation strategies contained in the *Crisis Prevention Support Plan* for the Youth included speaking one-on-one with a trusted staff member, taking a “cool down” period and limiting involvement with others. A Mental Health Clinician could have supported the Youth and the Officers in attempting to use these strategies.

Force Review Committee

The *Force Review Committee* found the incident was not in compliance with the *Crisis Prevention and Management Policy*. Nevertheless, this was not due to the lack of *Mental Health* involvement. In fact, this was not even raised as a concern.

Use of Force Review Project

II. Inter-disciplinary Treatment Team

Observation One: Role of Mental Health Clinicians

2.1 Mental Health Clinicians and custody staff members did not partner effectively to de-escalate and manage Youth conflicts.

Policy, Practice and Training Recommendations

1. Within 90 days, implement procedures to increase the presence and intervention of Mental Health Clinicians in force incidents; require that Mental Health Clinicians intervene when a Youth with a *Mental Health Designation* or an identified disability is involved.
 2. Within 6 months, conduct pilot project on a *Mental Health Unit* in which there are not any Youth Correctional Counselors and Mental Health Clinicians are the living unit staff members; if effective at reducing force incidents, then expand to all *Mental Health Units*.
3. Integrate Mental Health Clinicians into the rehabilitative process on living units through cultural change, enhanced communication and teamwork across disciplines.
 4. Promote *Inter-disciplinary Treatment Teams* where members are equally valued and respected; reward collaboration.
 5. Re-establish mandatory *Inter-disciplinary Treatment Team* meetings.
 6. Encourage Mental Health Clinicians to act as role models and mentors for Correctional Peace Officers.
 7. Evaluate cost-effectiveness of expanding the role of the Mental Health Clinician to include Licensed Clinical Social Workers and/or Licensed Marriage and Family Therapists.
 8. Incorporate cross training between Mental Health Clinicians and Correctional Peace Officers.

Use of Force Review Project

INTERVENTION

3.1 Before, during and after conflicts between two Youth, staff members did not intervene effectively to prevent incidents from escalating.

3.2 Staff members did not de-escalate conflicts using alternative interventions other than unstructured dialogue.

3.3 Staff members did not intervene effectively to de-escalate conflicts among gang involved Youth.

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.

3.5 Transitional events, transfers and movements were vulnerable times for Youth that triggered behaviors which led to non-compliance and conflict.

3.6 Youth were not reintegrated constructively into the correctional community after conflicts occurred.

Use of Force Review Project

III. Intervention

Observation One: Conflict Resolution Sessions

3.1 Before, during and after conflicts between two Youth, staff members did not intervene effectively to prevent incidents from escalating.

Authority

According to the Crisis Prevention and Management Policy:

Conflict Resolution Team

A team of Correctional Peace Officer staff tasked with interacting closely with the facility's Youth population, applying behavioral and intervention strategies in shaping the facility's social environment, resolving Youth conflicts that exist and/or potentially exist.

Conflict Resolution Team Strategies

- Extensive daily contacts and motivational interviews with facility Youth*
- Small and large group counseling/training on issues and topics related to positive peer interactions and pro-social decision-making*
- Ongoing communication with staff throughout the facility concerning existing and potential conflicts*

Quantitative Analysis

In the total sample of 245 cases, 110 or 45% involved incidents related to conflicts between two Youth.

Qualitative Analysis

- 1. In the sample of 100 qualitatively reviewed cases, 50 or 50% involved incidents related to conflicts between two Youth.*
- 2. In the sample of 31 cases identified as especially egregious, 4 or 13% involved incidents that occurred shortly after a member of the Conflict Resolution Team had intervened; despite Conflict Resolution Team intervention, force was deemed necessary.*

Case Snapshot

The following case snapshot describes an attempt to resolve a conflict between two Youth, where staff members did not structure the intervention effectively to prevent an incident from occurring.

[Additional case examples included: 94, 96 and 98.]

Case 76

In Case 76, a male Youth, 17 years of age and a male Youth, 19 years of age, who resided at Preston on Sequoia Living Unit, engaged in a one-on-one fight. Chemical agents were used to subdue an attacker, effect custody and gain compliance with a lawful order to stop fighting.

Mental Health and Disability Status

At the time of the incident, neither Youth had a Mental Health Designation or an identified disability.

Crisis Prevention Support Plan

At the time of the incident, neither Youth had a Crisis Prevention Support Plan in place.

Use of Force Review Project

III. Intervention

Observation One: Conflict Resolution Sessions

3.1 Before, during and after conflicts between two Youth, staff members did not intervene effectively to prevent incidents from escalating.

Intervention

Two Youth had committed to non-violent problem solving. Per administration direction, the Youth were escorted into the dayroom for a *Crisis Intervention Session*. The Youth were told to be seated; no further support or guidance was provided. While taking a seat, Youth A kicked off his shower shoes and ran across the dayroom to Youth B. Youth B stood up and was hit on the face and upper torso by Youth A. At this point, the Officers pressed their alarms and instructed the two Youth to lie on the ground or chemical agents would be applied. Youth A continued attacking Youth B who backed away. The Officers issued another verbal warning that was ignored. The Officers applied chemical agents. The Youth stopped fighting and lay on the ground.

Comments

Six staff members were present: two Youth Correctional Counselors, a Senior Youth Correctional Counselor, a Parole Agent, a Case Manager, and a member of the *Conflict Resolution Team*. Given the number of staff members present, intervention could have occurred before and during the incident to prevent further escalation. Prior to the incident, staff members could have provided the Youth with additional support or guidance via increased structure, which reduces anxiety and decreases the potential for violence. Engaging the Youth in a game or some other structured activity, versus a verbal back-and-forth discussion, would have achieved this purpose. During the incident, staff members observed Youth A kicking off his shower shoes and running across the dayroom toward Youth B. Intervention at this point might have included physical restraint of Youth A, blocking the path of Youth A, and/or moving Youth B out of the way, all of which could have possibly prevented the one-on-one fight that occurred.

Commitments to non-violence that are not paired with other interventions do not always prevent aggression, hostility and fighting. Interventions that might prevent violence include offering skills training, reinforcing more adaptive behavior, implementing meaningful consequences for fighting, working with the Youth to modify thoughts and expectations and helping the Youth to gain control by exposing them to their anger without fighting.

Use of Force Review Project

III. Intervention

Observation One: Conflict Resolution Sessions

3.1 Before, during and after conflicts between two Youth, staff members did not intervene effectively to prevent incidents from escalating.

Policy, Practice and Training Recommendations

<p>1. Within 90 days, implement an <i>Incentive Program</i> for reducing force incidents; reward staff members for using effective conflict resolution skills with their colleagues and for encouraging their use among the Youth.</p>

2. Revise current practices around *Conflict Resolution Sessions* to reflect effective, evidence based practices. Consider factors such as:
 - Environment: Where *Conflict Resolution Sessions* are conducted, who is present, and if other Youth are around.
 - Proximity: The distance between the Youth during *Conflict Resolution Sessions* and whether a staff member should sit between the Youth.
 - Commitment: Contracts do not guarantee commitment to non-violence; the Youth should demonstrate a commitment to nonviolence in other ways, such as identifying and meeting specific behavioral goals.
 - Youth Participation: The role of the Youth in identifying goals and expectations; as well as how the other Youth on the living unit might support or hinder conflict resolution.
 - Consequences: How violence can be extinguished and non-violence can be reinforced.
3. Facilitate a peer culture of non-violence that identifies group goals and rewards peaceful interaction.
4. For two Youth who have had conflict and committed to non-violence, structure participation in a joint activity that both can enjoy.
5. Role model effective conflict resolution skills for the Youth; resolve conflicts in front of the Youth and identify skills used.
6. Train and coach staff members on effective conflict resolution techniques.
[Consider the existing LETRA training curriculum.]

Use of Force Review Project

III. Intervention

Observation Two: Alternatives to Unstructured Dialogue

3.2 Staff members did not de-escalate conflicts using alternative interventions other than unstructured dialogue.

Authority

According to the Crisis Prevention and Management Policy:

All Division of Juvenile Justice staff have the responsibility to emphasize a continuum of prevention and de-escalation strategies in order to effectively minimize crisis situations including but not limited to communication, assessments, relationship/rappport building, presence, planning, and instructions

Assessing Youth Behavior

When crisis behavior is observed by staff, it is best, whenever possible, to assess the behavior to better determine how to resolve the situation. Some ways to resolve crisis behavior include, but are not limited to:

Unresolved Personal Concerns

Crisis behaviors which are the result of historic or past traumas, which may be stimulated by events in or outside of the current living environment (a Youth abused by his father acts out when his counselor sets limits, or a Youth fights after every time he calls home). These crisis situations are more difficult to resolve as they require understanding of the issues motivating the acting out behavior and helping the Youth to develop alternative coping skills.

De-escalation Strategies

- *Dealing with power struggles and non-compliance*
- *Verbal and nonverbal interventions*
- *Reflective Listening*
- *Empathy*
- *Motivational Interviewing Skills*
- *Dealing with low-function Youth, mental health Youth, and Youth with disabilities*
- *Mediation or Conflict Resolution (Letra)*

Quantitative Analysis

In the sample of 245 cases, only 7 or 3% included any indication that staff members used alternative interventions or methods like a cool down period.

Qualitative Analysis

In the sample of 100 qualitatively reviewed cases, only 4 or 4% included any indication that staff members used alternative interventions or methods like a cool down period.

Case Snapshot

The following case snapshot describes an incident where staff members did not use alternative interventions in attempting to de-escalate a conflict.

[Additional case examples included: 1, 2, 7, 42, 62, 66, 70, 76 and 81.]

Use of Force Review Project

III. Intervention

Observation Two: Alternatives to Unstructured Dialogue

3.2 Staff members did not de-escalate conflicts using alternative interventions other than unstructured dialogue.

Case 86

In Case 86, a male Youth, 17 years of age, who resided at *Ventura* on *Cases de Los Caballeros Living Unit*, refused to leave the kitchen. Chemical agents were used to gain compliance with a lawful order to exit the kitchen.

Mental Health and Disability Status

The Youth had a *Mental Health Designation*. In addition, the Youth had an identified disability; accommodations cited on the *Youth with Disabilities List* included providing access to a *Staff Assistant*, allowing extra time for completing tasks and formulating verbal responses, as well as using simplified, concise language. The evidence suggested that during the incident interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place that was not utilized during the incident. According to the plan, the Youth demonstrated past suicidal behavior, assaultive behavior, argumentativeness and disregard of instruction. Effective crisis prevention and de-escalation strategies for the Youth included speaking one-on-one with a trusted staff member who validated his feelings and focused him on his goals; limiting external stimuli, including the number of people around him; taking space and speaking to his godfather. According to the plan, when force was necessary, chemical agents were more effective with the Youth than physical force.

Intervention

The Youth refused to leave the kitchen after breakfast. Youth Correctional Officers responded to a Code 2 on the living unit and attempted to dialogue with the Youth to gain compliance. The Youth did not comply. The behavior of the Youth was identified as interfering with the operations of the living unit. Youth Correctional Counselors escorted the other Youth out of the kitchen. One of four Youth Correctional Officers present instructed the Youth to place his hands behind his back to be handcuffed. The Youth did not comply. The Youth was informed that chemical agents would be used. The Youth stood up, raising his hands in an upward motion towards his upper body; the behavior of the Youth was interpreted as argumentative and unpredictable. Chemical agents were applied to the chest and facial areas of the Youth. The Youth was instructed to place himself in a prone position on the floor. The Youth complied.

Alternative Interventions

Dialogue was the only intervention used. There were three Youth Correctional Officers present and, at no time, was the safety of anybody threatened. Alternative interventions should have been considered, several of which had been identified in the *Crisis Prevention Support Plan* for the Youth, none of which were implemented. In fact, having three Youth Correctional Officers involved actually precluded use of two identified crisis prevention and de-escalation strategies, namely limiting external stimuli and taking space. This is even more disconcerting, given that the Youth had a *Mental Health Designation* and an identified disability.

Use of Force Review Project

III. Intervention

Observation Two: Alternatives to Unstructured Dialogue

3.2 Staff members did not de-escalate conflicts using alternative interventions other than unstructured dialogue.

Force Review Committee

The *Force Review Committee* found the incident was not in compliance with the *Crisis Prevention and Management Policy*. Nevertheless, this was not due to the lack of alternative interventions or prevention techniques. In fact, this was not even raised as a concern.

Use of Force Review Project

III. Intervention

Observation Two: Alternatives to Unstructured Dialogue

3.2 Staff members did not de-escalate conflicts using alternative interventions other than unstructured dialogue.

Policy, Practice and Training Recommendations

<p>1. Within 90 days, implement an <i>Incentive Program</i> for reducing force incidents; reward staff members for using alternative interventions.</p>

2. Discourage the use of the generic term “dialogue” in reports; require staff members to document the specific interventions used, whether the techniques used are *Motivational Interviewing*, praise, clarification of consequences, forced choice, etc.
3. Use proximity when intervening; for example, when safe to do so, staff members should move to a position between Youth in conflict and/or remove Youth from the line of violence.
4. Train and coach staff members on how to use alternative interventions to manage conflicts
5. Train and coach staff members on basic behavioral principles like praise, reinforcement and extinction.

Use of Force Review Project

III. Intervention

Observation Three: Gang Management

3.3 Staff members did not intervene effectively to de-escalate conflicts among gang involved Youth.

Authority

According to the Crisis Prevention and Management Policy:

Assessing Youth Behavior

When crisis behavior is observed by staff, it is best, whenever possible, to assess the behavior to better determine how to resolve the situation. Some ways to resolve crisis behavior include, but are not limited to:

Unresolved Conflict

[Unresolved conflict is]...Crisis behaviors resulting from a conflict that has been left unresolved. These can often be resolved through conflict resolution intervention.

Gang Management and Intervention Policy [In Process]

Quantitative Analysis

In the total sample of 245 cases, 110 or 45% involved incidents related to conflicts between two Youth.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 50 or 50% involved incidents related to conflicts between two Youth.
2. In the sample of 100 qualitatively reviewed cases, at least 12 or 12% involved incidents related to conflicts between Youth from rival gangs.
3. In the sample of 31 cases identified as especially egregious, 4 or 13% involved incidents that occurred shortly after a *Conflict Resolution Team* had intervened; despite *Conflict Resolution Team* intervention, force was deemed necessary.

Case Snapshot

The following case snapshot describes an incident where staff members did not intervene effectively to de-escalate a conflict among gang involved Youth.

[Additional case examples included: 76 and 96.]

Case 94

In Case 94, a male Youth, 18 years of age, and a male Youth, 22 years of age, who resided at *Preston* on *Redwood Living Unit*, engaged in a one-on-one fight in the dayroom. One of the Youth was identified as a *Bulldog*; the other as a *Northerner*. Chemical agents were used to subdue an attacker, effect custody and gain compliance with a lawful order to stop fighting.

Use of Force Review Project

III. Intervention

Observation Three: Gang Management

3.3 Staff members did not intervene effectively to de-escalate conflicts among gang involved Youth.

Mental Health and Disability Status

At the time of the incident, neither Youth had a *Mental Health Designation* or an identified disability.

Crisis Prevention Support Plan

Neither Youth had a *Crisis Prevention Support Plan* in place.

Intervention

The two Youth participated in a problem solving session after being informed individually of the expectations for programming without violence and signing a *No Violence Contract*. The Youth were handcuffed and allowed to speak to one another for five minutes during the problem solving session. After five minutes of conversation in the presence of the Youth Correctional Counselor and Sergeant, the Youth reiterated their intention to program without violence and the handcuffs were removed.

Use of Force

When the handcuffs were removed, both of the Youth began striking one another; a fight ensued. One of the three Youth Correctional Counselors warned the two Youth to stop fighting or chemical agents would be used. The Youth continued to fight. The alarm was pressed and the Sergeant instructed a Youth Correctional Counselor to apply chemical agents. Chemical agents were applied. The two Youth stopped fighting, went to the ground and were handcuffed.

COMMENTS

Contracts in and of themselves do not reduce the risk of violence. To reduce the risk of violence, contracts should be paired with other interventions. Effective interventions are structured so that Youth have the opportunity to experience one another as individuals. An example of a structured activity that might be successful would be for rival gang members to be assigned to the same team in a ping pong match. Rather than being allowed to rely on fellow gang members, the structured activity requires Youth from rival gangs to work together to complete a task or achieve a common goal.

With respect to the above incident, a total of five staff members were present in the dayroom, three Youth Correctional Counselors, a Sergeant, and a member of the *Conflict Resolution Team*; in addition, one Youth Correctional Counselor was in the hallway and another was in the school area. Given the number of staff members available, interventions such as a structured activity should have been considered.

Use of Force Review Project

III. Intervention

Observation Three: Gang Management

3.3 Staff members did not intervene effectively to de-escalate conflicts among gang involved Youth.

Policy, Practice and Training Recommendations

1. Review the *Gang Charter* within the *Division of Juvenile Justice* and implement an effective, evidenced-based *Gang Intervention* strategy.
[Look to literature and research on integrating segregated groups.]
2. Work with gang involved Youth to develop aspects of their identity other than gang affiliation; help gang involved Youth explore alternative, pro-social ways to get their needs met.

Use of Force Review Project

III. Intervention

Observation Four: Youth with Disabilities and Mental Health Issues

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.

Authority

According to the Mental Health Remedial Plan:

Policies and procedures relating to the use of force will include sections on mentally ill Youth. Policy will recognize that:

- 1. Because of potential medical complications, in any controlled use of force, oleoresin capsicum spray (OC – also known as pepper spray or mace) is not to be used on Youth who are on psychotropic agents. In addition, some individuals who are very aggressive, agitated, and intoxicated, or suffer from a severe mental illness may have altered perceptions and responses to pain and therefore may not respond as desired and may become more agitated by exposure.*
- 2. If at all possible, controlled use of force (i.e., use of force not requiring immediate action) will include the presence of mental health personnel if the Youth is on a mental health caseload. In addition, all controlled use of force is to be proceeded by a cooling down period to allow the Youth to voluntarily comply with staff instructions.*
- 3. The Institutional Force Review Committee is to include a representative from mental health when a use of force incident on a mentally ill Youth is reviewed.*

Principles of Mental Health Assessment and Treatment Policy [Currently, Mental Health is developing the policy.]

Use of Force Review Project

III. Intervention

Observation Four: Youth with Disabilities and Mental Health Issues

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.

Authority

According to the Wards with Disabilities Program Remedial Plan:

Department staff shall ensure that reasonable modifications are made to programs, services, and activities for wards with disabilities.

Reasonable accommodation shall be afforded wards with disabilities to ensure equally effective communication with staff, other wards, and the public.

The Department shall provide reasonable accommodations or modifications for known physical and mental disabilities of qualified wards.

CYA staff shall be aware of accommodations afforded to wards with disabilities in developing and implementing Security procedures including use of force, count, searches, transportation, visiting, and property.

a) Dialogue and Verbal Instruction

- (1) Peace officer staff shall attempt to resolve situations with wards with disabilities using dialogue and verbal instructions whenever possible. Accommodations for wards with disabilities who have specific language, cognitive and/or hearing impairments shall include but not be limited to: 1) clear and understandable warnings of the rule being violated and the consequences of further non-compliance, 2) a sufficient and reasonable amount of time after the warning is given for the ward with a disability to respond, 3) prolonged attempts at resolution via dialogue and instruction, and 4) use of interpreters or staff assistants to establish or enhance communication.*

b) Chemical Restraints

- (1) Peace officer staff shall give sufficient warning prior to applying chemical agents to wards with disabilities. When warnings are given to wards with disabilities, peace officers shall consider the following factors: 1) clear and understandable warnings are given to wards with cognitive and hearing impairments, and 2) a sufficient and reasonable amount of time is afforded after the warning is given for wards with disabilities to respond.*

Use of Force Review Project

c)

III. Intervention

Observation Four: Youth with Disabilities and Mental Health Issues

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.

Quantitative Analysis

1. In the sample of 245 cases, 122 or 48% involved at least one (1) Youth with an identified disability.
2. In the sample of 245 cases, 177 or 72% involved at least one (1) Youth with a *Mental Health Designation*.
3. In the total sample of 245 cases, 197 or 80% involved at least one (1) Youth with a *Mental Health Designation* or an identified disability.
4. During the review period of March 2009 through May 2010, one (1) Youth with a *Mental Health Designation* and an identified disability requiring accommodations was involved in 40 different force incidents.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 54 or 54% involved at least one (1) Youth with an identified disability.
2. In the sample of 100 qualitatively reviewed cases, 76 or 76% involved at least one (1) Youth with a *Mental Health Designation*.
3. In the sample of 100 qualitatively reviewed cases, 85 or 85% involved at least one (1) Youth with a *Mental Health Designation* or an identified disability.
4. In the sample of 100 qualitatively reviewed cases, only 2 or 2% included any indication that staff members modified intervention strategies to meet the individual needs of a Youth with a disability.
5. In the sample of 100 qualitatively reviewed cases, 0 or 0% included any indication that staff members modified intervention strategies to meet the individual needs of Youth with a *Mental Health Designation*.

Case Snapshot

The following case snapshot describes an incident during which staff members did not modify intervention strategies to meet the individual needs of a Youth with a *Mental Health Designation*.

[Additional case examples included: 2, 4, 8, 16, 42, 62 and 86.]

Use of Force Review Project

III. Intervention

Observation Four: Youth with Disabilities and Mental Health Issues

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.

Case 32

In Case 32, a female Youth, 17 years of age, who resided at *Ventura* on *Alborada Living Unit*, tried to tie clothes around her neck in an apparent attempt toward hurting herself. Physical force was used to overcome resistance. The Youth continued attempts at hurting herself and, for a second time, physical force was used to overcome resistance. Subsequently, the Youth refused to take her medication; the On-call Doctor had ordered an emergency injection. For a third time, physical force was used to overcome resistance.

Mental Health and Disability Status

The Youth had a *Mental Health Designation*. At the time of the incident, the Youth was assigned to a *Mental Health Unit*, was on *Suicide Watch* and prescribed medication by a psychiatrist. The evidence suggested that interventions were not adjusted to accommodate the individual needs of the Youth in crisis. On the date of the incident, the Youth did not have an identified disability.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place that was not utilized during the incident. According to the plan, the Youth demonstrated past suicidal and self-injurious behavior, including tearing her shirt and tying it around her neck, as well as impulsive, unpredictable, and/or violent behavior, causing self harm, harm to others and to state property. When escalated, the mental health challenges of the Youth including hearing voices and experiencing black outs often impacted her behavior. In crisis, the Youth responded well to staff members with whom she had rapport and who spoke to her in a calm manner. The Youth also responded better when there was a limited audience. The Youth responded poorly to being spoken to in a punitive manner and to feeling embarrassed.

Effective crisis prevention and de-escalation strategies for staff members working with the Youth included avoiding triggering comments, gently reminding the Youth about her job and other motivators and accomplishments, checking in with the Youth, providing her with positive feedback, working one-one with staff members, utilizing support staff members like a psychologist or casework specialist, allowing the Youth to call her mother, maintaining a strength-based approach, remaining impartial, refraining from antagonizing comments, limiting audience members, approaching the Youth in a non-threatening manner and speaking calmly. According to the plan, when force was necessary, chemical agents were advised due to the tendency of physical force to trigger past trauma.

Use of Force Review Project

III. Intervention

Observation Four: Youth with Disabilities and Mental Health Issues

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.

Custody Response

Correctional Peace Officers entered the room of the Youth and used physical force, strengths and holds, to remove clothing from the Youth. After the clothing was removed, the officers exited the room and secured the door.

Subsequently, the Youth attempted to tie another piece of clothing around her neck and hurt herself. For a second time, Correctional Peace Officers entered the room of the Youth and used physical force, strengths and holds, to remove clothing from the Youth.

Notwithstanding the previous interventions, the Youth continued to engage in self harm and refused to take her medication. An emergency injection had been ordered by the on-call doctor. While the Nurse administered the injection, Youth Correctional Officers used physical force, strengths and holds, to overcome the resistant Youth. After the injection was administered, the Officers exited the room and secured the door.

Mental Health Response

No Mental Health Clinician was involved before, during or following the incident. Clearly, something was maintaining the self-harming behavior, whether it was experiencing relief from her emotional pain, getting attention from staff members and/or something else. Nevertheless, a Mental Health Clinician could have worked with the Youth and the staff members to identify effective ways to reinforce the Youth that would support getting her needs met in a more appropriate way.

Modified Intervention

Throughout the incident, there was no indication that staff members who intervened recognized that the Youth had a *Mental Health Designation*. Consequently, intervention strategies were not modified to meet the individual needs of the Youth. This is particularly concerning given the wealth of information in the *Crisis Prevention Support Plan* and the interventions suggested therein. Had the intervention methods been modified, possibly, the repeated use of force could have been prevented.

Use of Force Review Project

III. Intervention

Observation Four: Youth with Disabilities and Mental Health Issues

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.

Policy, Practice and Training Recommendations

1. Within 30 days, issue an official statement that when intervening with a Youth with a *Mental Health Designation* or an identified disability, chemical agents should not be used as a daily management tool; provide training and coaching.
2. Within 30 days, identify accommodations for every Youth with a *Mental Health Designation* or an identified disability in each *Crisis Prevention Support Plan*. If not specified, require that a Mental Health Clinician identify appropriate accommodations.
3. Within 30 days, for a Youth with an identified disability, include the *Youth with Disabilities Coordinator* on the *Treatment Team*.

4. When intervening with a Youth with a *Mental Health Designation* or an identified disability, amend the *Crisis Prevention and Management Policy* to emphasize safe passage of time and patient interaction rather than reliance on force.
5. Train and coach staff members on meeting the special needs of a Youth with a *Mental Health Designation* or an identified disability in the following areas:
 - *Basic Behavioral Principles*
 - *Communication Techniques*
 - *Crisis Intervention*
 - *Conflict Resolution*
 - *Factors to Consider in Assessing Imminent Threat*
 - *Alternative Interventions*
 - *Warning Signs and Events that Precipitate Force*
 - *Preventing, Identifying and Working Through Power Struggles*
 - *Affects of Psychotropic Medications on Youth Behavior*; emphasize the potential impact during stressful events like force incidents.

Use of Force Review Project

III. Intervention

Observation Five: Transitional Events, Transfers and Movements

3.5 Transitional events, transfers and movements were vulnerable times for Youth that triggered behaviors which led to non-compliance and conflict.

Authority

According to the Crisis Prevention and Management Policy:

Prevention strategies include, but are not limited to:

Consistency and Routine Program Service Delivery

Many crisis situations can be prevented by providing consistency and a daily routine. Youth who experienced unpredictable childhoods often face anxiety, uncertainty, and fear in their daily lives as they face the many different types of transitional periods. Consistency and routine help Youth to develop a sense of safety and security, creating an environment that promotes changes in Youth behavior. Consistency can be increased through:

- *Knowing and implementing program routines*
- *Knowing and adhering to department policies*
- *Recognizing daily transitional and/or high risk periods and helping Youth to prepare and cope with them*
- *Communication between staff and with the Youth*
- *Intentional, planned, and structured communication with treatment and security staff between shifts and/or following an incident to assure successful implementation of Youth treatment strategies and staff response.*

According to the Institutions and Camps Manual:

Each institution and camp shall develop controls and written procedures for all ward movements. These controls shall be based on a system which provides for advance communication of the movement and observation and accountability for all wards.

Written procedures shall include:

- *Observed movement.*
- *Escorted movement.*
- *Signed pass.*

This system shall be monitored on an ongoing basis to maintain effectiveness.

Use of Force Review Project

III. Intervention

Observation Five: Transitional Events, Transfers and Movements

3.5 Transitional events, transfers and movements were vulnerable times for Youth that triggered behaviors which led to non-compliance and conflict.

Quantitative Analysis

1. In the total sample of 245 cases, 119 or 49% occurred between the hours of 1400 and 2000, the transition period during which Youth reintegrate back into the living unit from a structured school or work environment.
2. In the total sample of 245 cases, 197 or 80% involved at least one (1) Youth with a *Mental Health Designation* or an identified disability.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 35 or 35% involved incidents that occurred during transitional events, transfers, or movements.
2. In the sample of 100 qualitatively reviewed cases, 85 or 85% involved at least one (1) Youth with a *Mental Health Designation* or an identified disability.

Case Snapshot

The following case snapshot describes an incident that occurred during school movement involving Youth non-compliance and conflict.

[Additional case examples included: 62, 70, 75, 86 and 88.]

Case 87

Five male Youth, four of whom were 17 years of age and one of whom was 18 years of age, who resided at *Ventura* on the *Cases de Los Caballeros Living Unit*, engaged in fighting on the roadway during school movement. Physical force and chemical agents were used to gain compliance with lawful orders to stop fighting.

Mental Health and Disability Status

At the time of the incident, none of the five Youth presented with a *Mental Health Designation*; however two of the Youth had an identified disability requiring accommodations. Accommodations for one of the Youth included allowing extra time, flexible scheduling and use of a small group setting; accommodations for the second Youth included provisions for a *Staff Assistant*. The evidence suggested that interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

None of the five Youth had a *Crisis Prevention Support Plan* in place.

Use of Force Review Project

III. Intervention

Observation Five: Transitional Events, Transfers and Movements

3.5 Transitional events, transfers and movements were vulnerable times for Youth that triggered behaviors which led to non-compliance and conflict.

Movement

While the Lieutenant was supervising first period school movement, Youth were observed on the roadway fighting. In response, the Lieutenant issued instructions for the Youth on the roadway to get down. The Lieutenant then called a Code 3 and responded. The Lieutenant observed a one-on-one fight and a two-on-one fight.

Youth Correctional Counselor One ordered both of the Youth engaged in the one-on-one to stop fighting. After repeating the order for a second time and notifying both of the Youth that chemical agents would be used if both did not get down, Youth Correctional Counselor One applied chemical agents. Both of the Youth continued to fight. At this time, after noticing chemical agents had not yet been sprayed on the Youth engaged in the two-on-one fight, Youth Correctional Counselor One moved to assist and from five feet away sprayed the three Youth involved in the two-on-one fight with a two second burst of chemical agents.

Simultaneously, Youth Correctional Counselor Two issued instructions to the Youth involved in the two-on-one fight to break it up or mace would be used. When the Youth did not comply, Youth Correctional Counselor Two dispensed chemical agents to the upper body and facial areas of the two attackers but, the two Youth continued to attack the third. Youth Correctional Counselor Two then sprayed the two attackers with a second burst of chemicals. At this point, the two Youth continued to attack the third and the three fell to the ground. At the same time, the Sergeant instructed the Youth to stop fighting or chemicals would be sprayed. All three of the Youth on the ground continued to fight. While the three Youth continued to fight, Youth Correctional Counselor Two attempted to pull one of the Youth off of the pile. Then, from six to seven feet away, the Sergeant dispensed chemical agents to the faces of the group. While continuing to spray chemical agents but fearing for the safety of the Youth who was being attacked, Youth Correctional Counselor Two pulled one of the attackers away from the victim. Simultaneously, Youth Correctional Officer One instructed the two remaining Youth to stop fighting and get on the ground or chemical agents would be used. When the Youth continued to fight, Youth Correctional Officer One dispensed chemical agents to the facial area of the attacker. At the same time, Youth Correctional Counselor Two was able to pull the second attacker away. In response, the Youth got on the ground and were handcuffed.

As one of Youth from the one-on-one fight, attempted to advance toward the two-on-one fight, the Sergeant blocked his path and instructed the Youth to get on the ground or chemical agents would be used. When the Youth did not comply and continued to advance, from approximately five to six feet away, the Sergeant dispensed a burst of chemical agents toward the face of the Youth. The Sergeant then instructed the Youth to get on the ground; the Youth complied and was handcuffed.

Use of Force Review Project

III. Intervention

Observation Five: Transitional Events, Transfers and Movements

3.5 Transitional events, transfers and movements were vulnerable times for Youth that triggered behaviors which led to non-compliance and conflict.

Concerns

The reports submitted by Youth Correctional Counselor One were inconsistent as to whether or not the Youth were warned prior to the application of chemical agents. The report issued by Youth Correctional Counselor Two did not indicate how the two Youth were pulled off of the third Youth. Additionally, Youth Correctional Officer Two observed the incident and submitted a report that did not identify which of the staff members used chemical agents. Youth Correctional Officer Three observed the incident and submitted a report that did not indicate any use of force. Finally, the Lieutenant submitted a report that did not identify the Youth involved.

Institution Force Review Committee

The *Institution Force Review Committee* issued the following *Finding*:

Not in compliance with the CPM [Crisis Prevention and Management] policy and training.

- *[A] YCC [Youth Correctional Counselor]...report lacks detail in the use of C/A [Chemical Agents].*
- *The incident seemed chaotic.*

COMMENTS

Change, including transitional events, transfers, and movements causes anxiety. Change that is perceived as unpredictable and/or uncontrollable is especially anxiety-provoking. Structuring transitional events, transfers, and movements has the potential to decrease Youth anxiety. Most likely, as anxiety decreases and the Youth experience events as predictable and controllable a corresponding decrease in non-compliance and conflicts will occur during such times. This is particularly true for Youth with a *Mental Health Designation* or an identified disability. An example of structuring transitional events could be, when preparing for school movement, describing in detail how to line up, the path that will be taken and the behavioral expectations upon arrival. Behavioral expectations might include instructing the Youth to immediately line up outside the school area and sit in their assigned seats upon entering the classroom. Presenting change as positive, versus negative, also can decrease anxiety. For example, when a Youth is transferring to another living unit, staff members could really “talk up” the program to which the Youth is transferring.

Use of Force Review Project

III. Intervention

Observation Five: Transitional Events, Transfers and Movements

3.5 Transitional events, transfers and movements were vulnerable times for Youth that triggered behaviors which led to non-compliance and conflict.

Policy, Practice and Training Recommendations

Within 6 months, implement an evidence-based policy on management of transitions, transfers and movements, including special provisions for a Youth with a *Mental Health Designation* or an identified disability; deliver training and provide coaching as necessary.
[Look to the literature and research on anxiety management.]

Use of Force Review Project

III. Intervention

Observation Six: Reintegration

3.6 Youth were not reintegrated constructively into the correctional community after conflicts occurred.

Authority

According to the Crisis Prevention and Management Policy:

Crisis Prevention

Through oversight, training, and development, staff maintain a productive and positive environment which aids in reducing the potential for crisis situations. Implementing and adhering to policies, procedures, program structures, and daily routines helps to meet the basic needs of the Youth and enhances prevention efforts.

Consistency and Routine Program Service Delivery

Many crisis situations can be prevented by providing consistency and a daily routine. Youth who experienced unpredictable childhoods often face anxiety, uncertainty, and fear in their daily lives as they face the many different types of transitional periods. Consistency and routine help Youth to develop a sense of safety and security, creating an environment that promotes changes in Youth behavior. Consistency can be increased through:

- *Knowing and implementing program routines*
- *Knowing and adhering to department policies*
- *Recognizing daily transitional and/or high risk periods and helping Youth to prepare and cope with them*
- *Communication between staff and with the Youth*
- *Intentional, planned, and structured communication with treatment and security staff between shifts and/or following an incident to assure successful implementation of Youth treatment strategies and staff response.*

Quantitative Analysis

1. In the total sample of 245 cases, 110 or 45% involved incidents related to conflicts between two Youth.
2. In the total sample of 245 cases, 119 or 49% occurred between the hours of 1400 and 2000, the transition period during which Youth reintegrate back into the living unit from a structured school or work environment.

Use of Force Review Project

III. Intervention

Observation Six: Reintegration

3.6 Youth were not reintegrated constructively into the correctional community after conflicts occurred.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 50 or 50% involved incidents related to conflicts between two Youth.
2. In the sample of 100 qualitatively reviewed cases, 10 or 10% involved incidents that occurred when Youth were being reintegrated into the correctional community following conflicts.
3. In the sample of 31 cases identified as especially egregious, 4 or 13% involved incidents that occurred shortly after a *Conflict Resolution Team* had intervened; despite *Conflict Resolution Team* intervention, force was deemed necessary.

Case Snapshot

The following case snapshot describes an incident where Youth were not reintegrated constructively into the correctional community after a conflict.

[Additional case examples included: 76, 94 and 98.]

Case 96

In Case 96, two male Youth, 18 years of age, who resided at *Preston* on *Oak Living Unit*, were involved in a one-on-one fight. Chemical agents were used to subdue an attacker, effect custody and gain compliance with a lawful order to stop fighting.

Mental Health and Disability Status

One of Youth had a *Mental Health Designation* and an identified disability requiring accommodations. Accommodations included modifications to testing procedures at school and provisions for a *Staff Assistant*. The evidence suggested that interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

The second Youth had a *Crisis Prevention Support Plan* in place, yet it was not utilized during the incident. According to the plan, the Youth demonstrated past disruptive and aggressive behavior. In crisis, the Youth tended toward impulsive behavior and responded well when staff members used simple language, checked in with him to ensure understanding and engaged the Youth in conversation to problem solve. Effective crisis prevention and de-escalation strategies for staff members working with the Youth included assessing for medication compliance, allowing the Youth to take space, verbalizing his thoughts and feelings when ready, using active listening skills, a low voice, and *Motivational Interviewing* techniques. In addition, the plan noted that the Youth responded well to staff members with whom he had rapport. Conversely, the Youth responded poorly to staff members he did not know and who ultimately ended up serving as an audience for his performance.

Use of Force Review Project

III. Intervention

Observation Six: Reintegration

3.6 Youth were not reintegrated constructively into the correctional community after conflicts occurred.

Reintegration

Prior to release from their rooms, the Youth were informed of behavioral expectations. The Youth stated that the expectations were understood. The Youth were instructed to walk into the dayroom and take a seat. Immediately upon entering the dayroom, however, the Youth engaged in fighting.

COMMENTS

When released from their rooms, from the perspective of the Youth, nothing had changed. The Youth had not been given the opportunity to decrease their anxiety, identify reasons to not fight or learn new skills to cope effectively. Moreover, there is no evidence, for the Youth with a *Crisis Prevention Support Plan* in place, any of his identified crisis prevention and de-escalation strategies were utilized. Finally, the two Youth were not motivated to choose non-violence over fighting. Possibly, if consistent reinforcement for peaceful interactions and consequences for fighting had been experienced, the Youth would have made different choices when entering the dayroom and the fight could have been prevented.

Use of Force Review Project

III. Intervention

Observation Six: Reintegration

3.6 Youth were not reintegrated constructively into the correctional community after conflicts occurred.

Policy, Practice and Training Recommendations

1. Within 90 days, implement a standardized *Youth Integration Process* based upon relevant research and literature; provide training and coaching as necessary.

2. Maintain positive programming throughout the correctional community.
 - Structure activities throughout the day.
 - Follow a consistent schedule.
 - Utilize common rehabilitative language.
 - Develop an effective token economy.
 - Enforce communal rules and expectations.
3. Educate Youth on the legal ramifications of hurting others in the correctional community, including other Youth, staff members and citizen volunteers.

Use of Force Review Project

USE OF FORCE

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

4.2 Force was used to effect custody or gain compliance with a lawful order when a single Youth was not an immediate danger to others.

4.3 Chemical agents were applied to Youth repeatedly when not effective.

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Use of Force Review Project

IV. Use of Force

Observation One: Youth Covering Windows

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

Authority

According to a memorandum issued by Sandra Youngen, Director; Division of Juvenile Facilities on April 13, 2007:

For safety and security purposes, it is imperative staff have a clear unobstructed view of all Youth while they are in their rooms. When Youth cover windows and obstruct the view of staff, it is a security issue requiring immediate intervention.

- 1. Staff will immediately attempt to establish verbal contact with the Youth(s):*
 - a. If verbal contact is made, notify Control that you have a Youth who is covering his/her window, but verbal contact has been made.*
 - b. If no verbal contact can be established, notify your coworkers and request their assistance. Contact Control and apprise them of the situation and request the assistance of a Security Supervisor. Continue with the attempt to make verbal contact while trying to establish visual contact via the outside window, food port or by any other means where visual contact can be safely established to determine the well-being of the Youth.*
 - c. If visual contact is made and the Youth is in no imminent danger, notify Control that you have established a visual and there is no imminent danger.*
 - d. If you are unable to establish verbal or visual contact with the Youth, using a minimum of two staff, cautiously open the room door, do a quick visual assessment and remove the obstruction from the window. The door will be secured if the Youth is not in imminent danger and visual contact will be maintained until the arrival of the security supervisor.*
 - e. If the Youth is observed to be in immediate danger, staff will activate their personal alarm and safely proceed with the necessary life-saving procedures.*

- 2. Once the Security supervisor arrives on the scene and is apprised of the situation:*
 - a. The Security Supervisor will evaluate the situation and formulate/implement an appropriate response depending on the critical needs of the situation.*
 - b. If an extraction is deemed necessary, the Department's Use of Force Policy will be followed.*
 - c. When the situation is deemed under control, the Security Supervisor will ensure the situation was not part of a suicide attempt. If the situation is deemed a suicide attempt or the Youth was attempting to harm him/herself, the Youth will be safely secured per policy and a mental health referral will be processed immediately.*
 - d. If it is determined the Youth behavior was not to harm him or herself, the Security Supervisor will take the appropriate action to ensure the Youth does not continue to cover the window by getting a verbal commitment or by removing articles that can be used to cover windows.*

Use of Force Review Project

IV. Use of Force

Observation One: Youth Covering Windows

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

Quantitative Analysis

Two (2) of 245 or less than 1% of the incidents in the sample involved controlled force.

Qualitative Analysis

In the sample of 100 cases qualitatively reviewed, 4 or 4% involved a Youth covering a room window.

Youth

- In 4 of 4 or 100% of the incidents, the Youth involved was a minor; ages 17 years, 3 months; 17 years, 0 months and 16 years, 8 months.
- In 4 of 4 or 100% of the incidents, the Youth involved had a *Mental Health Designation*.
- In 2 of 4 or 50% of the incidents, the Youth involved had a disability; one (1) of the 2 Youth required accommodations including a *Staff Assistant*.
- In 2 of 4 or 50% of the incidents, the Youth involved had a *Crisis Prevention Support Plan* on file.
- In 2 of 4 or 50% of the incidents, the Youth was on *Suicide Risk Reduction* status.
- In 2 of 4 or 50% of the incidents, the Youth had his clothing cut off outside the room while restrained; both times the Youth was left in his boxers and neither time was clothing used to cover the windows.
- In 1 of 4 or 25% of the incidents, the Youth was prescribed medication by a Psychiatrist.

Incidents

- Four (4) of 4 or 100% of the incidents were identified in the sample of 31 cases deemed especially egregious
- Three (3) of 4 or 75% of the incidents involved application of chemical agents; 2 of 4 or 50% of the incidents involved physical force.
- Three (3) of 4 incidents or 75% involved a male; one (1) of 4 incidents or 25% involved a female.
- Three (3) of 4 or 75% of the incidents involved a Youth who resided at *N.A. Chaderjian* on the *Sacramento Living Unit*; one (1) of 4 or 25% involved a Youth residing at *Ventura* on *Alborado Living Unit*.
- Two (2) of 4 or 50% of the incidents involved controlled force; 2 of 4 or 50% of the incidents involved immediate force.
- Two (2) of 4 or 50% of the incidents involved the same Youth; one incident occurred on November 9, 2009 and the other, one month later, on December 11, 2009.

Case Snapshots

The case snapshot that follows describes two connected incidents where a Youth covered his windows. In the first incident, the Youth attempted to jam the lock to his door and in the second the same Youth refused to follow a lawful order to be handcuffed; a *Room Extraction* followed.

[Additional case examples included: 8, 42 and 72.]

Use of Force Review Project

IV. Use of Force

Observation One: Youth Covering Windows

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

Case 66

In Case 66, a male Youth, 17 years; 0 months, who resided at *N.A. Chaderjian* on *Sacramento Living Unit*, was not compliant with a lawful order. Chemical agents, mechanical restraints as well as physical strengths and holds were used to overcome resistance and effect custody.

Mental Health and Disability Status

The Youth had a *Mental Health Designation* and resided on an *Intensive Behavior Treatment Unit*. On the date of the incident, the Youth had not been identified as having a disability.

Crisis Prevention Support Plan

The Youth was involved in a *Room Extraction* on November 9, 2009. After the incident, a *Crisis Prevention Support Plan* was not developed for the Youth. Possibly, the *Room Extraction* that occurred on December 11, 2009, could have been prevented if the Officers responding had been able to access critical information contained in a well developed plan like descriptions of previously exhibited crisis behaviors, required *Mental Health* accommodations, motivators, successful de-escalation techniques and preferred interventions. In the sample of 245 cases, the Youth was involved in five force incidents [10, 66, 71, 72, and 195]. After the five incidents had taken place, a *Crisis Prevention Support Plan* was created with notations beginning March 22, 2010.

FIRST INCIDENT: YOUTH COVERING HIS WINDOW [1820 HOURS-12/11/09]

Jammed Door Lock

Intervention

A Youth Correctional Counselor observed that a Youth had covered his room window with white paper. The staff member attempted to dialogue with the Youth but he would not respond. The staff member opened the tray slot and saw the Youth was standing next to it. The staff member again tried to dialogue with the Youth without success. At the request of the Youth Correctional Counselor, a Psychiatric Technician and a Registered Nurse arrived on the scene and attempted to dialogue with the Youth without success. After approximately ten minutes of the Licensed Psychiatric Technician attempting dialogue, the Youth suddenly stuck his arm out of the tray slot and with an unknown object attempted to stick a piece of plastic into the key hole.

Chemical Agents

The Youth Correctional Counselor immediately applied a burst of MK-4 from approximately three to five feet to the facial area of the Youth. The Youth Correctional Counselor noted that the facility had several incidents with Youth jamming their locks where the locksmith had to be called. The Youth Correctional Counselor further noted that the incidents placed the Youth in danger, as staff members would not be able to enter the room in emergency situations. There was no indication of a warning before chemical agents were applied. Physical restraints were not considered as a viable option under the circumstances.

Use of Force Review Project

IV. Use of Force

Observation One: Youth Covering Windows

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

SECOND INCIDENT: YOUTH COVERING HIS WINDOW [1820 HOURS-12/11/09]

Refusal to Follow a Lawful Order

Intervention

After application of chemical agents, the Youth told the Licensed Psychiatric Technician “just go back I’m not suicidal or homicidal anything bitch.” The Registered Nurse then asked the Youth if he needed medical attention and he said no. The Youth Correctional Counselor asked the Youth if he wanted a shower and fresh laundry and the Youth stated, “No you are going to have to extract me out of this room.” Next, the Lieutenant was called and attempted to dialogue with the Youth. In response, the Youth again began to cover his front and back windows. The Lieutenant told the Youth that if he did not uncover his window an *Extraction Team* would be assembled to move him to another room. The Youth told the Lieutenant to do what he had to do. The Lieutenant then asked the Licensed Psychiatric Technician to dialogue with the Youth again. The efforts of the Licensed Psychiatric Technician were not successful. The Lieutenant then asked a peer to dialogue with the Youth. The effort was not successful. At the time, a Psychologist was on grounds and also attempted to convince the Youth to uncover the windows. The Youth again refused. The Lieutenant asked the Licensed Psychiatric Technician to dialogue with the Youth for a third time; the effort was not successful.

Room Extraction Approval

The Lieutenant requested approval from the Executive Officer and the On Call Psychologist to conduct a *Room Extraction*. The request was granted despite the fact that there was no evidence to suggest the Youth or staff members were in imminent danger. At this point, the decision was made to use controlled force.

Extraction Team

Under the supervision of the Lieutenant, an *Extraction Team* was formed that consisted of five members, three (3) Youth Correctional Counselors and two (2) Youth Correctional Officers. One of the Youth Correctional Counselors operated the video camera. The Psychologist, the Licensed Psychiatric Technician and the Registered Nurse were also on site and witnessed the *Room Extraction*.

Physical Strengths and Holds

The Lieutenant opened the door. A Youth Correctional Counselor entered the room and pinned the Youth on the bed with the shield. A Youth Correctional Officer grasped the right wrist of the Youth and pulled it free from the mattress. Another Youth Correctional Counselor gained control of the upper extremities of the Youth and guided him to the floor.

Mechanical Restraints

A Youth Correctional Officer then grasped the right wrist of the Youth and bent his hand in a 90-degree angle toward the center of his back. Another Youth Correctional Officer assisted a second Youth Correctional Counselor in placing the Youth in handcuffs and leg irons.

Use of Force Review Project

IV. Use of Force

Observation One: Youth Covering Windows

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

SECOND INCIDENT [Continued]

Physical Restraints

Despite being handcuffed, the Youth continued to struggle and lunged toward the Lieutenant and had to be physically restrained. Once he was under control, the Lieutenant asked the Registered Nurse to cut the clothing off the Youth. The Registered Nurse complied. Once the clothing was removed, the Youth was moved to another room where he was placed on the bed on his stomach. The leg irons were removed and then the handcuffs.

Extraction Team Exit

The *Extraction Team* members then exited one-by-one. The Youth attempted to rush toward the door but the last member of the *Extraction Team* managed to exit safely.

COMMENTS

Policy

The Memorandum issued by Sandra Youngen, Director; *Division of Juvenile Facilities*, April 13, 2007, on the subject of *Youth Covering Room Windows* was never incorporated into policy. It is unclear whether the memorandum is known and accessible to staff members at the facilities.

De-escalation

The facility did a good job in attempting to de-escalate the situation by having two Youth, a Registered Nurse, Mental Health Clinician and a Licensed Psychiatric Technician [on three occasions] speak to the Youth prior to using *Controlled Force* on a Friday evening.

Imminent Danger

During the first and second incidents on December 11, 2009, at no time was the Youth or the staff members in imminent danger. The incident may have been averted if the staff members had exercised more patience and continued to pursue de-escalation efforts. By proceeding with the *Room Extraction*, the Youth apparently achieved his objective in a power struggle. A total of 13 staff members, two (2) Youth Correctional Officers, seven (7) Youth Correctional Counselors, a Lieutenant, Psychologist, Licensed Psychiatric Technician and a Registered Nurse were involved in the incident. Collectively, the staff members were unable to successfully de-escalate one non-compliant Youth without intervening through a *Room Extraction*.

Second Room Extraction

Approximately 30 days earlier, on November 9, 2009, the Youth had been involved in a *Room Extraction* as a result of covering his window. The *Room Extraction* conducted on November 9, 2009, did not seem to have a deterrent affect on the Youth. In fact, likely, the experience with the previous *Room Extraction* reinforced the behavior because it was repeated. Not only was the experience repeated, during the second *Room Extraction*, the Youth continually asked to be extracted.

Use of Force Review Project

IV. Use of Force

Observation One: Youth Covering Windows

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

COMMENTS [Continued]

Mental Health Intervention

Alternative interventions the Psychologist implemented or recommended are unknown because a *Supplemental Behavior Report* was not submitted.

Clothing Removal

The Youth had his clothing cut off outside of his room while restrained and was left in his boxers; it was unclear that the clothing provided a safety threat.

Institution Force Review Committee

The members of the *Institution Force Review Committee* were not documented.

Force Review Process

Prior to using chemical agents, an appropriate warning was not issued and an alarm was not pressed. These were identified as inappropriate actions following use of force rather than inappropriate actions prior to and/or during use of force. This illustrates the focus in the *Force Review Process* on documentation. Staff members should be cognizant and deliberate prior to, during and following use of force.

Use of Force Review Project

IV. Use of Force

Observation One: Youth Covering Windows

4.1 When Youth covered room windows, inconsistent procedures were used to intervene.

Policy, Practice and Training Recommendations

Within 90 days, amend *the Crisis Prevention and Management Policy* to include a standardized protocol for intervening with Youth who cover room windows; deliver training as necessary.

- Develop the policy using an *Interdisciplinary Team* that includes representatives from *Mental Health, Medical and Juvenile Facilities*.
- Emphasize avoidance of force; when force is used, the policy should stress using the least amount necessary.
- Clearly define the rules that govern the removal of Youth clothing.
- Include special provisions for a Youth with a *Mental Health Designation* or an identified disability.

Use of Force Review Project

IV. Use of Force

Observation Two: Single Youth

4.2 Force was used to effect custody or gain compliance with a lawful order when a single Youth was not an immediate danger to others.

Authority

According to the Crisis Prevention and Management Policy:

Crisis Prevention and Management Policy

The California Department of Corrections and Rehabilitation, Division of Juvenile Justice operates under a Crisis Prevention and Management policy emphasizing a philosophy of proper prevention and intervention strategies to accomplish the treatment, education, and supervision functions with discretion and minimal reliance on the use of force.

All Division of Juvenile Justice staff have the responsibility to emphasize a continuum of prevention and de-escalation strategies in order to effectively minimize crisis situations including but not limited to communication, assessments, relationship/rapport building, presence, planning, and instructions.

Correctional Peace Officers may use reasonable force as required in the performance of their duties, but shall not use unnecessary or excessive force.

Unnecessary Force

The use of force that an objective, trained, and competent Correctional Peace Officer faced with similar facts and circumstances, would consider unnecessary to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.

Staff Self-Assessment

Staff's ability to self-assess and understand how their own challenges might impact their actions in a situation is critical to the success of resolving crisis situations. There are many variables which could impact a staff's ability to effectively resolve crisis situations and it is critical for staff to be aware of what they are so that they can either effectively resolve their own challenges or seek the assistance of other staff.

Knowing when to ask for assistance or how to assist a co-worker experiencing difficulty is crucial to preventing the escalation of crisis situations. For example, a "Tap Out" strategy is when a staff would intervene with a co-worker by helping them out of a situation where they do not see how they are contributing to the escalation of the situation.

Use of Force Review Project

IV. Use of Force

Observation Two: Single Youth

4.2 Force was used to effect custody or gain compliance with a lawful order when a single Youth was not an immediate danger to others.

Quantitative Analysis

In the sample of 245 cases, 45 or 18% of incidents involved a single Youth not engaged in assaultive behavior; chemical agents were applied during 8 or 17% of the incidents.

Qualitative Analysis

1. In the 100 qualitatively reviewed cases, 25 of 100, or 25% involved *Single Youth Incidents*.
2. In the 100 qualitatively reviewed cases, 6 of 25, or 24% involved a single Youth being maced who was judged not to be an immediate danger to others by an objective, trained and competent Correctional Peace Officer serving as a *Subject Matter Expert*.
3. In the 100 qualitatively reviewed cases, 3 of 6, or 50% involved a single Youth being maced multiple times who was judged not to be an immediate danger to others by an objective, trained and competent Correctional Peace Officer serving as a *Subject Matter Expert*.

Case Snapshots

The case snapshot that follows describes an incident where officers applied chemical agents repeatedly when a single Youth was not in immediate danger to others.

[Additional case examples included: 8, 16, 42, 70, 86 and 88.]

Case 88

In Case 1, a male Youth, 19 years; 7 months, who resided at *Ventura* on *AV Living Unit*, was not compliant with a lawful order. Chemical agents were used to overcome resistance and effect custody.

Mental Health and Disability Status

On the date of the incident, the Youth did not have a *Mental Health Designation* or an identified disability.

Crisis Prevention Support Plan

On the date of the incident, the Youth did not have a *Crisis Prevention Support Plan* in place.

Immediate Force Authorized

When attempts at dialogue for twenty minutes failed to gain cooperation, the Lieutenant authorized immediate force; use of chemical agents.

Escalation

After force was authorized, the Officers approached the Youth. When the Officers approached, the Youth jumped over some chairs and ran toward the rear left corner of the dayroom. When the Youth ran away, the Officers followed. Simultaneously, the Officers repeatedly instructed the Youth to calm down and comply with handcuffing. The Youth continued to refuse to comply with instructions and began to pace with clenched fists. According to the Officers, the Youth exhibited an unpredictable demeanor.

Use of Force Review Project

IV. Use of Force

Observation Two: Single Youth

4.2 Force was used to effect custody or gain compliance with a lawful order when a single Youth was not an immediate danger to others.

Chemical Agents

First Use of MK-9 OC

From 9-10 ft away, two Officers instructed the Youth to turn around and be handcuffed or chemical agents would be applied. The Youth refused and with clenched fists took two steps toward the first Youth Correctional Officer. In response, from 8 ft away, the first Youth Correctional Officer dispersed a one second burst of the MK-9 OC toward the upper chest and facial area of the Youth. The Youth immediately turned around and wiped his face with his shirt and then stood with clenched fists. The Youth then faced the two Officers, open and closed his fists, paced back-and-forth and stared with “anger.”

Second Use of MK-9 OC

The Officers continued to dialogue and issue instructions that the Youth failed to follow. Again, the Youth took two steps with clenched fists toward the first Youth Correctional Officer. Again, the first Youth Correctional Officer applied a one second burst of the MK-9 OC toward the upper chest and facial area of the Youth. In response, the Youth walked to an open window to get fresh air.

Third Use of MK-9 OC

The Officers continued to dialogue with the Youth and give instructions. Again, after about one minute, the Youth turned around and stepped with clenched fists toward the first Youth Correctional Officer. Again, the first Youth Correctional Officer administered a one second burst of MK-9 OC toward the upper chest and facial area of the Youth. In response, the Youth walked to an open window to get fresh air.

Fourth Use of MK-9 OC

The Officers continued to dialogue with the Youth and give instructions. The Youth then stepped with clenched fists toward the second Youth Correctional Officer. In response, the second Youth Correctional Officer administered a one second burst of MK-9 OC toward the Youth. Simultaneously, the Youth turned causing the chemical agents to disperse on the back of his head.

Youth Compliance

After administering four bursts of MK-9 OC, the Youth took a few steps toward the corner and stood silent for a few seconds. The Youth then complied with instructions by taking 4-6 steps backwards and placing both hands behind his back. The first Youth Correctional Officer then handcuffed the compliant Youth. Immediately, the Youth was escorted to the shower for initial decontamination.

Physical Force

The Officers applied chemical agents four times and the Youth continued to refuse to leave the living unit. The Officers continued with an intervention that was clearly not effective. When the Youth was isolated in the dayroom with his back turned away and at least three officers were present, two Youth Correctional Officers and a Lieutenant, physical force was not authorized. [Note that three additional Youth Correctional Counselors should have been on duty.]

Use of Force Review Project

IV. Use of Force

Observation Two: Single Youth

4.2 Force was used to effect custody or gain compliance with a lawful order when a single Youth was not an immediate danger to others.

Reasonable Force

During the incident, at no time were the Youth or the Officers in imminent danger. The force used was not appropriate or reasonable given the circumstances.

Training

After reviewing the incident, training on de-escalation techniques, controlled *Use of Force*, and/or the *Crisis Prevention and Management Policy* were not recommended by the Chief of Security, Superintendent or the *Institutional Force Review Committee*.

Use of Force Review Project

IV. Use of Force

Observation Two: Single Youth

4.2 Force was used to effect custody or gain compliance with a lawful order when a single Youth was not an immediate danger to others.

Policy, Practice and Training Recommendations

1. Within 30 days, issue an official statement that chemical agents shall not be utilized in situations involving a single non-compliant Youth.
2. Within 30 days, require that the Director of Juvenile Facilities conduct a special review and report to the Chief Deputy Secretary any deviation from policy regarding a single non-compliant Youth, with consideration given to those rare incidents involving serious assault on a staff member, use of a deadly weapon and escape.
3. Within 90 days, amend the *Crisis Prevention and Management Policy* to provide that chemical agents shall not be utilized in situations involving a single non-compliant Youth; provide training as necessary.

4. Require that the *Inter-disciplinary Treatment Team* review and adjust the *Individual Treatment Plan* for every Youth involved in multiple force incidents.
5. Train and coach staff members on preventing, identifying and working through power struggles.
6. Train and coach staff members on communication techniques to employ throughout the continuum of force options.
7. Train and coach staff members on when and how to ask a co-worker for assistance in preventing further escalation of a Youth in crisis.

Use of Force Review Project

IV. Use of Force

Observation Three: Repeated use of Chemical Agents

4.3 Chemical agents were applied to Youth repeatedly when not effective.

Authority

According to the Crisis Prevention and Management Policy:

Crisis Prevention and Management Policy

Correctional Peace Officers may use reasonable force as required in the performance of their duties, but shall not use unnecessary or excessive force.

Excessive Force

The use of more force than an objective, trained, and competent Correctional Peace Officer, faced with similar facts and circumstances would use to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.

Ineffective Force Option

When any force option selected and used proves to be ineffective, other force options will be reconsidered.

Quantitative Analysis

1. In the sample of 245 cases, chemical agents were applied to 786 of 863 or 91% of the Youth.
2. In the sample of 245 cases, 183 or 75% of the incidents involved application of chemical agents.
3. In the sample of 245 cases, 45 or 18% involved a single Youth not engaged in assaultive behavior; in the 45 cases involving a single Youth, 8 or 18% involved the application of chemical agents.

Qualitative Analysis

1. In the 100 qualitatively reviewed cases, 225 of 272, or 83% of the Youth were maced.
2. In the 100 qualitatively reviewed cases, 74 of 100, or 74% of the incidents involved a Youth being maced.
3. In the 100 qualitatively reviewed cases, 25 of 100, or 25% involved *Single Youth Incidents*.
 - In the 25 cases that involved single Youth incidents, 6 of 25, or 24% involved a Youth being maced.
 - In the 6 cases that involved *Single Youth Incidents* where a Youth was maced, 3 of 6, or 50% involved a Youth being maced multiple times.
 - In the 100 qualitatively reviewed cases, when a single Youth was maced multiple times during the same incident, 1 of 3, or 33% of the second applications were judged reasonable by an objective, trained, and competent Correctional Peace Officer serving as a *Subject Matter Expert*.
 - In the 100 qualitatively reviewed cases, when a single Youth was maced multiple times during the same incident, 0 of 1, or 0% of the third applications were judged reasonable by an objective, trained, and competent Correctional Peace Officer serving as a *Subject Matter Expert*.

Use of Force Review Project

IV. Use of Force

Observation Three: Repeated use of Chemical Agents

4.3 Chemical agents were applied to Youth repeatedly when not effective.

Qualitative Analysis [Continued]

4. In the 100 qualitatively reviewed cases, 50 of 100, or 50% involved *One-on-One Fights*.
 - In the 50 cases that involved *One-on-One Fights*, 47 of 50, or 94% involved a Youth being maced.
 - In the 47 cases that involved *One-on-One Fights* where a Youth was maced, 8 of 47, or 17% involved Youth being maced multiple times.
 - In the 100 qualitatively reviewed cases, when Youth were maced multiple times during the same incident, 8 of 8, or 100% of the second applications were judged reasonable by an objective, trained, and competent Correctional Peace Officer serving as a *Subject Matter Expert*.
 - In the 100 qualitatively reviewed cases, when a single Youth was maced multiple times during the same incident, 0 of 3, or 0% of the third applications were judged reasonable by an objective, trained, and competent Correctional Peace Officer serving as a *Subject Matter Expert*.

5. In the 100 qualitatively reviewed cases, 12 of 100, or 12% involved a *Group Disturbance*.
 - In the 12 cases that involved a *Group Disturbance*, 12 of 12, or 100% involved a Youth being maced.
 - In the 47 cases that involved a *Group Disturbance* where a Youth was maced, 8 of 12, or 66% involved Youth being maced multiple times.

Case Snapshot

The following case snapshot describes an incident where chemical agents were used repeatedly when not effective.

[Additional case examples included: 27, 70, 88 and 98.]

Case 1

In Case 1, a male Youth, 18 years; 10 months, and a male Youth, 19 years; 6 months, who resided at *N.A. Chaderjian on Kern Living Unit*, were involved in a one-on-one fight. Chemical agents were used to gain compliance and effect custody.

Mental Health and Disability Status

At the time of the incident, neither Youth had a *Mental Health Designation* or an identified disability.

Crisis Prevention Support Plan

[Discussed in Section I: Prevention; Observation 1.1 Crisis Prevention Support Plan and in Observation 1.2 Antecedent and Proximate Events.]

1. Youth A did not have a *Crisis Prevention Support Plan* in place.
2. Youth B had a *Crisis Prevention Support Plan* in place. During the incident, the plan for Youth B was not utilized.

Use of Force Review Project

IV. Use of Force

Observation Three: Repeated use of Chemical Agents

4.3 Chemical agents were applied to Youth repeatedly when not effective.

Escalation

Youth A walked to his room and hung his shirt on the door handle. Then while yelling out, Youth A walked toward the group of Youth who had originally laughed at him. At this point, Youth Correctional Counselor Three walked toward Youth A and told him not to get into a fight. Youth A ignored the warning and called Youth B out. In response, Youth B looked back, stood and turned to face Youth A. Youth A continued walking toward Youth B. Then, to become more accessible, Youth B walked around the chairs. At this time, a number of Youth who had been seated with Youth B took a standing position and looked in the direction of Youth A. In response, Youth Correctional Counselor One walked toward the group and yelled, "No, we're not going to do this, have a seat." Youth Correctional Counselor Two removed his MK-4 Pepper Spray and pressed his alarm. Notwithstanding, Youth A and B began to swing closed fists at each other. In response, the Lieutenant and Counselors One, Two and Three issued verbal orders for the group to "get down." With the exception of Youth A and B, all Youth complied.

Chemical Agents

First Use of Capstun Z-505

The Lieutenant then instructed Youth A and B to stop fighting or chemical agents would be used. Both Youth A and B continued to fight. At this point, the Lieutenant removed and raised his Capstun Z-505 without dispersing it. In response, Youth A and B stopped fighting and started to go to the ground. But, Youth B changed his mind, and went toward Youth A and began hitting his upper body. For a second time, the Lieutenant instructed Youth A and B to stop fighting or chemical agents would be used. Both Youth A and B continued to fight. In response, from five (5) feet away, the Lieutenant dispersed one burst of the Capstun Z-505 toward Youth A and B. Then, the Lieutenant stepped back to let the chemical agents take effect.

Second Use of Capstun Z-505

According to the Lieutenant, the chemical agents were not effective; Youth A and B continued to fight. In response, the Lieutenant dispersed a second burst of the Capstun Z-505 toward Youth A and B. Then, once again, the Lieutenant stepped back to let the chemical agents take effect. According to the Lieutenant, the chemical agents were still not effective; Youth A and B continued to hit each other.

Third Use of Capstun Z-505

Next, Youth A and B went down to the floor holding each other with one arm and punching with the other. In response, from 5 feet away, Youth Correctional Counselor One applied a third burst of Capstun Z505 toward Youth A and B. Youth A and B continued punching and moving around on the ground.

Physical Force

At this point, the Lieutenant intervened by pulling Youth A toward him and away from Youth B. Simultaneously, the Lieutenant again raised his Capstun Z-505 as if he intended to disperse it.

Use of Force Review Project

IV. Use of Force

Observation Three: Repeated Use of Chemical Agents

4.3 Chemical agents were applied to Youth repeatedly when not effective.

Youth Compliance

After administering three bursts of Capstun Z-505, Youth A being separated from Youth B through physical force and the Capstun Z-505 being raised again, Youth A and B complied with verbal orders and laid out face down on the ground. The Lieutenant then instructed Counselor Three to apply handcuffs to Youth A and escort him to the shower. Simultaneously, Counselor One applied handcuffs to Youth B. Counselor Three then escorted Youth A to the shower area and Counselor Two escorted Youth B to the shower area.

Prevention

If any of the four staff members involved in the incident had been more proactive and intervened using alternative methods, possibly, this force incident could have been prevented. The initial intervention employed was chemical agents. Clearly, the use of chemical agents proved less than effective.

Training

After reviewing the incident, training on Warning Signs, Alternative Interventions, and/or the *Crisis Prevention and Management Policy* were not recommended by the Chief of Security, Superintendent or the *Institutional Force Review Committee*.

Use of Force Review Project

IV. Use of Force

Observation Three: Repeated Use of Chemical Agents

4.3 Chemical agents were applied to Youth repeatedly when not effective.

Policy, Practice and Training Recommendations

1. Within 30 days, require that the Superintendent and Senior Psychologist conduct a special review of any incident involving three or more applications of chemical agents to the same Youth and when necessary, take appropriate corrective action.
2. Educate staff members on transference and counter-transference.
3. Encourage the use of the “*Tap-out Strategy*” in which colleagues assist co-workers in exiting interactions where they are contributing to the escalation of a Youth in crisis.
4. Train and coach staff members on using the least restrictive force option necessary to effect custody.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

Authority

According to the Crisis Prevention and Management Policy:

Immediate Use of Force: Authorization

Any DJJ employee may use immediate force in self-defense or in the defense of others, or when the behavior of a Youth constitutes an imminent threat to the security of the facility. (See Appendix B for examples of situations where the use of immediate force may be necessary.) The force used by an employee in these situations must be reasonable force as defined in this policy.

Controlled Use of Force: Authorization

A controlled use of force is appropriate when the presence or conduct of a Youth poses a threat to safety or security, and the Youth is located in an area that can be controlled or isolated. These situations do not normally involve the imminent threat to other persons or a significant breach of facility security. The Superintendent shall designate a pool of Correctional Peace Officer managers that can authorize a controlled use of force. A controlled use of force requires the presence of a Superintendent's designee which shall not be less than that of a Lieutenant.

Quantitative Analysis

1. In the total sample of 245 cases, 243 or 99% involved incidents where *Immediate Force* was used and only 2 or 1% involved incidents where *Controlled Force* was used.
2. During the period of July 2009 through June 2010, the *Division of Juvenile Justice* had a total of 1,637 Use of Force Incidents: 1,628 or 99% where *Immediate Force* was used and 9 or 1% where *Controlled Force* was used.

**Compstat data for July 2009 through June 2010.*

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 98 or 98% involved incidents where *Immediate Force* was used and only 2 or 2% involved incidents where *Controlled Force* was used.
2. In the sample of 100 qualitatively reviewed cases, 13 or 13% involved force due to a single Youth being non-compliant. In the 13 cases, an objective, trained and competent Correctional Peace Officer serving as a *Subject Matter Expert* judged that the Youth did not demonstrate assaultive, destructive or self-injurious behaviors; commit suicidal gestures or attempt to escape.
[Case Numbers include: 42, 53, 54, 59, 62, 66, 72, 78, 80, 85, 86, 88 and 100.]

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

Case Snapshot

The following case snapshots describe two incidents where *Immediate Force* was used when *Controlled Force* should have been considered.

[Additional case examples included: 8, 42, 70 and 88.]

Case 62

A female Youth, 18 years; 4 months, who resided at *Ventura* on the *Buena Ventura Living Unit*, refused to go to her room after lunch. Physical force and mechanical restraints were used to overcome resistance and gain compliance with a lawful order.

Mental Health and Disability Status

The Youth had a *Mental Health Designation*. The Youth also had an identified disability; however no accommodations were identified on the *Youth with Disabilities List*. The evidence suggested that during the incident interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place that was not utilized during the incident. According to the plan, the Youth had past suicidal behavior and ideation, hallucinations, irritable mood, gang involvement and assaultive behavior. Effective crisis prevention and de-escalation strategies for the Youth included speaking one-on-one with a trusted staff member, taking a “cool down” period and limiting involvement with others.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

Custody Response

Youth	<ol style="list-style-type: none"> 1. The Youth refused to go to her room after lunch. 2. The Youth threw her lunch across the dayroom.
Custody	A Youth Correctional Counselor called a code via his radio.
Youth	The Youth threw a trashcan.
Custody	<ol style="list-style-type: none"> 1. Six (6) Youth Correctional Officers and a Case Manager responded to the code. 2. The Case Manager attempted to dialogue with the Youth and encouraged compliance for several minutes.
Youth	The Youth continued to refuse to go to her room.
Immediate Force	Two Youth Correctional Officers used physical force and attempted to apply mechanical restraints to the Youth.
Youth	The Youth pulled away.
Immediate Force	<ol style="list-style-type: none"> 1. A Youth Correctional Officer used physical force and transitioned the Youth to a prone position. 2. Four (4) Youth Correctional Officers then used physical force and applied mechanical restraints to the Youth.
Custody	The Youth was escorted to a <i>Safe Room</i> .
Youth	The Youth refused to kneel down for mechanical restraints to be removed.
Immediate Force	Three (3) Youth Correctional Officers used physical force to transition the Youth to a prone position on the bed and remove mechanical restraints.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

COMMENTS

Immediate Force

Seven (7) Youth Correctional Officers and one (1) Case Manager responded to the incident. The Case Manager spoke to the Youth for ten to fifteen minutes; the Youth still refused to go to her room. At this point, Officer One decided that the Youth was interfering with daily operations and school movement; so, the Youth was instructed to place her hands behind her back to be handcuffed. At the time, the Youth was sitting at the table with her hands to her side.

Management Response

It is unclear why the Duty Lieutenant had not yet responded to the incident and it is equally unclear how a Youth Correctional Officer decided on his own to turn a *Controlled* situation into *Immediate Force*.

Controlled Force

If the situation posed a valid safety and security threat, with eleven (11) Correctional Peace Officers present, *Controlled Force* should have been considered to gain compliance and effect custody. The Youth was located in an area that could be isolated. The situation did not involve an imminent threat to other persons or a significant breach of facility security.

Imminent Danger

Immediate Force was used for the first time, when the Youth refused to go to her room, the second time, when she resisted and pulled away, and the third time, when she refused to kneel down. In none of these instances was the Youth an imminent threat to herself, to somebody else or to the security of the facility; per policy, *Immediate Force* was not authorized under these circumstances. If the Officers had exercised more patience and continued to pursue efforts to encourage the Youth to return to her room voluntarily, using force to gain compliance might have been averted. A total of eleven (11) Correctional Peace Officers, *seven (7) Youth Correctional Officers, three (3) Youth Correctional Counselors and one (1) Case Manager were involved with the incident. Collectively, the staff members were unable to successfully de-escalate one non-compliant, female Youth sitting at a table, without four (4) Youth Correctional Officers intervening, using physical force and applying mechanical restraints.

**Four (4) Officers used force, two Officers responded but did not use force and one (1) Officer escorted the Youth to the Outpatient Housing Unit.*

Mental Health Response

The incident involved a Youth with a *Mental Health Designation* and an identified disability who was assigned to a *Special Counseling Program*; the Youth presented with a history of suicidal behavior and ideation. Notwithstanding, no Mental Health Clinician intervened before, during or following the force incident. The force incident involved a series of power struggles; at no point was the safety of anyone threatened. Possibly, the power struggles could have been de-escalated and managed via an effective partnership between a Mental Health Clinician and the responding Officers. If *Controlled Force* was deemed necessary, a Mental Health Clinician could have intervened with the Youth as appropriate, post incident.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

COMMENTS [Continued]

Crisis Prevention Support Plan

The *Crisis Prevention Support Plan* for the Youth stated that effective prevention and de-escalation strategies included speaking one-on-one with a trusted staff member, taking a “cool down” period and limiting involvement with others. With eleven (11) staff members involved in the incident, the recommendation to limit involvement of others was clearly not implemented.

Youth Injury

1. In the *Patient’s Description of the Occurrence and Injury* section of the *Medical Report* the Youth stated, “*He slammed me, I will file a grievance.*”
2. In the *Description and Extent of Injury* section of the *Medical Report* the notation stated, “*Complained of pain on right wrist. No skin breakdown.*”
3. In the *Treatment* section of the *Medical Report* the notation stated, “*Ice to right wrist. [The Youth was] seen by the provider. Motrin (600 mg)... [Was given] for pain.*”
4. If the Youth had not been subjected to immediate physical force three separate times during the incident, the injury reported and treated might have been avoided.

Youth Interview

1. One week after the incident, in the *Chief of Security Section* of the *Use of Force Incident Review* form (DJJ 8.440), the notation in the *Comment Section* stated, “*...Also, [a] video is required because of the ward’s statement, ‘He slammed me’.*”
2. On the same day, on the *Report of Findings-Ward Interview* form (YA 8.438), in the *Summary of Interview Statements made by the Ward Section*, the notation stated, “*[the Youth] ‘didn’t want to do nothing’. She was told she had to state, ‘she didn’t want to do nothing’, on camera; she agreed.*”
3. The Watch Commander and Chief of Security signed the *Report of Findings-Ward Interview* form on March 8, 2010 and March 10, 2010, respectively, but the Superintendent signature line indicating concurrence was not signed.

Force Review Committee

The *Force Review Committee* found the incident was not in compliance with the *Crisis Prevention and Management Policy*. Nevertheless, this was not due to *Immediate Force* being used in a *Controlled* situation without management approval or to the lack of *Mental Health* involvement in the force incident. In fact, these were not even raised as concerns.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

Case 86

In Case 86, a male Youth, 17 years, 2 months, who resided at *Ventura on Cases de Los Caballeros Living Unit*, refused to leave the kitchen. Chemical agents were used to gain compliance with a lawful order.

Mental Health and Disabilities Status

The Youth had a *Mental Health Designation*. In addition, the Youth had an identified disability; accommodations cited on the *Youth with Disabilities List* included providing access to a *Staff Assistant*, allowing extra time for completing tasks and formulating verbal responses, as well as using simplified, concise language. The evidence suggested that during the incident interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place that was not utilized during the incident. According to the plan, the Youth demonstrated past suicidal behavior, assaultive behavior, argumentativeness and disregard for instruction. Effective prevention and de-escalation strategies included speaking one-on-one with a trusted staff member who validated his feelings, focusing on his goals; limiting external stimuli, including the number of people around him; taking space and speaking to his godfather. According to the plan, when force was necessary, chemical agents were more effective than physical force.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

Custody Response

Youth	The Youth refused to leave the kitchen after breakfast.
Custody	<ol style="list-style-type: none"> 1. A Youth Correctional Counselor called a code. 2. Three Youth Correctional Officers responded to the code. 3. Two Youth Correctional Officers attempted to dialogue with the Youth to gain compliance.
Youth	The Youth did not comply.
Custody	Youth Correctional Counselors escorted the non-involved Youth out of the kitchen.
Youth	A Youth Correctional Officer instructed the Youth to place his hands behind his back to be handcuffed.
Custody	The Youth did not comply.
Youth	A Youth Correctional Officer issued a warning that chemical agents would be used if the Youth did not comply.
Immediate Force	The Youth stood and then raised his hands in an upward motion towards his upper body.
Custody	<ol style="list-style-type: none"> 1. A Youth Correctional Officer dispersed chemical agents from approximately five feet away. 2. A Youth Correctional Officer instructed the Youth to place himself in a prone position on the floor.
Youth	The Youth complied.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

COMMENTS

Non-involved Youth

The Officers involved in the incident should be commended for making the decision to secure the non-involved Youth in their rooms, thus avoiding a potential large disturbance.

Immediate Force

Immediate Force was used when the Youth stood and raised his hands in an upward motion toward his upper body. One could definitely interpret this as a threat. Nevertheless, given that the other Youth had been escorted out of the kitchen and there were four Youth Correctional Officers present who were at least five feet away, the Youth did not have the means or the opportunity to hurt anybody.

Management Response

It is unclear why the Duty Lieutenant did not respond to the incident and it is equally unclear how a Youth Correctional Officer decided on his own to turn a *Controlled* situation into *Immediate Force*.

Crisis Prevention and Management Policy

The *Crisis Prevention and Management Policy* was violated because a supervisor responsible for the facility did not respond to the area and assess the situation to determine if efforts toward de-escalation had occurred. After assessment, a Duty Lieutenant may authorize *Immediate Force* to regain control of an area. In this instance, a Youth Correctional Officer decided on his own to turn a *Controlled* situation into *Immediate Force*.

Controlled Force

If the situation posed a valid safety and security threat, with the number of Correctional Peace Officers present; in addition, the Duty Lieutenant should have been at the scene, *Controlled Force* should have been used to gain compliance and effect custody. The Youth was located in an area that could be isolated. The situation did not involve an imminent threat to other persons or a significant breach of facility security. If the four (4) Officers had waited for the two (2) Counselors to secure the non-involved Youth, there would have been at least six (6) staff members present.

Imminent Danger

This was a *Controlled* situation, as the Youth was not threatening staff members, just refusing to follow instructions.

Mental Health Response

The Youth presented with a *Mental Health Designation* and an identified disability but no Mental Health Clinician was involved prior to, during or following the incident.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

COMMENTS [Continued]

Crisis Prevention Support Plan

During the incident, alternative interventions identified in the *Crisis Prevention Support Plan* for the Youth were not implemented. In fact, having four Youth Correctional Officers involved precluded use of two identified prevention and de-escalation strategies, namely limiting external stimuli and taking space.

Force Review Committee

The *Force Review Committee* found the incident was not in compliance with the *Crisis Prevention and Management Policy*. Nevertheless, this was not due to *Immediate Force* being used in a *Controlled* situation without management approval. In fact, this was not even raised as a concern.

Department Force Review Committee

Until the *Department Force Review Committee* reviewed the incident, *Immediate Force* being used in a *Controlled* situation without management approval was not addressed at any level. At *Ventura*, in Cases 62 and 86, the Security supervisors, the Chief of Security and the Superintendent did not appear to be aware that staff actions were outside of policy when making decisions about using *Controlled* versus *Immediate Force*; in this regard, refresher training might be helpful and should be considered.

Use of Force Review Project

IV. Use of Force

Observation Four: Controlled versus Immediate Force

4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.

Policy, Practice and Training Recommendations

1. Within 30 days, enforce the *Crisis Prevention and Management Policy* regarding authorization for *Immediate Force*; provide training as necessary.
 2. Within 30 days, enforce the *Crisis Prevention and Management Policy* regarding authorization for *Controlled Force*; provide training as necessary.
 3. Within 6 months, amend *Crisis Prevention and Management Policy* to reflect a continuum of interventions. Ensure the amended policy contains an array of interventions; include *Immediate Force* as the most restrictive intervention and other methods, such as time out, loss of privileges, time in safety area or zone as well as *Controlled Force*, as other viable options.
 4. Within 6 months, amend the *Crisis Prevention and Management Policy* to address barriers to implementing *Controlled Force*; survey staff members to identify ways to improve the current protocol.
-
5. Train and coach staff members on factors to consider in assessing imminent threat, including intent, means, opportunity and ability to cause great bodily injury or death.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Authority

According to the Crisis Prevention and Management Policy:

Use of Force: Authorized Use of Force Options

Options include:

- *Authoritative Warning Commands*
- *Chemical Restraints*
- *Firearms*
- *Less-Lethal Weapons*
- *Mechanical Restraints*
- *Physical Strengths and Holds*

Authoritative Warnings/Commands shall be used as the first use of force option if time permits. Other options are not listed in continuum order and staff shall consider the most reasonable option for the situation.

When any force option selected and used proves to be ineffective, other force options will be reconsidered.

Chemical Restraints

While chemical restraints are not designed to be daily behavior management tools, chemical restraints may be used as a reasonable force option.

Due to potential medical complications, Chemical Agents/OC shall not be used on any Youth in a controlled use of force incident who is presently on psychotropic medication.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Quantitative Analysis

1. In the sample of 245 cases, 110 or 45% of the incidents involved a *One-on-One Fight*. Chemical agents were applied 101 of 110 or 92% of *One-on-One Fights*.
2. In the sample of 245 cases, 121 or 49% of the incidents involved a Youth with a *Mental Health Designation*. Of the 121 cases, 73 or 60% involved a Youth taking psychotropic medication.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 50% involved a *One-on-One Fight*. Chemical agents were applied in 47 of 50 or 94% of the incidents.
2. For the 50 of 100 qualitatively reviewed cases that involved a *One-on-One Fight*, it was determined that:
 - Chemical agents were deemed necessary in 37 of 50 or 74%.
 - *Physical strengths and holds may have been a viable option in 13 of 50 or 26%.
 - Staff members applied physical strengths and holds in 3 of 13 or 23% of the incidents where it may have been a viable option.

**Factors considered in the determination included number of staff members available to physically intervene and the location of the incident. Additional factors included the presence of objects such as chairs or desks, which increased the likelihood of injury, and other Youth.*

Case Snapshots

Two case snapshots follow that describe incidents where physical strengths and holds were a viable option but chemical agents were applied.

[Additional case examples included: 1, 6, 27, 63, 76, 77, 96 and 98]

Case 92

In Case 92, a male Youth, 18 years; 5 months, and a male Youth, 19 years; 6 months, who resided at *N.A. Chaderjian on Sacramento Living Unit*, were involved in a one-on-one fight. Chemical agents were used to overcome resistance and gain compliance with a lawful order.

Mental Health and Disability Status

Youth A and B had a *Mental Health Designation*, resided on an *Intensive Behavior Treatment Unit* and were prescribed psychotropic medication. On the day of the incident, neither Youth had an identified disability,

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Crisis Prevention Support Plan Youth A

Youth A had a *Crisis Prevention Support Plan* in place. According to the plan, the Youth was prescribed psychotropic medications. However, the Youth presented with a history of going off his medications. The types of behaviors the Youth exhibited when in crisis were described as periodic bouts of depression, difficulty controlling emotions and impulsivity. To prevent crisis situations the plan recommended regular contact with family, as well as regular positive contact with staff members. Motivators, for the Youth, included phone calls to his family and participation in *Family Nights*. During a crisis, recommended interventions included positive one-on-one interactions with staff members and allowing the Youth to have his space. The plan further stated that only if necessary or as a safety measure should physical restraint be used.

Crisis Prevention Support Plan Youth B

Youth B had a *Crisis Prevention Support Plan* in place. According to the plan, the Youth was prescribed psychotropic medications. The Youth was described as presenting with a history of violent and assaultive behavior including staff assaults. The Youth was also described as having *Mental Health* issues including impulsivity, mood instability and erratic behavior. During a crisis the Youth presented with a history of de-compensating to the point where he became belligerent and non-compliant. Once the Youth calmed down he was described as remorseful, expressing guilt for his actions. The plan stated that the Youth could black out when chemical agents were used escalating to the point where he became violent toward staff members and other Youth. The plan further stated that the Youth could become rigid, unapproachable, unpredictable and aggressive which had led to assaults on staff members.

To prevent a crisis, the plan stated that members of the *Treatment Team* for the Youth should be contacted immediately. The plan recommended that when the Youth became agitated and anxious, to intervene with dialogue. Medication compliance and communication with staff members with whom the Youth had rapport were viewed as motivators. The Youth was viewed as likely to calm down if allowed to communicate with his family. In a crisis, removing the Youth from external stimuli and/or to another living unit was seen as helpful. *Motivational Interviewing* and allowing the Youth to express his feeling were judged to be successful intervention techniques. The Youth was described as enjoying the opportunity to talk and needing the time as well appropriate space to do it. According to the plan, the Youth presented with a history that indicated chemical agents could provoke him into becoming violent toward the individual who administered it. To ensure the safety of staff members, it was recommended that chemical agents be used when the Youth had become assaultive toward others. The Youth was described as presenting with a history of resisting restraint including mechanical restraints. When force was necessary, the plan stated that there should be enough staff members present to gain compliance.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Custody Response

Escalation [Grouping of Youth A, C, D, E and F]

Youth Correctional Counselor Two observed that Youth A, C, D, E and F were grouping along the perimeter fence. Counselor Two then noticed Youth C and D engaged in a heated discussion; Youth D was accusing Youth C of making disrespectful comments to other Youth on the living unit. Shortly after observing the heated discussion, Youth B walked over and stood beside Youth C. Without warning, Youth B then walked towards the center of the *Recreation Area* and began challenging Youth A to a fight. Youth A then began to walk towards Youth B; the two Youth assumed fighting stances.

De-escalation [Youth Correctional Counselor Two]

To de-escalate the situation, Counselor Two tried to position himself between the potential combatants but was unsuccessful in preventing the fight that ensued.

One-on-one Fight [Between Youth A and B]

The two Youth stepped back, came together and began striking each other with closed fist punches to the head and upper torso areas. Youth Correctional Counselor One activated his alarm; Counselor Four tried to alert the *Communication Center* but his battery failed. Simultaneously, the Youth Correctional Counselors issued instructions for the Youth to go to the ground; the non-combatants complied. Counselors One and Two then moved toward the combatants and issued an order for the Youth to break it up and go to the ground; the two kept striking each other.

Warning [Youth Correctional Counselors One and Three]

The two Youth continued to throw punches; Youth Correctional Counselors One and Three then issued a warning to get down or chemical agents would be used.

Chemical Agents [Youth Correctional Counselor One]

For a moment, Youth B backed away, however, then Youth A advanced. In response, from approximately 6-7 feet away, Counselor One administered a single stream of MK-4 OC Pepper Spray to the side of the face of Youth A. Youth A immediately dropped to the ground.

Flight to the Individual Recreation Areas [Youth B Flees with Youth C Following]

Youth C then started walking toward Youth B who was running toward the *Individual Recreation Areas*. At this time, Counselors Two and Four were pursuing Youth B; Counselor Two was giving multiple instructions to stop running, not to climb onto the *Individual Recreation Areas*. Youth C was following Youth B and attempting to dissuade him from climbing onto the structure. As Youth B climbed onto the structure, Counselor Two was unsuccessful in restraining Youth B or in stopping Youth C from following. Next, Youth C was observed pleading with Youth B to calm down and leave the top of the *Individual Recreation Area*. After pacing around the structure for awhile, Youth B finally came down, lay on the ground and placed his hands behind his back; Counselor Four then applied Mechanical Restraints to Youth B.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Custody Response [Continued]

Resolution

Once Youth B came down from the *Individual Recreation Area*, Youth Correctional Counselor One and Youth Correctional Officer One escorted Youth A back to the living unit and into the shower for decontamination. Youth Correctional Officer Two escorted Youth B back to the living unit. At this time, the Youth Correctional Counselors instructed the remaining Youth to line up along the *Recreation Area* wall, return to the living unit and seat themselves quietly in the dayroom chairs. Youth E resisted instructions to be seated and continued walking around the dayroom arguing with Youth Correctional Counselor Two. All the other Youth were structured and then placed in their respective rooms for showers.

Viable Alternative Force Option

Since there were four (4) Youth Correctional Counselors and three (3) responding Youth Correctional Officers present during the incident, the non-combatants were on the ground and Youth B apparently was retreating, physical strengths and holds may have been a viable option to chemical agents for restraining Youth A.

COMMENTS

Warning Signs

If more than one of the four Officers involved in the incident had intervened using alternative methods, possibly, this force incident might have been prevented. Obvious signs that an incident was about to occur were observed:

1. Youth A, C, D, E and F were grouping along the perimeter fence.
2. Youth C and D were engaged in a heated discussion; Youth D was accusing Youth C of making disrespectful comments to other Youth on the living unit.
3. Shortly after the heated discussion began, Youth B walked over and stood beside Youth C.
4. Without warning, Youth B walked towards the center of the *Recreation Area* and began challenging Youth A to a fight.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

COMMENTS [Continued]

Crisis Prevention Support Plan

Given the *Crisis Prevention Support Plan* for Youth B, if physical intervention was an option, it should have been implemented. Had Youth A been restrained without the use of chemicals, most likely Youth B would not have fled to the top of the *Individual Recreation Areas* with Youth C following, which obviously was unsafe. The plan for Youth B clearly stated the following:

1. The Youth was prescribed psychotropic medications.
2. The Youth could black out when chemical agents were used escalating to the point where he became violent toward staff members and other Youth.
3. The Youth presented with a history that indicated chemical agents could provoke violence toward the individual who administered it.
4. The Youth had *Mental Health* issues including impulsivity, mood instability and erratic behavior.
5. The Youth presented with a history of de-compensating to the point where he became belligerent and non-compliant during a crisis.
6. The Youth presented with a history of resisting restraint including mechanical restraints.
7. When force was necessary, there should be enough staff members present to gain compliance.

Individual Recreation Areas

During the incident, Counselor Two gave multiple instructions for Youth B to stop running and not climb onto the *Individual Recreation Areas*. At the same time, Youth C was attempting to dissuade Youth B from climbing onto the structure. Counselor Two was not successful in keeping Youth B from climbing onto the structure or in stopping Youth C from following. Youth C pleaded with Youth B to calm down and leave the top of the structure. Eventually, both you came down safely. Nevertheless, clearly, two Youth climbing onto the top of an *Individual Recreation Area* is not safe and steps should be taken to prevent a similar event from occurring in the future.

Physical Strengths and Holds

In the sample of 245 cases, 73% of the incidents involved at least one Youth with a *Mental Health Designation*. In *Immediate Force* situations staff members do not always know whether a Youth is taking psychotropic medication, when feasible, physical strengths and holds may be preferable to using chemical agents.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Case 94

In Case 94, a male Youth, 18 years; 0 months, and a male Youth, 22 years; 3 months, who resided at *Preston on Redwood Living Unit*, engaged in a one-on-one fight in the dayroom. Chemical agents were used to subdue an attacker, effect custody and gain compliance with a lawful order to stop fighting.

Mental Health and Disability Status

On the day of the incident, neither Youth had a *Mental Health Designation* or an identified disability.

Crisis Prevention Support Plan

On the day of the incident, neither Youth had a *Crisis Prevention Support Plan* in place.

Custody Response

One-on-one Counseling

A Sergeant and Conflict Resolution Team Member spoke with Youth A and B separately about the desire of each to program in a pro-social setting. Both staff members spoke at length about the expectation that conflicts were to be resolved without violence and expressed the desire of the *Redwood Treatment Team* for the Youth to succeed in achieving their program objectives.

Commitment to Non-violence

Each Youth verbally agreed and willingly signed a *No-violence Contract*. Both Youth were then brought into the day room in handcuffs and allowed to problem solve for five minutes. At the conclusion of their conversation, both Youth assured staff members that their intention was to program; both again committed to non-violence.

Mechanical Restraints Removed; One-on-one Fight

Notwithstanding, once the handcuffs were removed, the two Youth began striking each other in the head and chest with closed fists.

Verbal Instructions

The Sergeant and Youth Correctional Counselors instructed the Youth to stop fighting and get on the ground; the Youth continued to fight.

Warning

Next, the Sergeant and Youth Correctional Counselors warned the Youth to stop fighting or chemical agents would be applied; the Youth continued to fight.

Alarm Activation

The Sergeant and Youth Correctional Counselors pressed their personal alarms.

Immediate Force Authorized

The Sergeant then instructed Youth Correctional Counselor One to apply chemical agents.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Custody Response [Continued]

Chemical Agents

From three to four feet away, Youth Correctional Counselor One then dispersed a short burst of MK-4 to the faces of both Youth; the instructions to stop fighting and get down were continuously repeated.

Youth Compliance; Mechanical Restraints

After the chemicals were dispersed the two Youth immediately stopped fighting, went to the ground, placed their hands behind their backs and were handcuffed.

Decontamination and Medical Attention

The Youth were given a shower and clean clothing; the Registered Nurse treated each Youth.

Viable Alternative Force Option

During the incident, five (5) staff members were in the dayroom, four (4) Youth Correctional Counselors and a Sergeant. One of the Youth Correctional Counselors was a member of the *Conflict Resolution Team*. In addition, a fifth Youth Correctional Counselor was in the hallway and a sixth was in the school area. Based on the number of staff members in the dayroom, to gain compliance and effect custody of the two combatants, physical strengths and holds may have been a viable option to using chemical agents.

COMMENTS

Conflict Resolution Sessions

Cases 76, 94, 96 and 98 all involved force being used after a *Conflict Resolution Session*; it is unclear whether this method for resolving conflicts promotes cooperation or confrontation, particularly with young men. The practice in the aforementioned incidents seemed to be setting the Staff-facilitators and the Youth-participants up for failure. Three of the four cases occurred at *Preston* and one occurred at *N.A. Chaderjian*; in every case, chemical agents were used to gain compliance and effect custody after a one-on-one fight.

Crisis Prevention Support Plans

Since there is a possibility that a *Conflict Resolution Session* will result in a physical altercation, a *Crisis Prevention Support Plan* should be developed for each Youth-participant and reviewed by every Staff-facilitator prior to any *Conflict Resolution Session*. On the day the incident occurred in case 92, neither Youth had a *Crisis Prevention Support Plan* in place.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Case 98

In Case 98, a male Youth, 18 years; 8 months, and a male Youth, 19 years; 2 months, who resided at *N.A. Chaderjian* on the *Kern Living Unit*, were involved in a one-on-one fight. Chemical agents were used to subdue an attacker, gain compliance and effect custody.

Mental Health and Disability Status

On the day of the incident, neither Youth A or B presented with a *Mental Health Designation*.

1. According to the *Youth with Disabilities List*, Youth A did not have an identified a disability.
2. According to the *Youth with Disabilities List*, Youth B had an identified disability; the accommodations included access to a *Staff Assistant*. The evidence suggested that during the incident interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

On the day of the incident, neither Youth A or B had a *Crisis Prevention Support Plan* in place.

Crisis Intervention Session; Mechanical Restraints

On the day before the force incident, while in mechanical restraints, Youth A and B participated in a *Crisis Intervention Session*; during the session both Youth agreed to program together.

Crisis Intervention Session; Without Mechanical Restraints

On the day of the force incident, the Senior Youth Correctional Counselor instructed three Youth Correctional Counselors to engage Youth A and B in a second *Crisis Intervention Session* without handcuffs. Prior to the second session, both Youth again indicated willingness to program together.

Escalation

After having been searched, Youth B was seated in the dayroom next to Youth Correctional Counselors One and Three. After being searched by Youth Correctional Counselor Two, Youth A was released from his room and walked with Youth Correctional Counselor Two toward the dayroom. As Youth A reached the bottom of the stairs, Youth B rose from his seat and started advancing. Both Youth A and B then began to throw closed fist punches to the head and upper torso of the other.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Custody Response

Use of Chemicals Agents; Round One

1. After failing to heed a warning to stop fighting or chemical agents would be used, Youth Correctional Counselor Two applied “several bursts” of MK-4 Pepper Spray to the facial areas of both Youth.
2. After issuing a chemical warning, Youth Correctional Counselor Three applied a “continuous burst” of MK-4 pepper spray to the facial areas of both Youth.

Use of Chemical Agents; Round Two

1. Youth Correctional Counselor Two issued another verbal order to stop fighting that was ignored. Youth Correctional Counselor Two then applied a “continuous burst” of pepper spray to the facial areas of both Youth. Youth Correctional Counselor Two recalled that Youth B “seemed to have complied and was beginning to follow staff instructions.”
2. According to Youth Correctional Counselor Three, after the first round of chemicals, the two Youth separated and attempted to clear their eyes from the pepper spray. Youth A moved toward the dayroom television set screaming out unintelligible challenges. Meanwhile, Youth B stopped his advancement but refused to obey a second set of orders to get on the ground. Youth B then made a move to engage with Youth A. In response, Youth Correctional Counselor Three applied a 2-second burst of MK-4 Pepper Spray to the facial area of Youth B.
3. Youth B then laid on his stomach and placed his hands behind his back. Youth Correctional Counselor Three placed handcuffs on Youth B.

Use of Chemical Agents; Round Three

As Youth A started to approach Youth B by going around the dayroom chairs, Youth Correctional Counselor One applied a one second burst of chemical agents to Youth A that hit near his shoulder.

Use of Chemical Agents; Round Four

1. After his second application of chemical agents, Youth Correctional Counselor Two stated, “it was obvious the chemical agents were having little effect” [on Youth A]. Next, Youth Correctional Counselor Two chased and attempted to block the path of Youth A, who was still attempting to fight with Youth B.
2. Youth Correctional Counselor Two then chased Youth A to the front of the television; at this point, another continuous burst of MK-4 Pepper Spray was administered to the facial area of Youth A.
3. Youth Correctional Counselor Two stated, “My last application of pepper spray finally was successful in getting ward [name] to reluctantly lie on the dayroom floor near the TV.”

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Medical Evaluation

A Registered Nurse evaluated both Youth and concluded there were no injuries other than Youth B sustaining a bloody nose.

Debriefing

A *Debriefing Session* was conducted with the Watch Commander following the force incident.

Force Review Committee

1. The Committee found that staff actions prior to and during the force incident were in compliance with policy and training.
2. The Committee found staff actions following the force incident were not in compliance. Examples of issues identified included: failure to sign reports, not mentioning whether a Youth was given a shower or clean clothing, incomplete identification of the staff members involved and failure to identify the chemical agents used. Advisory memorandums were issued to three staff members.

Prior to the Crisis Intervention Session

1. The day before the force incident, none of the Youth Correctional Counselors attended the *Crisis Intervention Session*. Seventeen minutes before the force incident occurred, Youth Correctional Counselor Three was redirected to assist with the session. Youth Correctional Counselor Two notified the Youth Correctional Officer in the *Unit Tower* that the Youth A and B would be programming together which could be a problem. According to the Youth Correctional Officer who observed Youth A coming down the stairs, "it was plain to see the two were going to fight."
2. There was no indication that any of the three Youth Correctional Counselors were familiar with the accommodations required for Youth A.

COMMENTS

More Effective Force Option

1. The staff members involved clearly anticipated that the two Youth might engage in a fight during the *Crisis Intervention Session*. Prior to the fight between the two Youth, there were obvious warning signs that a fight might occur. Throughout the force incident, there was no indication that staff members had considered physical strengths and holds as a viable force option.
2. After the first round of chemical agents, the two Youth separated to clear their eyes. One Youth was walking toward the dayroom television. Under these circumstances, if force had to be deployed, physical strengths and holds may have been a more effective force option than using chemical agents.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

COMMENTS [Continued]

More Effective Force Option

3. After the second round of chemical agents, Youth B had complied and went to the floor to be handcuffed by Youth Correctional Counselor Three. As Youth A started to approach Youth B by going around the dayroom chairs, if force had to be deployed, the use of physical strengths and holds on Youth A might have been a more effective force option.
4. After applying two rounds of chemical agents, Youth Correctional Counselor Two stated that it was obvious that the chemical agents were having little effect on Youth A. Youth Correctional Counselor One then applied another round of chemical agents. Due to the prior applications having little affect, if force had to be deployed after three rounds of chemicals agents, physical strengths and holds might have been a more effective force option.

Use of Force Review Project

IV. Use of Force

Observation Five: Viable Alternative Force Option

4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.

Policy, Practice and Training Recommendations

1. Within 30 days, in an effort to reduce the use of chemical agents, when physical force is a viable force option, encourage the use of physical strengths and holds.
2. Within 6 months, conduct a pilot project that removes the use of chemical agents on a *Mental Health Unit*.

Use of Force Review Project

HEALTH CARE SERVICES

5.1 Medical care and reporting of Youth injury were inconsistent.

5.2 Force was used on Youth who had engaged in self-injurious behavior with no immediate intervention by a Mental Health Clinician.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Authority

According to the Crisis Prevention and Management Policy:

Immediate and Controlled Use of Force Written Report Requirements

Employee

Prior to leaving the facility, every employee who was involved in or witnessed a Use of Force Incident, completes and submits a Behavior Report and Use of Force form. If the employee is unable to complete the required documentation due to an injury, the employee may dictate the information to a Correctional Peace Officer Supervisor by proxy. This can be accomplished in person or via telephone.

Use of Force Written Report Guidelines

Written reports regarding both immediate and controlled use of force will be documented on a Behavior Report and Use of Force form. Reports are to be written in the first person. Identify important information in the contents of the report as follows...

- *Describe any observed employee or Youth injuries and the cause of the injury, if known...*

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Authority

According to the Crisis Prevention and Management Policy:

Health Care Professional

Prior to leaving the facility:

1. *Completes and submits an applicable Behavior Report form.*
2. *Documents in Section Five (5) of the Use of Force form if medical attention was or was not rendered including the following:*
 - *Date, time, and location of medical attention.*
 - *The reason and type of medical attention.*
 - *A quote of the Youth's own words in the patient description section.*
 - *Witnesses' names and their summary of occurrence and injury.*
 - *Specific examination and documentation of observations of the area of the Youth where force was applied.*
 - *Description and extent of the injuries sustained, medical treatment rendered and disposition.*
 - *Documentation of any refusal of medical examination and/or treatment by the Youth.*
 - *The name of the Health Care Professional (type or print) and their signature.*
 - *If a review of the Youth's Unified Health Record was completed prior to the facilitation of a Controlled Use of Force incident, checks the appropriate box.*
3. *Enters all information in the WIN System with the exception of the employee's signature*

According to the Access to Care Policy:

Division of Juvenile Justice (DJJ) Youth shall have unimpeded access to clinically indicated health care services (medical, mental health and dental care) regardless of disciplinary status of the facility or any shortage of personnel.

Access to Care

Youth can be seen by a qualified health care provider, be given a professional clinical judgment and receive routine care in a timely manner.

Sufficient health care and non health care staff shall be on hand to ensure that adequate escort, security and health care services are provided.

Access to care shall be available to Youth at all security levels.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Authority

According to the Crisis Prevention and Management Policy:

Allegations of Unnecessary or Excessive Force: Report of Inquiry

Use of Force violations of statute, regulation, policy, and procedures are subject to administrative, criminal, and civil sanctions if deemed appropriate and necessary.

Watch Commander

- 1. Verbally notifies the Chief of Security as soon as practical.*
- 2. If there are injuries, arranges for the Youth to be medically examined and requests a full medical assessment of the injuries.*
- 3. Ensures that a Health Care Professional evaluates the Youth.*
- 4. Interviews the examining Health Care Professional regarding the extent of the injuries and requests an evaluation of whether the injuries are consistent with the degree of force alleged.*
- 5. Ensures the Use of Force Report form, section five has been properly completed.*
- 6. Ensures each employee who witnessed the allegation and/or each employee who witnessed the event leading to the allegation immediately submits a report in memorandum format.*
- 7. Interviews the Youth following the Youth Interview Format regarding the allegation as soon as practical, but no later than 48 hours after receipt of notification of the allegation. The interview will be video recorded if the Youth has injuries. Photographs are to be taken of the Youth's anatomy where the Youth alleges the injury occurred. Results of the interview shall be documented on the Report of Findings – Youth Interview form.*
- 8. Submits an Incident Review Package including all of the following documents relating to the allegation to the Chief of Security...*

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Quantitative Analysis

In the total sample of 245 cases, only 5* or 2% involved incidents in which staff members consistently reported Youth injury.

Qualitative Analysis

In the sample of 100 qualitatively reviewed cases, only 2* or 2% involved incidents in which staff members consistently reported Youth injury.

**Data is not interpretable due to lack of definition of injury and consequent inconsistent reporting (see case snapshots).*

Case Snapshots

The case snapshots that follow describe four force incidents where medical care and reporting of Youth injury were inconsistent.

[Additional case example included: 67]

Case 2 [Single Youth Non-compliance]

A female Youth, 20 years of age, who resided at *Ventura* on the *Alborado Living Unit*, refused to go to a "Strip Room." Physical force and mechanical restraints were used to effect custody and overcome resistance.

Mental Health/Disabilities

The Youth had a *Mental Health Designation*. There is evidence that interventions were adjusted to accommodate the individual needs of the Youth in crisis, including the involvement of a Mental Health Clinician. The Youth did not have an identified disability.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place, some of which was utilized during the incident. According to the plan, the Youth experienced manic episodes, was prescribed psychotropic medication that needed to be taken regularly and worked herself up emotionally when she perceived she had nothing to lose. Additionally, the Youth was known to cover her window. Effective crisis prevention and de-escalation strategies for staff members working with the Youth included speaking slowly, interacting with her one-on-one, remaining calm, explaining the situation and possible consequences, placement in her room at the beginning of a crisis or moving her to another room away from a crisis. Other suggestions included limiting the number of staff members involved with the Youth. As the Youth reacted aggressively to touch, the plan recommended using physical force as a last resort.

Prior to Force

The Youth had committed to good behavior and was released from the *Temporary Detention Program*. During school movement, the Youth requested to speak with a staff member to avoid attacking another staff member; the request was not granted.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Case 2 [Single Youth Non-compliance-Continued]

Prior to Force [Continued]

Upon returning to the living unit, the behavior of the Youth escalated, as manifest through the Youth pacing around the dayroom, flipping chairs, jumping on tables, hitting the television screen, and kicking over a large container of water. A Youth Correctional Counselor attempted to dialogue with the Youth to no avail. A code was called. The Youth sat down and refused to go to her room. Two Youth Correctional Officers responded to the code. The Youth was given clear instructions to go to her room and was informed that the Mental Health Clinician would speak with her once she complied. Crying, the Youth stated that her feelings were hurt and asked to speak with the Mental Health Clinician immediately.

The Mental Health Clinician arrived, instructed the Youth to go to her room, and informed the Youth that she would speak with her once her work was finished. The Youth verbally agreed to go to her room but did not move. A Youth Correctional Officer instructed the Youth to go to her room; the Youth did not respond. The Mental Health Clinician informed the Youth that she would speak with her if she went to her room. The Youth did not comply and insisted that she was not going to eat or take her medication. The Mental Health Clinician advised the Youth to go to a “Strip Room” for 10 minutes and that she would speak with her afterward.

The Youth agreed to go to the “Strip Room.” The Youth Correctional Officers assisted the Youth to her feet, and the Youth took three or four steps before changing her mind and sitting on the dayroom floor. The Youth stated that she wanted to go to her own room. The Youth Correctional Officers attempted to assist the Youth to her feet, but the Youth began kicking her feet and swinging her arms.

Force

The Youth Correctional Officers used physical holds and restraints to place the Youth on her stomach and apply handcuffs. The Youth Correctional Counselor used physical holds and restraints to secure her lower body. After several minutes of dialogue, the Youth agreed to enter the “Safe Room.” The Youth Correctional Officers assisted the Youth to her feet and escorted the Youth to the “Safe Room.”

Post Force: Medical

A Youth Correctional Officer transported the Youth to the *Outpatient Housing Unit* for medical assessment. The Youth described the incident to the Registered Nurse as follows:

“I got my feelings hurt. I’m sad. I was throwing chairs in the day room, and they said I was going in the strip room. I’m upset. My stomach hurts. I don’t have any appetite. I got bruises on my arm and knee.”

The Registered Nurse described the injuries the Youth sustained as bruising on the right bicep and right forearm; superficial abrasion on the left knee. The Youth declined pain medication. The Registered Nurse described treatment provided as,

“Declined pain medication; vital signs, reassurance.”

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

COMMENTS

Inconsistent Reporting

After the incident, reports of the injuries the Youth sustained were inconsistent. The Youth reported bruises on her arm and knee and the Registered Nurse reported bruising on the right bicep and right forearm as well as a superficial abrasion on the left knee. The Watch Commander and Assistant Superintendent reported no injuries due to force. Since *Section Five* of the *Use of Force* form (YA 8.412) does not require the Health Care Professional to make a determination as to the cause of injuries cited and/or treated, it is unclear how other respondents determined that the injuries were not due to force.

Nexus between Youth Injury and Force

The inconsistencies in reporting appears to be related to the fact that the licensed Health Care Professional reporting Youth injuries sustained after a force incident is only responsible for treating but not for determining the cause of the injury. Given that the Health Care Professional treating the Youth is not required to make a determination as to causation, it is unclear how any other employee is qualified to make that determination without a documented, eyewitness account of the specific injury or without consulting with a physician after all of the reporting and evidence has been gathered.

Allegations of Unnecessary or Excessive Force: Report of Inquiry

If there were allegations of unnecessary or excessive force, it was the responsibility of the Watch Commander to request a full medical assessment of the injuries, ensure that a Health Care Professional fully evaluated the Youth, interview the examining Health Care Professional regarding the extent of the injuries, request an evaluation of whether the injuries were consistent with the degree of the force alleged and to offer the Youth a video recorded interview.

Institution Force Review Committee

No concerns around inconsistent reporting of the injuries the Youth sustained were noted by the *Institution Force Review Committee*.

Youth Statement

There was information in the *Youth Statement* given to the Registered Nurse that had potential value for members of the *Interdisciplinary Treatment Team* that should have been communicated appropriately.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Case 72 [Single Youth-Room Extraction]

A male Youth, 16 years of age, who resided at *N.A. Chaderjian* on the *Sacramento Living Unit*, refused to comply with instructions and stop covering his window. Physical force was used to effect custody.

Crisis Prevention Support Plan

At the time of the incident, it is unknown whether or not the Youth had a *Crisis Prevention Support Plan* in place. Subsequently, the Youth did have a plan developed with entries beginning on March 22, 2010. According to the plan, the Youth had demonstrated impulsive behavior, engaged in physical altercations with other Youth, been uncomfortable expressing himself to unfamiliar staff members and escalated his behavior when unable to communicate or get his point across. Known effective crisis prevention and de-escalation strategies for the Youth included talking with trusted staff members, taking a time out to draw, walking away and being reminded about his goal to return home so that he could care for his daughter. It was also noted that when the Youth was isolated with nothing to do, his negative thoughts tended to spiral which lead to escalation.

Mental Health/Disabilities

The Youth had a *Mental Health Designation*. There is limited evidence that interventions to accommodate the individual needs of the Youth were attempted. The On-Call Mental Health Clinician was contacted. Nevertheless, her only contribution was to approve the *Room Extraction*. There is no evidence that she suggested alternative interventions, coached staff members on interacting with the Youth or addressed the emotional functioning of the Youth. The Youth did not have an identified disability.

Prior to Force

While in his room, the Youth covered the light and back window. The Youth was instructed to uncover the light. The Youth did not do so and covered himself with a sheet. To ensure the safety of the Youth inside the room, the Youth Correctional Counselors opened the door, uncovered the light and instructed the Youth to uncover himself. The Youth did not uncover himself. The Youth Correctional Counselors pulled the sheet off the Youth and exited the room. After exiting the room, the Youth Correctional Counselors noticed that the Youth had covered his door window. The Youth Correctional Counselors then applied the safety chain, opened the door and uncovered the door window. In response, the Youth again covered his door window and refused to comply with instructions to be handcuffed through the tray slot. The instructions were given so that the items being used to cover the door window could be removed safely.

The Lieutenant responded to the incident and dialogued with the Youth for approximately fifteen minutes. The Youth informed the Lieutenant that he was stressed out and wanted off of the living unit. The Lieutenant called the Supervising Casework Specialist assigned to the Youth at home. The Supervising Casework Specialist approved the Youth for placement on the *Temporary Intervention Program* on another living unit for the night. Nevertheless, the Youth continued to cover his door window, did not comply with being handcuffed through his tray slot and did not respond to the *Suicide Risk and Screening Questionnaire* questions being asked him. Thus, the Lieutenant called the On-Call Mental Health Clinician and the Executive Officer, both of whom authorized a *Room Extraction*.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Case 72 [Single Youth-Room Extraction-Continued]

Force

The Lieutenant assembled a five member room *Extraction Team*. The Youth was given one more chance to allow team members to handcuff him through his tray slot; the Youth continued to refuse. Team members opened the door, entered the room, attempted to restrain and gain control of the Youth; the Youth was perceived as resistive. After a short struggle, team members placed the Youth in handcuffs and leg irons. Then Youth was removed from his room. One of the Force Users in *Section One* of the *Use of Force* form (YA 8.412) described the type of force used in the following way:

“Placing Youths left legs bending it at the knee behind the right leg then taking his right leg bending it at the knee over the left leg placing the Youth into a figure four leg lock and placing leg irons on his ankles.”

Post Force: Medical

Upon removal from his room, the Youth was placed in front of the wall and given the opportunity to be seen by the Registered Nurse who was present. The Youth refused medical attention and stated, “Fuck the MTA.” The Registered Nurse then cut all the clothing off of the Youth, except for his socks and underwear. The Youth was perceived as resistive during this process. After the clothing was removed, the Youth was escorted to another room. Following a debriefing, the Registered Nurse again offered the Youth medical attention but the Youth refused.

COMMENTS

Youth Refusal for Medical Attention

It is recognized that staff members attempted to provide the Youth with medical attention. Nevertheless, both times the Youth was offered medical attention, others, including members of the *Extraction Team*, were present. It is instructive to note that another *Room Extraction* occurred with the same Youth approximately one month later. The Youth was offered medical attention under similar circumstances and again refused. Assuming the desired outcome was for the Youth to receive medical attention, there were more effective ways to offer services, including securing a more private environment and, as suggested by the *Crisis Prevention Support Plan*, having a trusted staff member speak with the Youth and take the time to understand his concerns.

Inconsistent Reporting

After the incident, reports of the injuries the Youth sustained were inconsistent. The Registered Nurse noted that the Youth had a two inch scratch on his right shoulder. The Registered Nurse also noted that the Youth was limping and demonstrating partial weight bearing on his left foot. The Watch Commander and Assistant Superintendent reported no injuries due to force. Since *Section Five* of the *Use of Force* form (YA 8.412) does not require the Health Care Professional to make a determination as to the cause of injuries cited and/or treated coupled with the fact in this case *Section Five* was incomplete, it is unclear how other respondents determined that the injuries were not due to force. This is particularly unclear given the description of the types of force used in contrast to the report from the Registered Nurse stating that the Youth was limping.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Case 72 [Single Youth-Room Extraction-Continued]

COMMENTS [Continued]

Nexus between Youth Injury and Force

The inconsistencies in reporting appears to be related to the fact that the licensed Health Care Professional reporting Youth injuries sustained after a force incident is only responsible for treating but not for determining the cause of the injury. Given that the Health Care Professional treating the Youth is not required to make a determination as to causation, it is unclear how any other employee is qualified to make that determination without a documented, eyewitness account of a specific injury or without consulting with a physician after all of the reporting and evidence has been gathered.

Crisis Prevention and Management Policy

The descriptions of the incident recorded in *Section Five* of the *Use of Force* form (YA 8.412) were incomplete, indicating a lack of compliance with the *Crisis Prevention and Management Policy*.

Institution Force Review Committee

No concerns around inconsistent reporting of the injuries the Youth sustained were noted by the *Institution Force Review Committee*.

CASE 75 [Disturbance]

Six male Youth, three 17 years of age, two 18 years of age and one 19 years of age, who resided at *Ventura*, engaged in fighting in the school area. Chemical agents were used to gain compliance with lawful orders to stop fighting.

Crisis Prevention Support Plan

None of the Youth had a *Crisis Prevention Support Plan* in place at the time of the incident.

Mental Health/Disabilities

Three of the Youth involved in the incident had a *Mental Health Designation*: one resided on a *Mental Health Living Unit*; another one resided on a *Mental Health Living Unit* and was on *Suicide Watch* or *Suicide Precaution*; one was prescribed *Psychotropic Medication* and received *Outpatient Mental Health Services*. Additionally, three of the Youth had an identified disability; accommodations cited on the *Youth with Disabilities List* included provisions for a *Staff Assistant* for two of the Youth and no cold showers or strenuous activity for the third. There is no evidence that interventions were adjusted to accommodate the individual needs of the Youth in crisis.

Two One-on-One Fights

Four Youth were observed fighting during class change, striking one another with closed fist punches. A Youth Correctional Officer warned the Youth to stop fighting or chemical agents would be applied. The Youth continued to fight. Youth Correctional Officer A dispersed chemical agents from approximately three feet away. The Youth continued to fight. Youth Correctional Officer B dispersed chemical agents from approximately six feet away. The four Youth separated and got into a prone position on the ground.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

CASE 75 [Disturbance-Continued]

Another One-on-One Fight

Two Youth were observed exchanging closed fist punches. Youth Correctional Officer C warned the Youth to stop fighting or chemical agents would be applied. The Youth continued to fight. Youth Correctional Officer C dispersed chemical agents from approximately seven feet away. The two Youth separated and got into a prone position on the ground.

Post Force: Medical

All the Youth were escorted to the *Outpatient Housing Unit* and seen by a Registered Nurse.

- Youth A was seen at 0930 and described the incident as, “I got in a fight at school, the second one. I hurt my hand again, the first playing football and today in the fight. I can barely move it. I think I broke it.” The Registered Nurse identified the Youth’s injuries as a slightly swollen and bruised left hand with limited movement in the third and fourth fingers. The Registered Nurse referred the Youth for evaluation of his hand, provided the Youth with pain medication and released the Youth to the care of a Youth Correctional Officer.
- Youth B was seen at 0935 and described the incident as, “I had to take care of business.” The Registered Nurse identified the injuries the Youth sustained as redness to his neck and scalp secondary to chemical exposure. The Registered Nurse rinsed the hand, neck and face of the Youth with cool water and applied a buffer solution before releasing the Youth to the care of a Youth Correctional Officer.
- Youth C was seen at 0950 and described the incident as, “They got me this time, Miss, but they got their butts kicked. Shit.” The Registered Nurse identified the injuries the Youth sustained as redness to his neck. The Registered Nurse rinsed the neck and face of the Youth with cool water and applied a buffer solution before releasing the Youth to the care of a Youth Correctional Officer.
- Youth D was seen at 1130 and described the incident as, “I got in a fight.” The Registered Nurse identified the injuries of the Youth as soft tissue damage to his left thumb and right knuckles, along with minor swelling in his right cheekbone. The Registered Nurse offered the Youth an ice pack, provided the Youth with pain medication and released the Youth to the care of a Youth Correctional Officer.
- Youth E was seen at 1230 and declined to describe the incident. The Registered Nurse identified the injuries the Youth sustained as superficial abrasion to the left eyelid, left forehead, and left parietal area of his head. The Registered nurse cleansed the abrasion and released the Youth to the care of a Youth Correctional Officer.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

CASE 75 [Disturbance-Continued]

Post Force: Medical [Continued]

- Youth F was seen at 1303 and described the incident as, “I was attacked” and complained of pain in his right hand. The Registered Nurse identified no injuries, referred the Youth for evaluation, provided the Youth with pain medication and released the Youth to the care of a Youth Correctional Officer.

Incident Review: Medical

According to the *Institution Force Review Committee-Use of Force Incident* (DJJ 8.443), none of the Youth sustained injuries due to force. According to *Section 1-Watch Commander Review*, contained in the *Use of Force Incident Review* (DJJ 8.440), Youth D suffered soft tissue injury to his left thumb and right knuckles and that Youth E suffered superficial abrasion to his left eyelid due to force used. According to the *Section 3-Superintendent/Assistant Superintendent/Designee Review*, medical attention was provided to the Youth and there were no injuries due to force.

COMMENTS

Access to Care

One Youth was seen by a Registered Nurse 2 hours and 11 minutes after the incident, one Youth was seen by a Registered Nurse 3 hours and 11 minutes after the incident, and one Youth was seen by a Registered Nurse a full 3 hours and 44 minutes after the incident; this was not care provided in a timely manner, per the *Access to Care Policy*. According to the *Watch Commander Review*, the Youth were not seen prior to re-housing due to the number of Youth involved. Regardless of any shortage of personnel, the time that elapsed between the incident and the delivery of care was not consistent with the *Access to Care Policy*.

Inconsistent Reporting

After the incident, reports of the injuries the Youth sustained were inconsistent. For example, Youth A reported belief that his hand was broken; the Registered Nurse reported that Youth A presented with a slightly swollen and bruised left hand; limited movement in the third and fourth fingers. The Watch Commander reported that Youth D suffered soft tissue injury to his left thumb and right knuckles and that Youth E suffered a superficial abrasion to his left eyelid. The Superintendent reported no injuries due to force. Since *Section Five* of the *Use of Force* form (YA 8.412) does not require the Health Care Professional to make a determination as to the cause of injuries cited and/or treated, it is unclear how other respondents determined that the injuries were not due to force.

Nexus between Youth Injury and Force

The inconsistencies in reporting appears to be related to the fact that the licensed Health Care Professional reporting Youth injuries sustained after a force incident is only responsible for treating but not for determining the cause of the injury. Given that the Health Care Professional treating the Youth is not required to make a determination as to causation, it is unclear how any other employee is qualified to make that determination without a documented, eyewitness account of a specific injury or without consulting with a physician after all of the reporting and evidence has been gathered.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

COMMENTS [Continued]

Institution Force Review Committee

No concerns around the Youth accessing care in a timely manner or inconsistent reporting of the injuries were noted by the *Institution Force Review Committee*.

Youth Statement

There was information in the *Youth Statements* to the Registered Nurse that had potential value for members of the respective *Interdisciplinary Treatment Teams* and should have been communicated appropriately.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Policy, Practice and Training Recommendations

1. Within 30 days, enforce the *Access to Care Policy*, especially timeliness of services.
2. Standardize *Section Five* of the *Use of Force* form (YA 8.412) completed by *Health Care Services* after each force incident. At a minimum, *Section Five* should include:
 - Youth name, identification number, sex and age.
 - The date and time of the incident, evaluation and treatment.
 - The location where medical treatment was provided.
 - Whether the Youth has a *Mental Health Designation* or an identified disability.
 - Any accommodations provided, including a *Staff Assistant*.
 - Medications prescribed.
 - A *Youth Statement* describing the incident and how any injuries occurred.
 - A *Body Profile*, front and back, which charts each injury.
 - Description and extent of any injuries sustained.
 - Medical treatment rendered and disposition.
 - Any refusal for medical examination and/or treatment.
 - Names of every:
 - Officer who escorted the Youth to the *Outpatient Housing Unit*.
 - Health Care Professional who conducted the evaluation.
 - Health Care Professional who completed the form.
3. Enforce documentation requirements governing Health Care Professionals contained in the *Immediate and Controlled Use of Force Written Report Requirement* section of the *Crisis Prevention and Management Policy*.
4. Enforce requirements in the *Crisis Prevention and Management Policy* for documentation of any Youth injury observed and the cause of said injury, if known, on a *Behavior Report [Serious Misconduct (DJJ 8.403A) or Supplemental (YA 8.402)]* and *Use of Force* form (YA 8.412).
5. As misdiagnosing might impede access to care, ensure that documentation of any Youth injury by an employee other than a licensed *Health Care Professional* is limited to observations.
6. In the *Watch Commander Review*; Section 1 and the Superintendent / Assistant Superintendent / Designee Review; Section 3, of the *Use of Force Incident Review* form (DJJ 8.440), without an eyewitness account of a specific injury or concurrence from a physician, limit documentation of Youth injuries to observations; in the interest of decreasing inconsistencies in documentation, refrain from making judgments about whether injuries observed were due or not due to force.

Use of Force Review Project

V. Health Care Services

Observation One: Youth Injury

5.1 Medical care and reporting of Youth injury were inconsistent.

Policy, Practice and Training Recommendations [Continued]

7. Ensure that relevant *Youth Statements* given to Health Care Professionals post incident are communicated appropriately to living unit staff members.
8. Hold staff members accountable for responding to Youth injuries, in accordance with their duties, roles and qualifications; deliver training as necessary.

Use of Force Review Project

V. Health Care Services

Observation Two: Self-injurious Behaviors

5.2 Force was used on Youth who had engaged in self-injurious behavior with no immediate intervention by a Mental Health Clinician.

Authority

According to the Suicide Prevention, Assessment and Response Policy:

Expression of suicidal ideations, feelings, and self-injurious behaviors constitute a health care emergency which requires immediate and effective action. All Direct Care Staff in Division of Juvenile Justice (DJJ) facilities shall immediately report and respond to any communication or action indicating a Youth is, or may be, thinking of suicide or self-injurious behaviors and take all necessary precautions to prevent self-harm. Any DJJ facility employee who becomes aware of a Youth with current suicidal ideations, attempts at suicide, threats, or acts of self-injurious behavior shall immediately intervene with the Youth, provide 1:1 staff supervision, notify a member of the Health Care Staff, and contact the Duty Lieutenant or designee.

Suicidal ideations, feelings, and self-injurious behaviors exhibited by Youth are indicators of an increased level of psychological and/or psychosocial distress. Living Unit staff have the responsibility to respond to the individual's distress, resulting in decreased safety in the Living Unit (community), by confronting the precipitants of the distress and applying appropriate interventions. As soon as is clinically appropriate, and as often as necessary, following a suicidal ideation, threat, or act, the Youth and Living Unit staff shall meet in large and/or small group settings to engage in guided interactions. With the guidance of staff, Youth are encouraged to take accountability for their actions and to listen to the advice of their peers. The goal of these community and small group meetings is to empower the Youth to make positive changes, re-establish the conditions of safety, reinforce respect for each other, and to assess, establish, and modify achievable goals.

According to the California Court Case *Bellah v Greenson* (1978):

A therapist has a legal duty to take reasonable steps to prevent suicide by a client.

Use of Force Review Project

V. Health Care Services

Observation Two: Self-injurious Behaviors

5.2 Force was used on Youth who had engaged in self-injurious behavior with no immediate intervention by a Mental Health Clinician.

Quantitative Analysis

In the total sample of 245 cases, 9 or 4 % of incidents involved Youth [8 female; 1 male] who engaged in self-injurious behavior.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 8 or 8% of incidents involved Youth [7 female; 1 male] who engaged in self-injurious behavior.
2. In the 8 qualitatively reviewed cases involving Youth who engaged in self-injurious behavior, 2 or 25% indicated the *presence* of a Mental Health Clinician.
3. In the 8 qualitatively reviewed cases involving Youth who engaged in self-injurious behavior, 1 or 13 % indicated immediate *intervention* by a Mental Health Clinician.

Case Snapshots

The following case snapshot describes an incident during which force was used on a Youth who had engaged in self-injurious behavior and there was no immediate intervention by a Mental Health Clinician.

[Additional case examples included: 32, 81 and 82.]

Case 59

A female Youth, 18 years of age, who was residing at *Ventura on Alborada Living Unit*, refused to move to a *Safe Room* after attempting self-injury and stating that she wanted to kill herself. Physical force was used to gain compliance. Once in the *Safe Room*, the Youth refused to surrender the object in her hand; as a result, physical force was used for a second time. Finally, the Youth refused to cooperate with a pat down search; so for a third time, physical force along with mechanical restraints was used to gain compliance.

Mental Health and Disability Status

At the time of the incident, the Youth was assigned to a *Mental Health Unit*, was on *Suicide Watch* and prescribed medication by a psychiatrist. The evidence suggested that interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

The Youth had a *Crisis Prevention Support Plan* in place that was not utilized during the incident. According to the plan, the Youth had a history of self-injurious behavior, low self esteem, challenged interpersonal relationships, as well as poor social and coping skills. In crisis, the Youth responded well to speaking with staff members with whom she had good rapport, being spoken to in a tone that was calm but firm, having instructions repeated and consequences clarified; the removal of peers from around the Youth was viewed as helpful. Effective crisis prevention and de-escalation strategies included counseling, reading, coloring and speaking in a calm but firm tone.

Use of Force Review Project

V. Health Care Services

Observation Two: Self-injurious Behaviors

5.2 Force was used on Youth who had engaged in self-injurious behavior with no immediate intervention by a Mental Health Clinician.

Custody Response

A Youth Correctional Officer assigned to one-on-one *Suicide Watch* observed that the Youth was hiding behind the cabinet in her room and biting herself. A Senior Youth Correctional Counselor informed the Youth that she would be moved to a *Safe Room*, without a cabinet, if she continued hiding. The Youth continued to hide. In response, the Youth was informed that she would be moved to another room. Custody staff members used physical strengths and holds to move the Youth to the *Safe Room*. Once in the *Safe Room*, the Youth Correctional Officer noticed that the Youth was holding something in her hand. The Youth refused to surrender the object and the Youth Correctional Officer used physical holds to retrieve the item, which turned out to be a rosary. The Youth Correctional Officer then informed the Youth that a pat down search would be conducted. The Youth refused to cooperate; physical strengths and mechanical restraints were used to gain compliance. A pencil the Youth was holding in her hand was retrieved.

Mental Health Response

There was no immediate intervention by a Mental Health Clinician. Clearly, there was a safety issue, as the Youth was attempting self-injury and stating that she wanted to kill herself. Ensuring the safety of the Youth was the primary treatment needed at the time. Nevertheless, the interaction between custody staff members, who were insisting that the Youth move to a safer room, and the Youth, who was refusing to move, escalated quickly into a power struggle that continued to manifest through the interaction over the rosary and the subsequent pat down search. Ultimately, the focus transitioned to the Youth being non-compliant; the focus on self-injurious behavior and suicidal threats was lost. Granted the safety of the Youth needed to be ensured and, even if that required force at some point, the focus should have returned to the self-injurious behavior and suicidal threats; addressing non-compliance with a Youth intent on dying is contraindicated.

Immediate post-incident intervention by a Mental Health Clinician might have included a suicide assessment, a chain analysis of the self-injurious behavior and/or guidance to custody staff members on how to interact with the Youth while providing one-on-one supervision during *Suicide Watch*. These kinds of immediate post-incident interventions could have brought the focus back to the self-injury and suicidal threats without necessarily reinforcing the behaviors. Immediate pre-incident intervention by a Mental Health Clinician might have included modeling or coaching custody staff members on how to avoid and address power struggles and how to effectively maintain the focus on the self-injurious behavior and suicidal threats. Any immediate intervention the Mental Health Clinician provided would have been strengthened by invoking the strategies identified in the *Crisis Prevention and Support Plan* developed for the Youth

Use of Force Review Project

V. Health Care Services

Observation Two: Self-injurious Behaviors

5.2 Force was used on Youth who had engaged in self-injurious behavior with no immediate intervention by a Mental Health Clinician.

Policy, Practice and Training Recommendations

1. Within 30 days, issue an official statement requiring immediate intervention by a Mental Health Clinician when force is being considered with a Youth who has engaged in suicidal or self-injurious behavior.
2. Within 6 months, amend *Crisis Prevention and Management Policy* to include immediate intervention by a Mental Health Clinician when force is being considered with a Youth who has engaged in suicidal or self-injurious behavior.

3. Train and coach Mental Health Clinicians and Correctional Peace Officers on effective interventions with self-injurious Youth that include the following modes of treatment:
 - Individual therapy.
 - Skills training.
 - Living unit support.
 - Staff member conferencing.

Use of Force Review Project

DOCUMENTATION

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

Use of Force Review Project

VI. Documentation

Observation One: Use of Force Reports

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

Authority

According to the Crisis Prevention and Management Policy:

Every employee has an ethical and legal responsibility to report what they believe to be an incident of unnecessary or excessive force. Any employee observing unnecessary or excessive force shall make reasonable efforts to stop the violation and immediately report it to the Watch Commander/Supervisor verbally and follow up with a written report of their observations.

Any employee who uses or witnesses force, which appears greater than that required for un-resisted search, escorting, or handcuffing, must complete applicable reports and document all observations prior to departure from the facility.

See Appendix C, Written Report Guidelines, for additional information on completing documentation.

Qualitative Analysis

1. In the 100 qualitatively reviewed cases, 90 or 90% contained a documentation deficiency in the *Force Review Committee Analysis* form (DJJ 8.443), *Use of Force Incident Review* form (DJJ 8.440), *Use of Force Report* form (YA 8.412), *Level 3 Serious Misconduct Behavior Report* form (DJJ 8.403A), and/or *Behavior Report – Supplemental* form (YA 8.402). In only 34 of 90, or 38% of cases, were the documentation deficiencies identified through the review process.
2. *Force Review Committee Analysis Form* (DJJ 8.443)

This form provides a summary of the findings of the *Force Review Committee*. Examples of documentation deficiencies include:

- A conclusion that was not supported with the documents in the incident package. For example, despite no evidence to suggest that staff members had issued chemical warnings or activated their personal alarm prior to force, the *Force Review Committee* found staff actions to be compliant with policy, procedures and training.
- A conclusion that all reports had been completed when important elements, such as Behavior Reports, were missing from the incident package. In some instances, evidence suggested the Behavior Reports had not been submitted. It is unclear as to how the *Force Review Committee* performed an objective and thorough review without all relevant facts.
- Sections of the form were not completed.
- Most of the *Force Review Committee* reviews were late, some by three to four months.

Use of Force Review Project

VI. Documentation

Observation One: Use of Force Reports

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

Qualitative Analysis [Continued]

3. *Use of Force Incident Review Form (DJJ 8.440)*

This form presents the analyses of the force incident by the Watch Commander, the Chief of Security and the Superintendent. Examples of documentation deficiencies noted include:

- A conclusion that was not supported by the other documents in the incident package.
- A Watch Commander, despite having played an instrumental role in the incident, completed the *Watch Commander Section* of the report; it is unclear how the evaluation could be considered objective.
- An inconsistency between what was indicated on the form and the actual description by the staff members involved in the incident. The question of whether mechanical restraints had been applied, for example, was a frequent source of inconsistency due to a discrepancy in definition between the *Crisis Prevention and Management Policy* and *Performance-based Standards (PbS)*.
- A page of the form was missing from the incident package.
- A section of the form was not completed.
- A section of the form was unsigned.

4. *Use of Force Report form (YA 8.412), Level 3 Serious Misconduct Behavior Report form (DJJ 8.403A) and Behavior Report – Supplemental (YA 8.402)*

These reports provide the observations and accounts of staff members that have applied force or witnessed application of force by other staff members. Examples of documentation deficiencies noted include:

- Copying, as evidenced by matching descriptions of a force incident, including misspelled words and grammar errors.
- An inconsistency between accounts of the same event, for example the type of force used, which was not identified or resolved at any level of review.
- Poor report preparation including omissions of important information, such as events preceding the incident and force applied.

Case Snapshot

The case snapshot that follows demonstrates that in *Use of Force Reports* staff members did not always sufficiently describe incidents, reported conflicting information and omitted details.

[Additional case examples include: 27, 71, 87, 91 and 92]

Use of Force Review Project

VI. Documentation

Observation One: Use of Force Reports

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

Case 73

In Case 73, Youth were exiting the dining hall on the *Marshall Living Unit* at the *Southern Reception Center and Clinic*. Five Youth assaulted one Youth; physical strengths and holds, chemical agents and mechanical restraints were used to gain compliance with a lawful order to stop the attack.

Mental Health and Disability Status

At the time of the incident, each of the six Youth had a *Mental Health Designation*; four of the six Youth had an identified disability requiring accommodations, including utilization of a *Staff Assistant*. Other accommodations included checking for understanding, allowing extra time and minimizing distractions. Nevertheless, it does not appear that interventions were adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plans

On the day of the incident, none of the six Youth had a *Crisis Support Prevention Plan* in place.

Custody Response

Five staff members, including a Youth Correctional Counselor, a Youth Correctional Officer, a Senior Youth Correctional Counselor, a Casework Specialist and a Supervising Casework Specialist, escorted 22 Youth from the dining hall after the evening meal. As the Youth were exiting the dining hall, two Youth stepped out of formation, ran toward another Youth, and attacked him. Three other Youth then joined the two Youth who initiated the assault. The following are different accounts of the same incident.

1. The Youth Correctional Officer reported that, after issuing instructions to stop fighting and the Youth did not comply, two one-second bursts of MK-9 Fogger were applied to stop the assault. All six Youth were sprayed.
2. The Supervising Casework Specialist reported grabbing one of the assailants by the left arm, swinging him around to the floor and applying chemical restraints. The Supervising Casework Specialist did not indicate issuing a warning or whether any other staff members gave one.
3. The Senior Youth Correctional Counselor reported issuing “multiple” instructions to stop fighting or mace would be used. The instructions were ignored and the Youth Correctional Officer applied chemical agents. The Senior Youth Correctional Counselor also reported that when running toward him attempting to get away from the assailants, the Victim was instructed to get down on the floor or be maced, the Youth complied, and mechanical restraints were applied.

Use of Force Review Project

VI. Documentation

Observation One: Use of Force Reports

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

Custody Response [Continued]

4. The Youth Correctional Counselor reported gaining control of one of the assailants by placing his hand on the back of the right shoulder and guiding the Youth to the floor where mechanical restraints were applied. The Youth Correctional Counselor did not indicate issuing a warning or whether other any other staff members issued one.
5. The Casework Specialist reported that along with other unidentified staff members instructions were given repeatedly to stop fighting and get on the ground. After chemical agents were applied, the Casework Specialist reported applying mechanical restraints to an assailant who was in a prone position.

Medical Evaluation

A Registered Nurse evaluated all six Youth and found no significant injuries due to force.

Force Review Committee

The Committee at the facility found staff actions prior to, during and following force to be in compliance with policy, procedures and training.

COMMENTS

1. Unresolved discrepancies existed related to provisions for a warning prior to force. The *Superintendents Review* found staff actions prior to force to be non-complaint with policy because no warning was given by the Youth Correctional Officer who utilized chemical agents. However, the Superintendent also noted, “no chemical agent advisory due to immediate danger of Youth being attacked by five others.” Further, the *Superintendent Review* is inconsistent with the report of the Senior Youth Correctional Counselor, who claimed repeated warnings were given, the Casework Specialist, who stated Youth were repeatedly instructed to stop fighting, and the Youth Correctional Officer, who reported that the Youth were instructed to stop fighting. Overall, the claim by three of the staff members that instructions to stop fighting and/or warnings were provided is inconsistent with two staff members who did not mention instructions or warning.
2. Staff actions prior to force were not in compliance due to staff members not documenting the activation of an emergency alarm or making a radio call. Nevertheless, this was not identified by the Watch Commander, the Chief of Security, the Superintendent or the *Force Review Committee*.

Use of Force Review Project

VI. Documentation

Observation One: Use of Force Reports

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

COMMENTS [Continued]

3. Prior to departure from the facility, the Watch Commander noted not receiving applicable reports from all identified staff members involved in or witnessing the incident. However, the Watch Commander did not indicate who did not submit reports or if the reports had ever been received. This would suggest staff actions following the incident to be non-complaint, yet the Watch Commander did not respond to the question of whether or not staff actions following the incident were in compliance with policy, procedures and training. This omission was not identified during the reviews by the Chief of Security, the Superintendent or the *Force Review Committee*.
4. The Behavior Report submitted by the Supervising Casework Specialist did not identify the other staff members involved in the incident or their use of force. The Supervising Casework Specialist indicated two Youth Correctional Counselors were present at the scene, but there was a Behavior Report from only one Youth Correctional Counselor. It is likely that the Supervising Casework Specialist misidentified the Youth Correctional Officer involved in the incident as a Youth Correctional Counselor. Nevertheless, this discrepancy was not identified at any level of review.
5. A Licensed Psychiatric Technician, whose role in the incident is not described in any of the documentation and who is not even identified in some of the reports, submitted a Behavior Report. The Licensed Psychiatric Technician documented staff members using force on only one Youth.
6. The Casework Specialist documented multiple Youth attacking one Youth but did not identify all of the Youth involved. The Casework Specialist was present during the entire incident and completed a report on the Youth to whom he applied mechanical restraints. However, the Casework Specialist did not complete a report on any of the other Youth.
7. There was a time discrepancy on one of the medical reports and two other medical reports were unsigned.
8. The number of Behavior Reports submitted on each of the six Youth involved varied from seven to two. The Youth Correctional Counselor submitted a Behavior Report on one Youth but did not submit a Behavior Report on the other Youth.
9. The force incident occurred on December 1, 2009, but the *Force Review Committee* did not review it until March 25, 2010, or 114 days later.
10. The Youth involved in this incident had a *Mental Health Designation*, yet there was no documented involvement of a Mental Health Clinician. Additionally, other than requiring every Youth involved in a force incident to be seen by a Health Care Professional, usually a Registered Nurse, the current Use of Force forms contain no provision for input by a Mental Health Clinician or a Health Care Professional, despite the fact that Youth with a *Mental Health Designation* are involved in a disproportionate number of force incidents.

Use of Force Review Project

VI. Documentation

Observation Two: Use of Force and Behavior Reports

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

Policy, Practice and Training Recommendations

1. Within 30 days, ensure that every staff member, including Mental Health Clinicians, who observes, intervene, or is involved in a force incident, completes the appropriate reports; provide training as necessary.
2. Within 30 days, amend the *Crisis Prevention and Management Policy* to include a standard definition of force that excludes the application of authorized restraint equipment to a compliant Youth.
3. Within 9 months, revise the standards for *Use of Force and Behavior Reports*; provide training as necessary to any staff member who has interactions with Youth. At a minimum, ensure that each *Use of Force or Behavior Report*:
 - Identifies the status of the *Crisis Prevention Support Plan* for a Youth.
 - Describes the behavior of the Youth and the circumstances that necessitated using force.
 - Details the strategies used to de-escalate and manage the behaviors of a Youth prior to, during and after a force incident.
 - Cites the location and number of staff members and other Youth in the area at the time of the incident.
 - Indicates whether the living unit was on modified program and why.
 - Indicates whether a personal alarm was activated.
 - Cites the number and type of verbal instructions given prior to force.
 - Identifies the force used or observed, including the type, number of applications and duration of chemical agents.
 - Indicates whether a Youth was seen by a Registered Nurse, or designated medical personnel, for assessment after the incident.
 - Identifies the length of decontamination shower, whether clean clothes were provided and by whom.
 - Indicates whether a *Suicide Risk Screening Questionnaire* was conducted.
 - Indicates the reasons for clothes removal from a Youth, if applicable.
 - Indicates whether a Licensed Psychiatric Technician was notified an incident occurred.
 - Indicates whether a Youth was placed in the *Temporary Intervention Program*.
 - Describes involvement of any Mental Health Clinicians prior to, during and after the force incident.
 - Indicates whether the incident was gang related.
 - Indicates whether the Youth has a *Mental Health Designation* or an identified disability.
 - Indicates whether reasonable accommodations, including a *Staff Assistant* were provided.

Use of Force Review Project

VI. Documentation

Observation One: Use of Force Reports

6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.

Policy, Practice and Training Recommendations [Continued]

4. Implement a standardized *Use of Force Report* protocol system-wide; provide training as necessary. Noted elements missing from the current protocol include:
 - Separate *Medical* and *Mental Health* sections.
 - An *Incident Summary* prepared by the Watch Commander.
 - Identification of salient factors that preceded and followed a force incident.
 - Identification of each *Basis for Application of Force* that applies.
 - Designation of any section deemed inapplicable as such.

Use of Force Review Project

DEBRIEFING

7.1 After using force, incidents were not debriefed consistently.

Use of Force Review Project

VII. Debriefing

Observation One: Dissemination of Information Post Incident

7.1 After using force, incidents were not debriefed consistently.

Authority

According to the Crisis Prevention and Management Policy:

Follow-up or Debriefing Strategies

The following strategies, when used correctly, can assist staff in reducing the re-occurrence of a crisis situation. Staff should consider using the strategies listed below following a crisis situation:

- *Debrief with co-workers to determine what went well, what didn't, and what could be done differently*
- *Utilize a supervisor's review to develop a "Lesson's Learned" from the debriefing*
- *Update the Crisis Support Plan with successful outcome information*
- *Documentation*
- *Communication with the Youth's Treatment Team*
- *Proper referrals – Medical, Mental Health, etc.*
- *Follow-up or Debriefing Strategies*

Use of Force: Limitations

Correctional Peace Officers may use reasonable force as required in the performance of their duties, but unnecessary or excessive force shall not be used. Whenever possible, all reasonable prevention and de-escalation efforts shall be attempted to avoid force

At no time is an employee permitted to use force against a Youth for punishment, retaliation, or discipline.

Use of Force Review Project

VII. Debriefing

Observation One: Dissemination of Information Post Incident

7.1 After using force, incidents were not debriefed consistently.

Qualitative Analysis

During the qualitative review process, in the sample of 31 cases identified as especially egregious, *Debriefing Sessions* occurred following 4 or 13% of the incidents. In the other 27 cases, the *Debriefing Check Box* was marked as “Not Applicable” or left blank.

Debriefing Sessions

1. One (1) of 4 sessions was mandatory because of occurring after a *Controlled Force Incident*.
2. One (1) of 4 sessions involved the Watch Commander instructing Officers on the *Three-person Shield Technique*.
3. One (1) of 4 sessions was not referenced anywhere on the *Use of Force Incident Review* form (DJJ 8.440) except the check box.
4. One (1) of 4 sessions was conducted immediately following the force incident.
5. Zero (0) of the 4 sessions included any non-sworn staff members like Mental Health Clinicians.
6. Zero (0) of the 4 sessions indicated what actions, if any, could have been taken to improve incident response, intervene more effectively or prevent using force in the future.

Case Snapshot

The case snapshot that follows describes a force incident where critical information was not disseminated post incident which could have assisted staff members in reducing the likelihood of a similar crisis situation from occurring in the future.

[Additional case examples included: 1, 2, 4, 8, 59, 62, 82, and 86]

Case 35

In Case 35, a female Youth, 15 years; 5 months, who resided at *Ventura* and was temporarily assigned to the *Outpatient Housing Living Unit*, assaulted a Youth Correctional Officer. Physical strengths and holds were used to gain compliance and effect custody.

Mental Health and Disability Status

At the time of the incident, the Youth was assigned to a *Mental Health Unit* but was on *Suicide Watch* in a *Safe Room* in the *Outpatient Housing Unit*; the Youth was prescribed psychotropic medication. The Youth had an identified disability; however no accommodations were cited on the *Youth with Disabilities List*.

Use of Force Review Project

VII. Debriefing

Observation One: Dissemination of Information Post Incident

7.1 After using force, incidents were not debriefed consistently.

Crisis Prevention Support Plan

On the day of the incident the Youth had a *Crisis Prevention Support Plan* in place. According to the plan, approximately two months before the incident the Youth attempted suicide with a pillowcase around her neck; the Youth was described as almost unconscious. When in crisis, the plan stated that if the Youth did not take her medication, even one time, medical staff members should be notified immediately because the Youth would have a psychotic episode; in the meantime, staff members were asked to keep an extra eye on the Youth and check her constantly. Per documentation upon arrival, the Youth presented with a history of three serious suicide attempts. The Youth was described as not giving signs of distress, acting as if everything was okay, when it might not be. In juvenile halls, the Youth also presented with a history of violence against other Youth including using a weapon. To prevent crisis, the plan stated that if the Youth did not take her medication, this could become a trigger for her to hurt herself. The plan indicated that taking her medication on a regular basis was part of her *Treatment Focal Plan*. If the Youth refused her medication, a *Mental Health Referral* should be made immediately and a fifteen-minute watch of the Youth should be conducted. The plan stated, “Please give clear, concise instructions before engaging the Youth with chemical or physical restraints.”

Day and Time of the Incident

The force incident occurred at approximately 1434 hours on a Sunday.

Custody Response

Youth Correctional Officer One was posted on the *Outpatient Housing Unit*. During a hall check, Officer One assisted Youth Correctional Officer Two in opening a room door and escorting a Youth placed on one-on-one *Suicide Watch* to the restroom; the Youth complied with the escort. On the way back, the Youth requested her lunch that was sitting in the hallway. The Youth had not received her lunch due to her behavior during the morning shift. In response to the request, Officer Two retrieved the lunch bag from the floor. Officer Two then advised the Youth that she could have her lunch once it was checked. In response, the Youth grabbed the bag; and stated, “Fuck no, just give it to me; it has already been checked.” The Youth and Officer Two then began to struggle over the lunch. At this point, Officer Two pressed her personal alarm; however, the alarm did not go off. To de-escalate the situation, Officer One then positioned herself behind the Youth, tapped her on the shoulder and unsuccessfully tried to enter into dialogue. Officer One tried to convince the Youth to let go of the bag. Officer One further explained that policy was being followed; the lunch bag was sealed with tape and had a fork inside. The Youth then squeezed the bag hard, which burst it open; the contents spilled on the floor. After the bag burst, the Youth said, “Fuck you bitch,” and spat on Officer Two. The Youth then started laughing and said, “What are you going to do now?” Via radio, Officer Two then called a Code 3, staff assault, in the *Outpatient Housing Unit*. Simultaneously, Officer One grabbed both arms of the Youth and held her against the wall; Officer Two then applied mechanical restraints without any struggle from the Youth. Security arrived and placed the Youth in her room.

Youth Experience

Likely, the Youth experienced the insistence upon searching her lunch as an invasion of her property and a loss of control.

Use of Force Review Project

VII. Debriefing

Observation One: Dissemination of Information Post Incident

7.1 After using force, incidents were not debriefed consistently.

Mental Health Response

Officer One should be commended for using proximity in positioning herself behind the Youth and attempting dialogue. Unfortunately, it was a situation of too little, too late. The timeline of the day spent by the Youth is a little unclear. What is clear, however, is that the Youth did not receive her lunch at the expected time due to an unspecified behavior in the morning. It is also clear that the Youth was seen by a Mental Health Clinician for fifteen minutes at 1254 hours; the Mental Health Clinician described the Youth as agitated. In addition, the Mental Health Clinician indicated that the behavior of the Youth in the morning involved refusing to give her rosary to custody staff members. Thus, the Youth was highly agitated; something important had been taken away from her. The experience of being denied her lunch and then having Officer One attempt to dialogue with her was just too much for the Youth who could no longer contain herself.

Prior to the incident at 1245 hours, the Youth was seen by a Mental Health Clinician. Nevertheless, the extent of the intervention was to identify the Youth as continuing to be at risk for self-injurious behavior and to keep her on *Suicide Watch*, per the *Suicide Prevention and Reduction Policy*. Additional intervention by the Mental Health Clinician prior to the incident might have involved advocating for the Youth via reminding custody staff members of the basic right of the Youth to meals. Moreover, the Mental Health Clinician could have provided custody staff members with the *Crisis Prevention Support Plan* for the Youth, reviewed the plan with the Officers and explained the recommendations. Also, the Mental Health Clinician might have elucidated for custody staff members the need for the Youth to experience some control and, with custody staff members and the Youth, discussed appropriate ways to meet that need. For example, assuming the rosary represented faith to the Youth; perhaps there was some other religious symbol or item that could have met the need safely. Intervention by a Mental Health Clinician during the incident might have included coaching custody staff members on how to communicate with the Youth in crisis, including providing clear, concise instructions and offering the Youth forced choice options. Intervention by a Mental Health Clinician after the incident might have included meeting with the Youth to complete a behavior analysis of the incident; the vulnerabilities, the antecedents, the trigger, sequence of events, as well as the short and long-term consequences. Results from the analysis could have informed the *Treatment Plan* for the Youth and provided invaluable information in a debriefing.

Use of Force Review Project

VII. Debriefing

Observation One: Dissemination of Information Post Incident

7.1 After using force, incidents were not debriefed consistently.

COMMENTS

Withholding Lunch

According to the *Level 3 Serious Misconduct Behavior Report* (DJJ 8.403A), which Officer Two submitted, staff members withheld lunch from the Youth “due to her behavior during the AM shift.” Later, the Officers intervening insisted upon searching the lunch, which escalated into a staff assault. If staff members on *Second Watch* had not violated policy and withheld lunch from the Youth for behavior concerns, the incident including the staff assault might have been avoided.

Spit Mask

1. On the date of the incident, according to the *Medical Report* the Registered Nurse submitted, “Youth refused to wear “Spit Mask” before coming to the Clinic for assessment. The Youth was told that her refusal to put on a “Spit Mask” is considered her refusal to accept medical treatment and assessment.”
2. The *Medical Report* did not indicate whether a *Staff Assistant* or an advocate was offered to the Youth to help her understand the consequences of refusing medical attention.

Kneeling to Take Medication

On the day of the incident, according to a note the Licensed Psychiatric Technician entered into the *Chronological Record of Medical Care* at 2149 hours, the Youth was non-compliant with instructions all day. Moreover, the Youth was aggressive and had been threatening; spitting at staff members. Further, because she would not comply with having to be in a kneeling position, the note indicated that the Youth had not taken her medications. The note appears to imply that a power struggle over kneeling, which likely felt humiliating to the Youth, resulted in her not taking medication.

Mental Health Intervention

Immediately following the incident there is no indication that a Mental Health Clinician intervened to facilitate the Youth eating, receiving medical attention and taking her medication.

Crisis Prevention and Management Policy

To assist staff members in reducing the re-occurrence of crisis situations, the *Crisis Prevention and Management Policy* only suggests that staff members “consider” conducting *Debriefing Sessions* following force.

Debriefing

Even though a policy violation contributed to a Youth on *Suicide Watch* assaulting an Officer, the events prior to, during and following use of force were not debriefed.

Training

After reviewing the incident, training on de-escalation techniques and alternative interventions, as well as the *Suicide Prevention and Reduction* and *Crisis Prevention and Management* policies were not recommended by the Chief of Security, Superintendent or the *Force Review Committee*.

Use of Force Review Project

VII. Debriefing

Observation One: Dissemination of Information Post Incident

7.1 After using force, incidents were not debriefed consistently.

Use of Force Incident Review Form

In the *Watch Commander Section* of the *Use of Force Incident Review* form (DJJ 8.440), the respondent is required to answer the question, “Was a debriefing held immediately following the incident?” In an overwhelming number of the 100 qualitatively reviewed cases, this question was marked as “N/A” or left blank; *Debriefing Sessions* rarely occurred. Specifically, in Case 35, no *Debriefing Session* was conducted to discuss ways to improve response, intervene more effectively or prevent a similar incident from occurring in the future.

Force Review Committee

1. The *Force Review Committee* at the facility found that the response to the incident was in compliance with the *Crisis Prevention and Management Policy* and training; no actions were recommended or taken.
2. The *Force Review Committee* did not address that staff members violated policy and withheld lunch from the Youth for a behavior concern.
 - Two and a half hours after the noon hour, the Youth had not been given her lunch.
 - During that two and a half hour period the lunch had not been properly searched.
 - Officer Two retrieved the lunch from the floor next to the room the Youth was assigned.
 - The Youth was most likely hungry and interpreted the refusal to provide her lunch in a timely manner as punishment.
 - Officer Two who struggled with the Youth was spat upon.
3. The *Force Review Committee* did not question why a Youth on *Suicide Watch* assigned to a *Safe Room* on the *Outpatient Housing Unit* was not offered medical attention until more than two hours after the force incident; the time of the incident was cited as 1434 hours but the time of Medical Attention was cited as 1640 hours. [Medical Attention was refused.]
4. The *Force Review Committee* did not question why a Youth who was only 15 years old and had a *Mental Health Designation* and an identified disability was not offered a *Staff Assistant* or an advocate to help her understand the consequences of refusing medical attention.
5. The *Force Review Committee* did not express concerns about the Youth being asked to kneel when taking her medications. The Youth presented with a history of serious suicide attempts and was on *Suicide Watch*. According to the *Crisis Prevention Support Plan*, when in crisis, if the Youth did not take her medication, even one time, medical staff members should be notified immediately because she would have a psychotic episode.
6. The perspective of the Mental Health Clinician who participated in the *Force Review Committee* meeting is unknown; neither the *Use of Force Incident Review* form (DJJ 8.440) that the Watch Commander, Chief of Security and Superintendent are required to complete nor the *Use of Force* form (YA 8.412) that the Force Users and the Health Care Professional are required to complete after each force incident has a dedicated section for Mental Health Clinicians to record interventions, insights, concerns or recommendations.

Use of Force Review Project

VII. Debriefing

Observation One: Dissemination of Information Post Incident

7.1 After using force, incidents were not debriefed consistently.

Policy, Practice and Training Recommendations

*Within 6 months, require that force incidents are debriefed according to standardized policy and procedures; deliver training as necessary. Ensure the policy and procedures require:

- A representative sample of force incidents, including those stemming from one-on-one fights, assaults, noncompliance, self injuries, group disturbances and property destruction are debriefed at each facility annually.
- Staff members attend the debriefings from every discipline whose work directly or indirectly affects the Youth involved in the force incidents being discussed.
- The experience from the perspective of the Youth is represented; prior to selected debriefings, interviews are conducted with each Youth involved in the force incidents being discussed.
- Both positive and negative aspects of the force incidents are analyzed.
- Development of *Corrective Action Plans*, including accountability measures, to address the negative aspects of the force incidents is discussed.

**Ensure that policy and procedures are developed based upon relevant research, literature review and recognized Best Practices.*

Use of Force Review Project

TRACKING SYSTEM

8.1 The Use of Force Tracking System could not accurately account for the incidents of force that occurred during the sample period.

Use of Force Review Project

VIII. Tracking System

Observation One: Missing Use of Force Reports

8.1 The Use of Force Tracking System could not accurately account for the incidents of force that occurred during the sample period.

Authority

According to the Crisis Prevention and Management Policy:

The Use of Force incident packages reviewed by the FRC shall include the meeting minutes, all applicable documentation and, and video recordings. The Use of Force incident packages shall then be forwarded to the Division of Juvenile Facilities Use of Force Coordinator or Superintendent's designee within seven (7) calendar days of completion for Division Force Review Committee (DFRC) review.

Each facility shall maintain a database containing use of force information. The database shall be capable of producing various statistical reports to be utilized by managers to monitor trends and patterns of force used.

The Superintendent shall ensure that submitted use of force incident report information is accurately recorded in the Ward Information Network (WIN) system and the monthly COMPSTAT report form. This data shall be maintained by the facility Use of Force Coordinator or Superintendent's designee as a reporting tool to provide the Superintendent and management staff monthly and quarterly reports, as well as specific reports pertaining to and regarding the use of force. The report will provide a means of evaluating trends, reasons for the application of force, and the factors involved.

Use of Force Review Project

VIII. Tracking System

Observation One: Missing Use of Force Reports

8.1 The Use of Force Tracking System could not accurately account for the incidents of force that occurred during the sample period.

Quantitative Analysis

1. *Initially, of the 300 Behavior Reports selected through the random sample, 100 *Force Incident Packages* were not found in the files of the *Division Force Review Committee*.
2. Since multiple Behavior Reports are generated in force incidents, the actual number of missing *Force Incident Packages* was less than 100 because, sometimes, two or more of the Behavior Reports were related to the same incident.
3. Requests were made to the facilities for the missing *Force Incident Packages* and, except for the following; a majority of the documents were secured.
 - Of the 300 randomly selected Behavior Reports, 41 were related to force incidents that occurred at the *Southern Reception Center and Clinic*.
 - Initially, in the *Division Force Review Committee* files, *Force Incident Packages* related to only 12 of 41 or 29% of the selected Behavior Reports were found; the remaining 29 were related to 27 force incidents.
 - After repeated requests to the facility, staff members were able to locate 8 of the 27 missing packages. To date, 19 packages have not been submitted.
 - Staff members suggested that 7 of the unaccounted for Behavior Reports were created by mistake and 8 were “retained for copying during a major audit and never returned.”
 - Staff members are still trying to locate the remaining packages.
 - At *O.H. Close*, *Force Incident Packages* related to 4 identified Behavior Reports were not found; staff members indicated that the documents did not exist in the *Ward Information Network*.
 - The Division Chief of Security was able to locate Behavior Reports related to 3 of the 4 Behavior Reports.
 - Nevertheless, the *Force Incident Packages* could not be found.
 - At *Ventura*, staff members could not find two (2) *Force Incident Packages*.

**The 300 Behavior Reports were selected through a random sample generated by the Office of the Inspector General.*

Qualitative Analysis

1. The *Division Force Review Committee* did not have a system in place to ensure every *Force Incident Package* was submitted for review in a timely manner. Instead, the *Division Force Review Committee* reviewed only those packages received. Some facilities did not submit any packages for an entire month. For example, the *Southern Reception Center and Clinic* did not submit any packages for the entire months of December 2009 and February 2010. The occurrence of zero force incidents for an entire month is highly unlikely. When all force incidents are not accounted for, the integrity of the review process is seriously compromised.

Use of Force Review Project

VIII. Tracking System

Observation One: Missing Use of Force Reports

8.1 The Use of Force Tracking System could not accurately account for the incidents of force that occurred during the sample period.

Qualitative Analysis [Continued]

2. There currently is no mechanism in place to ensure that the *Force Review Committee* at each facility reviews every force incident. For example, in the 8 force packages submitted in response to inquiry, 3 did not contain the *Force Review Committee* minutes. When queried, the staff members stated that the Committee at the facility reviewed the cases. The *Force Review Committee* should have reviewed the cases on July 20, 2009, January 6, 2010, and February 27, 2010.
3. In response to inquiry, 4 of the 5 facilities indicated a database was not maintained that could produce statistical data to enable management to monitor trends and patterns of force. In contrast, *O.H. Close* provided evidence of a database that is exceptionally well designed for monitoring data.
4. In addition, the facilities are inconsistent when collecting and compiling data for submission to COMPSTAT. It was found that:
 - At *Ventura*, the Use of Force Coordinator compiles data as the Use of Force Reports come into her office and then submits the information to COMPSTAT. If a staff member uses force and files a Behavior Report but not a Use of Force Report, the information is lost.
 - At *N.A Chaderjian*, the Use of Force Coordinator utilizes the *Daily Operations Report* to compile the data before submitting it to COMPSTAT.
 - At *O.H. Close*, the Use of Force Coordinator cross references Behavior Reports and Use of Force Reports with *Force Review Committee* minutes to compile the data and then submits it to COMPSTAT.
 - At *Preston*, the Use of Force Coordinator utilizes Behavior Reports and Use of Force Reports to compile the data and then submits it to COMPSTAT.
 - At the *Southern Reception Center and Clinic* the Secretary for the Chief of Security and the COMPSTAT Coordinator review every Behavior Report to compile the data before submitting it to COMPSTAT.
5. Additionally, for the data submitted to COMPSTAT, the facilities did not maintain a schedule or worksheet linking the data to the Behavior Reports or the Use of Force Reports. Therefore, it is impossible to conduct an audit to ensure that the reported data is accurate, complete and reliable for decision-making purposes.

Use of Force Review Project

VIII. Tracking System

Observation One: Missing Use of Force Reports

8.1 The Use of Force Tracking System could not accurately account for the incidents of force that occurred during the sample period.

Policy, Practice and Training Recommendations

1. During development of the standardized *Use of Force Tracking System*, implement an interim monitoring process for ensuring the *Southern Reception Center and Clinic* adequately tracks force incidents.
2. Within 6 months, implement a standardized *Use of Force Tracking System* with controlled numbering to ensure every *Behavior Report* is reviewed and matched with a *Use of Force Report* when force is used; amend the *Crisis Prevention and Management Policy* accordingly and deliver training as necessary.

3. Adopt a *Use of Force Database* similar to the one operating at *O.H. Close* for all facilities statewide.

Use of Force Review Project

QUALITY ASSURANCE

9.1 The Force Review Process was ineffective, redundant, and produced inconsistent outcomes.

9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant, and produced inconsistent outcomes.

Authority

According to the Crisis Prevention and Management Policy:

QUALITY ASSURANCE

Each individual Use of Force Incident at a DJJ facility must be evaluated at both supervisory and management levels to determine if the force used was both proper and lawful under applicable laws, regulations, policy, procedures, and training. The policy and procedures set forth below shall be enforced to ensure the management team of the DJJ is aware of use of force incidents, and is able to properly monitor and provide a thorough review of each use of force incident.

Supervisory Evaluation of Use of Force Reports

All Use of Force Incidents shall be reviewed at a Supervisory level within 24 hours of the incident. The following factors must be evaluated:

- *Crisis prevention and management techniques used, if applicable*
- *Any efforts and/or resources used to minimize the use of force*
- *The need for the application of force*
- *The relationship between that need and the amount of force used*
- *The threat reasonably perceived by the employees involved*
- *Extent of the injuries suffered*

If at any point during the Use of Force Incident Review process, an incident is identified for preliminary inquiry or referred for an Office of Internal Affairs investigation by the Superintendent/designee, the use of force review process shall be suspended until such time a disposition is rendered following completion of the preliminary inquiry, investigation, or both.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant, and produced inconsistent outcomes.

Quantitative Analysis

Prior to, During and Following Force

1. In 11 of 245 or 4% of sample cases, the *Force Review Committees* at facilities found staff actions prior to a force incident were not in compliance with policy, procedures and training.
2. In 5 of 245 or 2% of sample cases, the *Force Review Committees* at facilities found staff actions during a force incident were not in compliance with policy, procedures and training.
3. In 81 of 245 or 33% of sample cases, the *Force Review Committees* at facilities found staff actions following a force incident were not in compliance with policy, procedures, and training.

Youth Facilities

1. At *N.A. Chaderjian*, in 49 of 61 or 80% of sample cases, the *Force Review Committee* at the facility found staff actions were not in compliance with policy, procedures and training.
2. At *Ventura*, in 18 of 71 or 25% of sample cases, the *Force Review Committee* at the facility found staff actions were not in compliance with policy, procedures and training.
3. At the *Southern Clinic*, in 4 of 18 or 22% of sample cases, the *Force Review Committee* at the facility found staff actions were not in compliance with policy, procedures and training.
4. At *O.H. Close*, in 4 of 38 or 11% of sample cases, the *Force Review Committee* at the facility found staff actions were not in compliance with policy, procedures and training.
5. At *Preston*, in 6 of 57 or 11% of sample cases, the *Force Review Committee* at the facility found staff actions were not in compliance with policy, procedures and training.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant, and produced inconsistent outcomes.

Qualitative Analysis

Prior to, During and Following Force

1. In 5 of 100 or 5% of qualitatively reviewed cases, the *Force Review Committees* at facilities found staff actions prior to a force incident were not in compliance with policy, procedures and training [8, 9, 19, 30 and 42].

Findings Prior to Force

- Living unit staff members did not follow procedures regarding covered windows. Also, the Licensed Psychiatric Technician did not provide sufficient intervention.
 - A Youth Correctional Officer had been assigned to one-on-one supervision of a female Youth; the Officer did not maintain sight supervision of the arms of the Youth, which had been placed inside her shirt.
 - A Youth Correctional Officer failed to sound a personal alarm and issue a warning that chemical agents would be used. This procedural lapse was found in numerous cases; however, the *Force Review Committees* at the facilities responded to the violation in various ways; sometimes the violation was considered a report writing error, others times it was not identified, while still other times it was identified but no action was taken.
 - Officers failed to activate their personal alarms or notify *Control* via the radio of an incident. The Officers did not follow each step involved in implementing the *Three Person Shield Technique*. Specifically, when a room window is covered and the Youth inside is not responding, prior to opening the door, a Youth Correctional Counselor or Youth Correctional Officer should check on the well being of the Youth via the outside window to the room.
2. In 1 of 100 or 1% of qualitatively reviewed cases, the Superintendent suggested that staff actions during a force incident were not in compliance with policy, procedures and training. The Superintendent stated that staff members should have applied physical force when repeated application of chemical agents was ineffective. For the same incident, the *Force Review Committee* at the facility found that it was a judgment call by the staff member but recommended training.
 3. In 34 of 100 or 34% of qualitatively reviewed cases, the *Force Review Committees* at facilities found staff actions following a force incident were not in compliance with policy, procedures and training. All of the issues noted were for procedural matters such as staff members failing to properly complete, sign or submit a report on time. Rarely, did the review process identify issues of consequence.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.

Qualitative Analysis [Continued]

Youth Facilities

The qualitative analysis found the *Force Review Committee* process at facilities, which focuses exclusively on compliance, produced inconsistent outcomes. The significant discrepancy in non-compliance rates between *N.A. Chaderjian* and the other facilities suggests either staff members at other facilities are much more observant of policy and procedures or the review process at *N.A. Chaderjian* is more thorough. The qualitative review of 100 cases found the process at *N.A. Chaderjian* was more thorough than other facilities.

Case Snapshots

The *Force Review Committee* at the facility reviewing the case in the snapshot that follows was not effective in recognizing the consequences of the security breach caused by the unlocked door, in questioning the supervision of the outside recreation area and in examining the medical documentation provided.

[Additional case examples included: 27, 62, 67, 75, 86 and 87]

Case 71

Mental Health and Disability Status

Each of the five Youth involved in the incident had a *Mental Health Designation*; each was assigned to an *Integrated Behavior Treatment Program*. Four of the Youth were on *Suicide Risk Reduction* status and five of the Youth were on medication prescribed by a Psychiatrist. Two of the Youth presented with a Disability. Accommodations for Youth D, the victim in the incident, included a *Staff Assistant*, as well as allowing extra time for the completion of tasks. Youth I, a non-combatant, had an identified disability; however no accommodations were identified on the *Youth with Disabilities List*.

Crisis Prevention Support Plans

Combatants

At the time of the incident, four of the five combatants, Youth B, C, D and E, had a *Crisis Prevention Support Plan* in place.

Non-combatants

At the time of the incident, none of the non-combatants had a *Crisis Prevention Support Plan* in place. However, subsequently, Youth F and G, had plans developed with entries beginning on March 22, 2010 and March 17, 2010, respectively. Youth H, I and J each had plans developed with entries beginning on May 25, 2010.

Youth A

On the date of the incident, the Youth did not have a *Crisis Prevention Support Plan* in place.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.

Youth B

According to the plan, Youth B was prescribed psychotropic medications. Youth B was described as having *Mental Health* issues including impulsivity, mood instability and erratic behavior. In addition, Youth B was described as presenting with a history of violent and assaultive behavior including staff assaults. The plan stated that Youth B could black out when chemical agents were used. Youth B could escalate to the point where he became violent toward staff members and other Youth. Moreover, chemical agents could provoke Youth B to become violent toward the individual who administered it. Youth B was described as presenting with a history of resisting mechanical restraints. When force was necessary, the plan stated that there should be enough staff members present to gain compliance.

Youth C

According to his plan, Youth C exhibited extreme mood swings. Youth C was prescribed psychotropic medication but was viewed as amendable to changes in medication. The plan stated it was good to have a Psychiatrist available for Youth C. The Youth was described as a *Parole Violator* who was hyper and disrespectful, with difficulty controlling his anger. Since returning to the *Sacramento Living Unit*, Youth C had focused much of his anger toward Youth Correctional Counselor [Insert name]. The plan recommended that since Youth C had already threatened to assault the Counselor with a broomstick in his hand, if possible, the Counselor should be removed from any situation in which Youth C was irrationally focused upon her. In all of his acting out incidents, several staff members had to assist in de-escalating Youth C to a manageable level. Further, Youth C was known to incite other Youth into acting out with him. Youth C was viewed as very impulsive, quickly reacting to new information. The plan stated that challenging the behaviors of Youth C would escalate his behavior.

Youth D

According to the plan, Youth D was described as high functioning most of the time but presented with a history of aggressive behavior. Considerations in a crisis included allowing Youth D to vent, providing clear, concise choices and alternatives. The plan stated it should be remembered that Youth D was paranoid. Motivators included allowing Youth D to talk with staff members and assisting him to make better choices. De-escalation strategies which worked well included: giving space, allowing a time out in his room or letting him make phone calls to his family. Providing additional support, one-on-one, if needed, was viewed as the most effective intervention.

Youth E

According to the plan, Youth E had been involved in several physical altercations, which resulted in the use of chemical agents. Youth E was viewed as struggling to interact appropriately with staff members and other Youth. Considerations in a crisis included that Youth E would not get down when instructed; Youth E was known to escalate in front of his peers. In addition, Youth E was viewed as escalating when challenged by staff members. In a physical altercation Youth E presented with a history of getting back up from the floor and further victimizing the other combatant by kicking him while down. The Youth presented with history of staff assault. When intervening, unless the staff member had really good rapport with the Youth E, it was recommended not to touch him. When being physically assaultive, chemical agents were viewed as effective. Youth E was known to get back on his feet after application of MK-4 Pepper Spray; Z-505 was viewed as more debilitating. To avoid further assault to the other combatant, the plan recommended physically restraining Youth E while he was down.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.

CUSTODY RESPONSE

Escalation

Youth Correctional Counselor One was behind the Youth Correctional Counselor counter speaking with Youth D when the exit door leading to the outside recreational area opened and Youth E entered from the outside program. Youth E then addressed Youth D asking him “what’s up?” Youth D turned to face Youth E and started to walk toward the center of the dayroom. Youth E began walking towards Youth D to meet him. Counselor One shouted to the other Youth in the dayroom to get down on the floor, sounded his alarm and stepped from behind the counter to intervene between the potential combatants.

Intervention [Dayroom]

One-on-One Fight

As Counselor One approached, Youth D and Youth E began to fight. Both combatants were instructed to get on the ground. Neither Youth D nor Youth E complied. Without giving a chemical warning, a Counselor One dispersed a “steady stream” of MK-4 at Youth D and E, which was not effective. Counselor One then dispersed a burst of Z-505 at Youth D and E, which again proved not to be effective. Simultaneously, Counselor Two entered the dayroom from the outside recreational area, gave instructions for the combatants to get down on the floor or chemical agents would be used. Then, from six feet away, Counselor Two dispersed one steady steam of MK-4 CN to the facial area of Youth D and Youth E.

Two-on-One Fight

At this time, Youth A entered the dayroom from the outside recreational area and joined Youth E in assaulting Youth D.

Almost a Three-on-One Fight becomes a second One-on-One Fight

Next, Youth C ran into the dayroom from the outside recreation area to join the assault on Youth D but, Youth B intervened and began attacking Youth C.

117 CN Gas Grenades

At this point, because the chemical agents were not judged effective and the situation seemed out of control, Counselor One yelled at the Youth Correctional Officer in the *Control Tower* to throw a grenade. Security had not yet responded, so the Officer yelled out in a very clear voice that a grenade was being thrown. When the 117 CN Gas Grenade landed, it made a loud popping sound that caused the combatants to stop for a moment.

Two-on-One Fight becomes a One-on-One Fight

Youth D took this opportunity to run towards the washer/dryer; Youth A followed and continued to assault Youth D. After a chemical warning, Counselor Two then dispersed one steady steam of MK-4 CN to the facial area of Youth A and Youth D. *Youth A and D separated and were willingly handcuffed in a prone position. At the same time, Counselor One focused his attention on the non-involved Youth in the dayroom. After allowing Youth D to use water from the restroom sink to rinse off the mace, Counselor Two escorted Youth D outdoors within the confines of the fencing adjacent to the classroom.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.

Intervention [Sally Port]

Second One-on-One Fight

After the 117 CN Gas Grenade was thrown, the Senior Youth Correctional Counselor entered the dayroom from the outside recreation area. After entering, the Senior Youth Correctional Counselor observed Youth C running toward him, followed by Youth B. When Youth C slowed down to get around the Senior Youth Correctional Counselor, Youth B struck Youth C several times in the back. At this point, the Senior Youth Correctional Counselor instructed Youth B and C to get down; then from three to four feet, without a chemical warning, dispersed mace to the face of Youth B. Youth B and C then stopped fighting; but Youth B ran back into the dayroom. At this point, Youth E entered the sally port. Youth E was instructed to get down; Youth C and E proned out on the sally port floor. At this time, the Senior Youth Correctional Counselor closed and physically locked the sally port door to the Sacramento dayroom.

Non-Combatants [Day Room]

During the incident, Youth F, G, H, I and J were non-combatants and lay prone on the dayroom floor.

**In his report, Counselor Two stated that: "It is important to note that this writer's chemical agent failed to perform as effectively as the 117-CN Grenade."*

Force Review Committee Findings

The *Force Review Committee* at the facility found staff actions prior to and during the force incident were in compliance with policy, procedures and training. The *Force Review Committee* at the facility found staff actions following the force incident were not in compliance. Examples of issues identified include failure to describe the amount of chemical agents used and the distance deployed; failure to mention alarm activation, failure to issue chemical warning and poor preparation of *Behavior Reports*.

Disposition

1. A Youth Correctional Counselor was provided training by his supervisor on how to properly write a *Behavior Report*.
2. *Advisory / Training Memorandums* were issued to staff members about the discrepancies noted in the *Behavior Reports*.
3. For the Senior Youth Correctional Counselor whose action triggered the incident, the *Force Review Committee* at the facility merely recommended that his supervisor meet and discuss the importance of ensuring the door was locked after exiting.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.

COMMENTS

Crisis Prevention and Management Techniques Used, If Applicable

1. The incident was prompted by the Senior Youth Correctional Counselor neglecting to secure the door behind him, which in turn allowed Youth A, C and E to enter the day room from the outside recreational area. The incident would not have occurred had the door been secured.
2. Youth A, C and E were not prevented from leaving the outdoor recreation area and entering the dayroom through the unlocked door. It is unclear why Counselor Three and the Senior Counselor supervising the outside recreation area did not intervene and stop the three Youth from leaving. Counselor Three did not submit a *Supplemental Behavior Report*, so there is no way of knowing what occurred.
3. The incident occurred on a Wednesday at 5:14 PM, it is equally unclear why management was not notified and did not intervene during or following the incident.

Unlocked Door and Unclear Supervision

Because of an unlocked door and unclear supervision in the outside recreation area, the following occurred and was subsequently not discussed during a debriefing or through the *Force Review Process*.

1. The Victim, Youth D, had a *Mental Health Designation* and an identified disability. Accommodations included access to a *Staff Assistant*. Besides the affects of the CN-117 Gas Grenade, the Youth was maced four separate times during the incident. Post incident, the Youth did not receive any documented intervention from a Mental Health Clinician or help from a *Staff Assistant*.
2. On the day of the incident, four Youth, A, B, H and J, were on *Suicide Watch* or *Suicide Precaution*. A second Youth Correctional Officer was serving *1:1 Suicide Watch*; however, even after submitting a *Supplemental Behavior Report*, it is unclear what role, if any, the Officer played in protecting his charge. Equally unclear is if any protections were given to the other three Youth on *Suicide Watch* or *Suicide Precaution*, especially post incident.
3. On the day of the incident, five Youth, B, C, G and I, were on medication prescribed by a Psychiatrist. There is no indication that the Officers who intervened or the Health Care Professionals providing treatment were aware of which Youth were prescribed medication or if any of the Youth were impacted post incident; this is especially important given the amount of chemical agents that were dispersed.
4. One the day of the incident, five Youth who were non-combatants, F, G, H, I and J, were exposed to chemical agents from the CN-117 Gas Grenade. Youth I presented with a Disability; Youth G, I and J were on medication prescribed by a Psychiatrist and Youth H and J were on *Suicide Watch* or *Suicide Precaution*.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.

COMMENTS [Continued]

Extent of the Injuries Suffered

The same medical documentation for each Youth involved in the incident was copied ten times, only the names and identification numbers changed. On each of the ten medical reports, it is stated that the incident took place at 1715 hours and all ten Youth were seen by Health Care Services at 1715 hours including the five non-involved Youth. This practice puts into question the descriptions of injury and the treatment given to the ten Youth involved in the incident and therefore puts into question whether injuries occurred that were not documented and whether undocumented injuries were left untreated.

Inter-Disciplinary Team

The members of the *Force Review Committee* at the facility were not documented so there is now way of knowing if *Mental Health* and *Health Care Services* were present during the review. Notwithstanding, there is no indication that representatives from either *Mental Health* or *Health Care Services* had any impact on the *Findings* that were issued.

Focus on Documentation

Prior to using chemical agents, an appropriate warning was not issued and a door was left unlocked. These were identified as inappropriate actions following use of force rather than inappropriate actions prior to and/or during use of force. This illustrates the focus in the *Force Review Process* on documentation. Staff members should be cognizant and deliberate prior to, during and following use of force. Apparently, the Youth in the outside recreation area were not being closely supervised and this was not discussed by the *Force Review Committee* at the facility, nor was a *Supplemental Behavior Report* from the third Youth Correctional Counselor made available to the Committee prior to their review.

Use of Force Review Project

IX. Quality Assurance

Observation One: Force Review Process

9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.

Policy, Practice and Training Recommendations

1. Within 90 days, review force incidents with every Youth at each *Case Conference*; update the *Crisis Prevention Support Plan* accordingly.

2. Expand the scope of *Use of Force Reviews* beyond policy compliance to include identifying *Best Practices*.
3. Require the inclusion of *Serious Incident Reports* in *Use of Force* packets.
4. Revise *Force Review Process* to increase efficiency and effectiveness; include flowchart.

[Please refer to the "Report of Site Visits to the California Department of Juvenile Justice Force Review Committees: Observations and Recommendations," submitted March 4, 2011, by Michael Gennaco, Expert to the Special Master.]

Use of Force Review Project

IX. Quality Assurance

Observation Two: Institution Force Review Committee

9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.

Authority

According to the Crisis Prevention and Management Policy:

Force Review Committee

Use of force incidents shall be reviewed by the Force Review Committee (FRC) within 30 days of occurrence. The FRC shall examine all levels of responsibility exercised by subordinate managers and supervisors, and ensure the appropriateness of completed documentation. The FRC shall make a determination concerning the appropriateness of the use of force based on the information and reports available.

On at least a monthly basis, the FRC shall meet to review all use of force incidents following the Use of Force review process. See Definitions for committee composition.

During the FRC meeting, the committee will document their findings of the appropriateness of actions taken using the Facility Force Review Committee Analysis-Use of Force Incident form. The FRC findings shall be based on a comparison of the documented facts of the incident against statute, regulation, policy, procedures, and training. Reviews may include an examination of documents and video recordings, as deemed necessary by the Superintendent/Assistant Superintendent.

The FRC shall examine each use of force statute, regulation, policy, procedures, and training issue that is involved in each incident. The FRC may determine and initiate requests for additional information or clarification. Requests for clarification will be initiated and tracked by the Use of Force Coordinator or Superintendent's designee. The FRC may make recommendations to initiate changes to procedures and/or training after a final review. The Superintendent may request an investigation based upon the findings of the FRC and will determine if any corrective action is appropriate.

The FRC shall complete a Synopsis Review form that extends recognition to staff who are properly and effectively using alternative tools to manage incidents without resorting to force or where it is clear that the force used was only the amount of force that was necessary to effect control.

All Use of Force incident packages reviewed by the FRC shall include the meeting minutes, all applicable documentation, and video recordings. The Use of Force incident packages shall then be forwarded to the Division of Juvenile Facilities Use of Force Coordinator or Superintendent's designee within seven (7) calendar days of completion for Division Force Review Committee (DFRC) review.

Use of Force Review Project

IX. Quality Assurance

Observation Two: Institution Force Review Committee

9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.

Quantitative Analysis

1. In the sample of 245 cases, 122 or 48% involved at least one (1) Youth with an identified disability.
2. In the sample of 245 cases, 177 or 72% involved at least one (1) Youth with a *Mental Health Designation*.
3. In the total sample of 245 cases, 197 or 80% involved at least one (1) Youth with a *Mental Health Designation* and/or an identified disability.
4. During the review period of March 2009 through May 2010, one (1) Youth with a *Mental Health Designation* and/or an identified disability requiring accommodations was involved in 40 different force incidents.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, 54 or 54% involved at least one (1) Youth with an identified disability.
2. In the sample of 100 qualitatively reviewed cases, 76 or 76% involved at least one (1) Youth with a *Mental Health Designation*.
3. In the sample of 100 qualitatively reviewed cases, 85 or 85% involved at least one (1) Youth with a *Mental Health Designation* and/or an identified disability.

Use of Force Review Project

IX. Quality Assurance

Observation Two: Institution Force Review Committee

9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.

Qualitative Analysis [Continued]

Force Review Committee

1. In the sample of 31 cases identified as especially egregious, analysis found that attendance was recorded for *Force Review Committee* meetings at the facilities in only 14 of 31 or 45% of opportunities. For the 14 cases in which attendance was recorded, 13 were from *Ventura* and 1 was from *Preston*.
 - In the 14 cases in which attendance was recorded, analysis found a Mental Health Professional at the supervisory level attended *Force Review Committee* meetings at the facilities in 14 of 14 or 100% of opportunities.
 - In the 14 cases in which attendance was recorded, analysis found a Health Care Professional attended *Force Review Committee* meetings at the facilities in 10 of 14 or 71% of opportunities.
2. In the sample of 31 cases identified as especially egregious, analysis found the *Force Review Committee* at the facilities sometimes relied upon incomplete information to make decisions. For example, in the *Watch Commander Review; Section 1* of the *Use of Force Incident Review* form (DJJ 8.440), the *Debriefing Box* was marked Not Applicable or left unchecked in 27 of 31 or 90% of opportunities.

In Case 88, a Youth was refusing to transfer to another living unit. A Lieutenant and two Youth Correctional Officers attempted dialogue for twenty minutes and then maced the Youth four times. None of the Youth Correctional Counselors on the living unit submitted *Behavior Reports* but the *Force Review Committee* at the facility reviewed the incident; no Findings were issued.
3. In the sample of 31 cases identified as especially egregious, analysis found the *Force Review Committee* at the facilities addressed behavioral interventions that might have obviated the need for force in 0% of opportunities.
4. In the sample of 31 cases identified as especially egregious, analysis found the *Force Review Committee* at the facilities made decisions as to whether an incident necessitated Immediate Force that did not rely upon established standards 2 times in Cases 70 and 86.

Use of Force Review Project

IX. Quality Assurance

Observation Two: Institution Force Review Committee

9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.

Case Snapshots

The *Force Review Committee* at the facility reviewing the case in the snapshot that follows did not record attendance, made decisions based upon incomplete documentation and did not address potential behavioral interventions that could have obviated the need to use force.

[Additional case examples included: 1, 7, 16, 35, 36, 45, 62, 70, 72, 86 and 88]

Case 67

Two male Youth, 17 years of age, who resided at *Preston* on the *Manzanita Living Unit*, engaged in a one-on-one fight. Chemical agents were used to effect custody and gain compliance with a lawful order to stop fighting.

Mental Health and Disability Status

One of the Youth involved in the incident had a *Mental Health Designation*. In addition, the same Youth had an identified disability; accommodations cited on the *Youth with Disabilities List* included provisions for a *Staff Assistant* as well as clarification of rules, adding structure, using visuals, extending time, utilizing a calculator and simplifying instructions. There is no evidence that interventions were adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

At the time of the incident, neither Youth had a *Crisis Prevention Support Plan* in place.

Force

Youth Correctional Counselor A applied chemical agents to both Youth separately from approximately six feet away. Youth Correctional Counselor B also applied chemical agents to both Youth from approximately six feet away. The Youth stopped fighting and lay on the ground in a prone position.

Post Force: Medical

Youth Correctional Officers arrived on the living unit and escorted the Youth to the *Outpatient Housing Unit* for medical assessment. The descriptions of the incident given to the Health Care Professional by the two Youth were not recorded. The Health Care Professional reported no injuries for either Youth and flushed their eyes; both Youth were released to the care of the Youth Correctional Officers.

Use of Force Review Project

IX. Quality Assurance

Observation Two: Institution Force Review Committee

9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.

COMMENTS

Observation versus Diagnosis of Injury

Youth Correctional Counselors are not qualified to make medical decisions, including diagnoses and assessment. In this case, it would have been appropriate for the Youth Correctional Counselors to observe that Youth B had trouble breathing rather than diagnosing an asthma attack. Also, it would have been appropriate for the Counselors to communicate to a Health Care Professional their concerns about the breathing difficulties Youth B experienced.

Inconsistent Reporting

In contrast to the reports submitted by the Youth Correctional Counselors, the Health Care Professional documented nothing with respect to Youth B having trouble breathing. The Watch Commander and the Assistant Superintendent reported that the Youth suffered no injuries due to force. The Youth Correctional Counselors involved with the incident submitted *Use of Force* (YA 8.412) as well as *Behavior Reports* [*Serious Misconduct* (DJJ 8.403A) and *Supplemental* (YA 8.402)] that indicated Youth B had a brief asthma attack and recovered. Since *Section Five* of the *Use of Force* form (YA 8.412) does not require the Health Care Professional to make a determination as to the cause of injuries cited and/or treated, coupled with the fact that *Section Five* was incomplete, it is unclear how other respondents determined that the breathing difficulties were not due to force.

Crisis Prevention and Management Policy

The descriptions of the incident recorded in *Section Five* of the *Use of Force* form (YA 8.412) were incomplete, indicating a lack of compliance with the *Crisis Prevention and Management Policy*.

Force Review Committee

1. Did not record attendance.
2. Did not make decisions based upon complete documentation.
3. Did not mention any concerns about the breathing difficulties the Youth experienced after being sprayed with chemicals.
4. Did not mention any concerns about the inconsistent reporting of the breathing difficulties the Youth experienced.
5. Did not address potential behavioral interventions that could have obviated the need for force.

Use of Force Review Project

IX. Quality Assurance

Observation Two: Institution Force Review Committee

9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.

Policy, Practice and Training Recommendations

1. Within 30 days, require that Health Care Professionals participate fully in *Institution Force Review Committee* meetings and document insights on the *Force Committee Review and Analysis Form* (DJJ 8.443).

2. Within 30 days, require that Mental Health Clinicians participate fully in *Institution Force Review Committee* meetings and document insights on the *Force Committee Review and Analysis Form* (DJJ 8.443).

3. If documentation is missing or an incident warrants investigation, require that *Force Review Committees* at the facilities suspend the process until all of the information is obtained or the investigation is completed.
4. Amend *Crisis Prevention and Management Policy* to include a requirement that the *Force Review Committees* at the facilities discuss potential behavioral interventions that might have obviated the need to use force.
5. Require that *Force Reviews* be based upon established standards and criteria as to what necessitates *Immediate* versus *Controlled* use of force.
6. Require that every attendee at a *Force Review Committee* meeting is documented on the *Force Review* form.
7. Request that the *Office of the Inspector General* re-examine its protocol, procedures and resources to ensure effective oversight of force, including overall reduction in incidents and focused attention upon Youth with a *Mental Health Designation* or an identified disability.

Use of Force Review Project

IX. Quality Assurance

Observation Three: Quarterly Qualitative Force Reviews

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

Authority

According to the Crisis Prevention and Management Policy:

QUALITY ASSURANCE

Each individual Use of Force Incident at a DJJ facility must be evaluated at both supervisory and management levels to determine if the force used was both proper and lawful under applicable laws, regulations, policy, procedures, and training. The policy and procedures set forth below shall be enforced to ensure the management team of the DJJ is aware of use of force incidents, and is able to properly monitor and provide a thorough review of each use of force incident.

Supervisory Evaluation of Use of Force Reports

All Use of Force Incidents shall be reviewed at a Supervisory level within 24 hours of the incident. The following factors must be evaluated:

- *Crisis prevention and management techniques used, if applicable*
- *Any efforts and/or resources used to minimize the use of force*
- *The need for the application of force*
- *The relationship between that need and the amount of force used*
- *The threat reasonably perceived by the employees involved*
- *Extent of the injuries suffered*

Force Review Committee

Use of force incidents shall be reviewed by the Force Review Committee (FRC) within 30 days of occurrence. The FRC shall examine all levels of responsibility exercised by subordinate managers and supervisors, and ensure the appropriateness of completed documentation. The FRC shall make a determination concerning the appropriateness of the use of force based on the information and reports available.

Division Force Review Committee

The DJJ Division of Juvenile Facilities at Headquarters shall review all Use of Force incidents received and select a minimum of ten (10) percent submitted to be further reviewed by the DFRC to ensure employee's actions are in accordance with Crisis Prevention and Management policy, procedures, and training. The DFRC review is a qualitative and quantitative review of selected incidents that the FRC has reviewed. The DFRC ensures facility executives are conducting qualitative analysis of each use of force incident. Each DFRC meeting shall result in a draft Report of Findings that is sent to the Superintendent. The facility shall respond to the DFRC's findings with a notice of factual accuracy. A Corrective Action Plan concerning problematic findings shall be developed as necessary. The DFRC is responsible for issuance of a final Report of Findings that is forwarded to the Director of Juvenile Facilities for review.

Use of Force Review Project

IX. Quality Assurance

Observation Three: Quarterly Qualitative Force Reviews

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

Qualitative Analysis

*In the sample of 100 cases, 1% of incidents when reviewed by the *Force Review Committee* had any indication that the *Interdisciplinary Team* assembled attempted to discern how staff members could have intervened more effectively or how future incidents with similar events could be prevented or de-escalated without force.

**In 1 of 100 incidents qualitatively reviewed, because a Youth was alone and not an immediate danger to others, the Force Review Committee at the facility noted that staff members could have waited for a Mental Health Clinician to intervene prior to applying physical force. There was no indication as to what actions could be taken to prevent a similar incident from occurring in the future.*

Case Snapshots

When reviewing the events described in the case snapshot that follows, the *Force Review Committee* at the facility did not attempt to discern ways in which the Officers might have intervened more effectively or how future incidents with similar events could be prevented or de-escalated without force.

[Additional case examples included: 1, 16, 35, 36, 62, 70, 86 and 88]

Case 7

One male Youth 18 years; 8 months, and one male Youth, 15 years, 10 months, residing at *N.A. Chaderjian* on the *Sacramento Living Unit*, engaged in a one-on-one fight. Chemical agents were used to subdue an attacker and gain compliance with a lawful order.

Mental Health and Disability Status

On the date of the incident, both Youth A and Youth B had a *Mental Health Designation*, were assigned to an *Intensive Behavior Treatment Program* and had been prescribed psychotropic medication. In addition, Youth A was either on *Suicide Watch* or *Suicide Precaution*. Both Youth A and B presented with a Disability; however no accommodations were cited on the *Youth with Disabilities List*.

Youth A

Accommodations for Youth A included access to a *Staff Assistant*, as well as allowing extra time to complete tasks, breaking down task steps, using simplified language, ensuring attention prior to giving instructions, asking that instructions and terminology be paraphrased and encouraging questions. In school, accommodations included reducing the number of questions or problems per assignment, allowing alternative modes of evaluation, using a small group setting, preferential seating near the teacher away from distractions, allowing use of notes, electronic speller and calculator, as well as allowing for breaks or timeouts as needed.

Youth B

Accommodations for Youth B included access to a *Staff Assistant*, allowing extra time for completion of tasks and to verbally formulate responses, asking that instructions and terminology be paraphrased. In school, accommodations included allowing alternative modes of evaluation and checking for understanding.

Use of Force Review Project

IX. Quality Assurance

Observation Three: Quarterly Qualitative Force Reviews

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

Crisis Prevention Support Plan

On the date of the incident, both Youth A and Youth B had a *Crisis Prevention Support Plan* in place. During the incident, the plan for neither was utilized.

Youth A

According to the plan, Youth A had a history of mental illness and suicidal behavior. The plan further stated that Youth A lacked a primary support system and was viewed as incapable of using appropriate coping skills. When redirected by staff members, Youth A was seen as aggressive and defiant. Considerations in crises included allowing a time-out in his room or dialoguing with staff members with whom he had rapport. To prevent crises, the plan recommended individual counseling sessions with members of his *Treatment Team*. Also, positive reinforcement and focusing on his strengths were viewed as beneficial. Telephone calls to immediate family helped Youth A to become calm and reestablish his focus on treatment goals. Effective de-escalation strategies included *Motivational Interviewing*, allowing the Youth to speak, express and vent his issues to staff members. Medication compliance was seen as assisting the Youth in focusing and in mood stabilization. In the event the Youth was involved in a physical altercation, chemical agents were judged effective. However, unless he was not willing to follow instructions, if Youth A was in crisis within a secure setting, dialogue was viewed as the most effective intervention. In the past, the presence of Security had proven effective.

Youth B

According to the plan, Youth B was described as having been fatally neglected and abandoned by his parents. Youth B was viewed as using aggression as self-preservation. Since entering the living unit, Youth B had been involved in a few physical altercations, which resulted in the use of chemical agents. Chemical restraints were viewed as effective with Youth B. Considerations in crises included identifying his preferred assistance and establishing a *Peer Buddy Program* to provide support for stressful times. Other considerations in crises included listening and responding with empathy. When intervening, the plan said to anticipate a long emotional drain-off before de-escalation. The plan stated that it was important to govern what was said in relation to the level of escalation and recommended using a soothing demeanor and clear language. When in crises, the plan recommended attempting to divert focus. When advised that he would be given a few minutes to cool down, Youth B was seen as benefiting from taking a time-out. Youth B was seen as becoming more verbally aggressive when there was an audience; however, Youth B was viewed as doing well with redirection or one-to-one intervention. To prevent crises, the plan recommended providing immediate redirection when he began to react in a negative manner. It was recommended that staff members approach Youth B in a non-confrontational manner. When confronted in front of his peers, Youth B was known to escalate to a higher level of aggression. If possible, when Youth B became verbally disrespectful, it was recommended that staff members speak with him privately. If he acted out at a level that required physical intervention, then Youth B was viewed as spent emotionally; and might cope by retreating to sleep. At this point, the debriefing process was seen as critical because revenge and vendetta were routing responses if resolution was not achieved. Real expression for well being after an event was seen as critical. The plan recommended using Medical and Mental Health follow-up; the message being, *"No matter what has happened we care about you."* When there appeared to be no other alternative, it was advisable that staff members not attempt to touch Youth B. When highly agitated, Youth B had verbalized that putting hands on him justified assaultive behavior toward staff members.

Use of Force Review Project

IX. Quality Assurance

Observation Three: Quarterly Qualitative Force Reviews

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

CUSTODY RESPONSE

Escalation

When supervising the day room, Youth Correctional Counselor One and Three observed Youth A and B arguing over which television channel to watch. Counselors One and Three then observed Youth A and Youth B standing face-to-face and arguing. Counselor One instructed both of the Youth to back off and leave the television on one channel. Counselor Three also gave the two Youth instructions to separate from each other. Youth A and B were attempting to change the channel on the box; then Youth A removed his hand from the box and took an aggressive stance with Youth B. At this point, both Youth A and B began punching each other with closed fists to the head and upper torso area. In response, Counselor Three issued two consecutive chemical agent warnings and both Counselor One and Three issued instructions to stop fighting.

First Use of MK-4 OC Pepper Spray [Youth A and B]

Counselor One then issued a warning that chemical agents would be used if the two Youth did not stop fighting. The two Youth did not comply; so from approximately five feet away, Counselor One dispersed a burst of MK-4 OC Pepper Spray toward the head and shoulder area of Youth A and B.

Second Use of MK-4 OC Pepper Spray [Youth B]

From approximately six feet away Counselor Three then dispersed a burst of MK-4 OC Pepper Spray to the facial area of Youth B. In response, both Youth separated. At this point, Youth A backed away and lay on the ground with his hands at his side.

Third Use of MK-4 OC Pepper Spray [Youth B]

Youth B would not get down and continued to make aggressive gestures toward Youth A. Youth B was again instructed to get on the ground. Youth B then moved toward Youth A. To avoid further altercation, Youth A jumped to his feet and then backed defensively into the *Parole Agent* office. At this time, Counselor One prepared to disperse a second burst of MK-4 OC Pepper Spray. In response, Youth B attempted to knock the canister of chemical agents from the hand of Counselor One. Notwithstanding, from approximately three feet away, Counselor One was able to disperse a burst of MK-4 OC Pepper Spray; however, the chemical agents did not take affect immediately. Again Youth A laid on the ground in a prone position with his hands behind his back and his ankles crossed. Youth B remained on his feet, continuing to challenge Youth A to a fight. Moments later, the chemicals began to take affect; Youth B then began to walk around the day room but would not follow instructions to get down.

First Use of Z-505 [Youth B]

Youth B then approached Counselor Two who had entered the day room from the *Parole Agent* office. As Youth B approached, Counselor Two issued instructions for Youth B to get on the ground or chemical agents would be used. Youth B did not comply and continued to walk around the day room swearing. Counselor Two then drew his Z-505 and again instructed Youth B to go to the ground. Youth B did not comply and from approximately six to eight feet away, Counselor Two dispersed a short burst of Z-505 to left side of the face of Youth B which immediately took affect. Counselor Two then instructed Youth B to get on the ground. Youth B complied, laid prone on the ground with his hands behind his back, ankles crossed, was handcuffed and placed in the shower for decontamination.

Use of Force Review Project

IX. Quality Assurance

Observation Three: Quarterly Qualitative Force Reviews

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

Force Review Committee

1. The *Force Review Committee* found staff actions prior to and during the force incident to be in compliance with policy, procedures and training.
2. The *Force Review Committee* found staff actions following the force incident not to be in compliance with policy, procedures and training.
 - No staff documented alarm activation.
 - The narrative description of the incident a Youth Correctional Counselor submitted was too brief. A *Supplemental Behavior Report* (YA 8.402) that the Lieutenant submitted was too brief and one of the boxes in the *Watch Commander Review* was not checked.

COMMENTS

Prevention and De-escalation

Other than issuing repeated instructions to back off, the Youth Correction Counselors made no other attempt to intervene or de-escalate the conflict.

Mental Health Response

No Mental Health Clinician was involved before, during or following the incident. Possibly, if a Mental Health Clinician had been available and partnered effectively with the Officers, the use of chemical agents four times on Youth B could have been avoided. Undoubtedly, there were power and control dynamics underlying the interactions between the Youth and the Officers. A Mental Health Clinician could have pointed this out and coached the Officers on ways to intervene that did not involve repeated application of chemical agents. Additionally, after the chemical agents were dispersed, a Mental Health Clinician could have elucidated the affect the chemical agents had on the Youth and assisted in identifying better ways to intervene in the future. Surely, there were more appropriate ways for the Youth to get his needs met than being sprayed with chemicals; many of which were imbedded within the accommodations identified for the Youth and or contained in the *Crisis Prevention Support Plan*.

Improved Performance

Youth B was only 15 years old, had a *Mental Health Designation*, was assigned to an *Intensive Behavioral Treatment Program* and was prescribed psychotropic medication. Youth B also had an identified disability that required accommodations including a *Staff Assistant*. The *Crisis Prevention Support Plan* described the Youth as having been fatally neglected and abandoned by his parents. The Youth was viewed as using aggression as self-preservation. The Youth was involved in a one-on-one fight where the other combatant complied with instructions to get down. Notwithstanding, in the day room on the living unit, three Youth Correctional Counselors and a responding Lieutenant were not able to intervene and de-escalate the Youth who had already been sprayed twice without dispersing chemical agents two more times. Despite the aforementioned, the *Force Review Committee* only completed a *Compliance Review* and issued findings related to staff actions following force in areas like alarm activation and report writing.

Use of Force Review Project

IX. Quality Assurance

Observation Three: Quarterly Qualitative Force Reviews

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

COMMENTS [Continued]

Redundant Compliance Reviews

Under the current *Crisis Prevention and Management Policy*, there is no explicit requirement for the *Force Review Committee* to perform qualitative review of cases to discern how staff members could have intervened more effectively or how future incidents with similar events could be prevented or de-escalated without force. Qualitative Review of 100 incidents found that the *Force Review Committees* at the facilities focused almost exclusively on whether staff actions prior to, during and following a force incident were in compliance with policy, procedures and training. In the *Watch Commander Review; Section 1* of the *Use of Force Incident Review* form (DJJ 8.440), the Watch Commander determines whether any procedural or training improvements should occur. Subsequently, the Chief of Security, Superintendent and the *Force Review Committee* repeat the same basic *Compliance Review* for every force incident. Currently, at every level, *Force Review* fails to qualitatively analyze incidents for the purpose of improving employee and/or organizational performance.

Use of Force Review Project

IX. Quality Assurance

Observation Three: Quarterly Qualitative Force Reviews

9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.

Policy, Practice and Training Recommendations

Require Facility and Division-level *Quarterly Qualitative Force Reviews* be conducted using a interdisciplinary team approach where trends, patterns, and best practices are identified; as necessary provide training, request *Corrective Action Plans* and make systems changes. At a minimum, ensure the following occurs:

- Forums for including the perspectives of Youth, families, and the community into the Quarterly Qualitative Review process are identified.
- Ways to reduce the amount of force used with Youth who have a *Mental Health Designation* or an identified disability are examined.
- Preventive steps and antecedent events, including staff members consulted, are included in discussions when reviewing specific force incidents.
- Participants in *Quarterly Qualitative Force Reviews* and those who serve on *Violence Reduction Committees* share outcomes with each other.

Use of Force Review Project

ACCOUNTABILITY

10.1 Recommendations from the Department Force Review Committee were sometimes disregarded.

10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.

Use of Force Review Project

X. Accountability

Observation One: Continuous Improvement

10.1 Recommendations from the Department Force Review Committee were sometimes disregarded.

Authority

According to the Crisis Prevention and Management Policy:

The DJJ Division of Juvenile Facilities at Headquarters shall review all Use of Force incidents received and select a minimum of ten (10) percent submitted to be further reviewed by the DFRC to ensure employee's actions are in accordance with Crisis Prevention and Management policy, procedures, and training. The DFRC review is a qualitative and quantitative review of selected incidents that the FRC has reviewed. The DFRC ensures facility executives are conducting qualitative analysis of each use of force incident. Each DFRC meeting shall result in a draft Report of Findings that is sent to the Superintendent. The facility shall respond to the DFRC's findings with a notice of factual accuracy. A Corrective Action Plan concerning problematic findings shall be developed as necessary. The DFRC is responsible for issuance of a final Report of Findings that is forwarded to the Director of Juvenile Facilities for review.

Qualitative Analysis

Qualitative analysis found that the facilities do not always fully address the findings and recommendations of the *Department Force Review Committee*. In many instances, while agreeing with the findings, a facility provided no explanation as to what action, if any, would be taken to address the deficiencies cited.

Selected Department Force Review Committee Findings and Facility Responses

1. Finding: Staff actions prior to using force were not in compliance because *Controlled Force* should have been applied or a supervisor should have assessed the situation and authorized *Immediate Force*.

The response from the facility stated, “[The]...*Force Review Committee* agrees that a supervisor should be present to assess the situation prior to immediate force being used.”

2. Finding: Based upon review of an incident, including the video and subsequent reports, additional time and intervention efforts could have been attempted prior to application of force.

The response from the facility did not address the issue.

3. Finding: After an incident, because of being an active participant in the application of force, a Lieutenant should not have been the respondent in a *Watch Commander Review*.

The response from the facility did not address the issue.

4. In two separate force incidents, a report from a Lieutenant lacked detail.

The response from the facility for the two incidents concurred with the findings without specifying what actions would be taken to remedy the deficiencies.

Use of Force Review Project

X. Accountability

Observation One: Continuous Improvement

10.1 Recommendations from the Department Force Review Committee were sometimes disregarded.

Case Snapshot

The following case snapshot describes an incident where recommendations from the *Department Force Review Committee* were disregarded.

[Additional case examples included: 7, 36, 67 and 91]

Case 70

In Case 70, a male Youth, 18 years; 1 month, refused to leave his room and assaulted a staff member. Chemical agents, physical strengths and holds, as well as mechanical restraints were used to gain compliance and subdue an attacker.

Mental Health and Disability Status

At the time of the incident, the Youth did not have a *Mental Health Designation* and was not identified as having a disability.

Crisis Prevention Support Plan

At the time of the incident, the Youth did not have a *Crisis Prevention Support Plan* in place.

Custody Response

In an apparent attempt to change rooms and get away from a peer, a Youth broke the light in his room. Subsequently, the Youth refused to transfer to his newly assigned room. In response, for about ten minutes, two Youth Correctional Officers arrived at the living unit and attempted to dialogue with the Youth. The dialogue did not convince the Youth to move to the newly assigned room. The Lieutenant arrived on the scene and instructed the Youth to turn around and be handcuffed; if the Youth did not comply with instructions force would be used. The Youth refused to comply and the Lieutenant instructed the two Officers to apply chemical agents.

Chemical Agents

Two rounds of chemical agents were administered. In each instance, one Youth Correctional Officer opened the door and the second Officer administered a burst of MK-9 OC into the room of the Youth. The door was then closed and the Youth was instructed to back up to the door, kneel down and be handcuffed. The Youth refused to comply.

Physical and Mechanical Restraints

The Lieutenant then instructed three Youth Correctional Officers to enter the room and remove the Youth. Upon entering the room, the Officers found the Youth laying face down on his bed. When approaching the Youth, one of the Officers slipped due to the chemical agents on the floor. When the Officers moved toward the bed, the Youth made a sudden move to his back and began to swing his fist at the facial area of one of the Officers; the Youth made contact. At this point, the Youth Correctional Officers used physical strengths and holds to subdue the Youth and then applied mechanical restraints. Subsequently, the Youth was moved to another room.

Use of Force Review Project

X. Accountability

Observation One: Continuous Improvement

10.1 Recommendations from the Department Force Review Committee were sometimes disregarded.

Force Review Committee Findings

1. The staff action prior to and during the use of force was found in compliance with policy, procedures and training.
2. The staff action following the use of force was found not in compliance with policy, procedures and training.
 - The Registered Nurse indicated a wrong date on the use of force form.
 - No *Serious Incident Report* was completed. [Even though a *Serious Incident Report* was prepared.]

Division Force Review Committee Findings

1. The incident was not an immediate use of force.
2. *Controlled Force* procedures may have avoided a staff battery.
3. One of the Youth Correctional Officers applied chemical agents inappropriately.
4. The actions of the Lieutenant placed the safety of staff members in jeopardy. [The Lieutenant should be required to attend *Extraction* training.]

Force Review Committee Response to the Department Force Review Committee Findings

The Superintendent at the facility disagreed with the *Department Force Review Committee* findings. The rationale of the facility was that the Youth was destroying state property in his room and could have seriously injured himself, thus *Immediate Force* was justified. The facility determined that no further action was needed.

Department Force Review Committee Follow-Up Response

The *Department Force Review Committee* noted that the destruction of state property, a light bulb, had occurred prior to the arrival of staff members. At the time when force was used, the Youth was refusing to be handcuffed and move to another room. None of the reports the Officers submitted indicated the Youth was in immediate danger or posed an immediate threat.

Use of Force Review Project

X. Accountability

Observation One: Continuous Improvement

10.1 Recommendations from the Department Force Review Committee were sometimes disregarded.

Policy, Practice and Training Recommendations

1. Ensure that Executive-level management actively monitors facility responses to recommendations issued by the *Department Force Review Committee* and when necessary; oversees the development of *Corrective Action Plans*.
2. Ensure that ten percent of incidents reviewed by the *Department Force Review Committee* are selected based upon established criteria. At a minimum the criteria should include:
 - Self-injurious behaviors and suicide attempts.
 - Serious injuries sustained by a Youth or a Staff Member.
 - Allegations of excessive or unnecessary force.
 - Single Youth Incidents.
 - Multiple applications of chemical agents.
 - Use of chemical agents on a Youth with a *Mental Health Designation* or an identified disability.

Use of Force Review Project

X. Accountability

Observation Two: Progressive Discipline

10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.

Authority

According to Section 3, Article 22 of the Department Operations Manual:

33030.1 Policy

All disciplinary action shall be imposed in a fair, objective, and impartial manner, and the California Department of Corrections and Rehabilitation (Department) shall consistently apply accepted principles of due process and progressive discipline when corrective or adverse action is imposed.

Adverse Action

[Adverse action is]...A documented action, which is punitive in nature and is intended to correct misconduct or poor performance or which terminates employment.

Corrective Action

[Corrective action is]...A documented non-adverse action (verbal counseling, in-service training, on-the-job training, written counseling, or a letter of instruction) taken by a supervisor to assist an employee in improving his/her work performance, behavior, or conduct.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, the *Force Review Committee* found that staff actions prior to a force incident were not in compliance in 5 of 100 or 5% of incidents.
2. In the sample of 100 qualitatively reviewed cases, the *Force Review Committee* found that staff actions during a force incident were not in compliance in 1 of 100 or 1% of incidents.
3. In the sample of 100 qualitatively reviewed cases, the *Force Review Committee* found that staff actions following a force incident were not in compliance in 34 of 100 or 34% of incidents.

Preventive Actions

At the facilities, the consequences for findings issued from the *Force Review Committee* were typically either *Verbal Counseling* or an *Advisory Memorandum*. *In the 100 qualitatively reviewed cases, except for when an Assistant Superintendent recommended that a staff member be subject to a *Work Improvement Discussion* for submitting a Behavior Report four days late, the actions taken for non-compliance with force policy, procedures and training consisted of preventive measures only.

**One (1) of the 39 other cases involved a staff member submitting a Behavior Report eight days late which speaks to the inconsistency of actions taken or recommended.*

Use of Force Review Project

X. Accountability

Observation Two: Progressive Discipline

10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.

Qualitative Analysis [Continued]

Progressive Disciplinary Actions for Multiple Policy Infractions

From the sample of 100 qualitatively reviewed cases, 0 of 40 involving non-compliance indicated if the *Force Review Committee* had considered whether *Advisory Memorandums* had been issued for prior policy infractions and if so, whether corrective action was necessary for current actions. Preventive measures are not useful if staff members are not confronted with the possibility of progressive disciplinary actions with more serious consequences should policy violations recur.

Facility Tracking Systems for Progressive Disciplinary Actions

1. At *N.A. Chaderjian*, Use of Force Coordinators at the facility tracked the **Advisory Memorandums* issued for policy and training infractions related to force. According to officials from *N.A. Chaderjian*, a *Work Improvement Discussion* would be conducted if a staff member received three *Advisory Memorandums* for a similar violation.
2. At *OH Close*, a system had been developed for tracking *Advisory Memorandums* issued for policy and training infractions related to force but the system had not been implemented. The Assistant Superintendent stated that no *Work Improvement Discussions* for multiple infractions of the force policy had received his concurrence during the previous seven months.
3. At *Preston*, Use of Force Coordinators at the facility tracked *Advisory Memorandums* issued for policy and training infractions related to force. According to officials from *Preston*, a *Work Improvement Discussion* would be conducted if a staff member received three *Advisory Memorandums* for a similar violation. *Preston* did not track the number of *Work Improvement Discussions* conducted.
4. At the *Southern Reception Center and Clinic* a system was not in place to track the *Advisory Memorandums* issued for policy and training infractions related to force. As such, the facility was unable to administer progressive disciplinary action for multiple infractions of the force policy that had been cited in *Advisory Memorandums*.
5. At *Ventura*, the Use of Force Coordinator maintained a copy of the *Advisory Memorandums* issued in a binder. From February 2010 to February 2011, no *Work Improvement Discussions* had been conducted for multiple policy infractions related to force.

**Advisory Memorandums are referred to as Training Memorandums as well.*

Use of Force Review Project

X. Accountability

Observation Two: Progressive Discipline

10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.

Case Snapshot

1. In the sample of 100 qualitatively reviewed cases, a Lieutenant was issued six *Advisory Memorandums*. The *Advisory Memorandums* were issued for incidents that occurred on July 16, 2009, November 9, 2009, December 11, 2009, December 26, 2009, February 7, 2010, and March 9, 2010.
2. In the 31 cases identified as especially egregious during qualitative review, the Lieutenant was issued 4 of the 6 above mentioned *Advisory Memorandums*.
3. The following case snapshot describes an incident identified as especially egregious that involves the same Lieutenant.

[Additional case examples included: 22, 35 and 62]

Case 99

In Case 99, a male Youth, 17 years; 2 months, and a male Youth, 20 years; 0 months, engaged in a one-on-one fight. Chemical agents were used to gain compliance and subdue an attacker.

Mental Health and Disability Status Youth A

The Youth had a *Mental Health Designation*, resided on an *Intensive Behavior Treatment Unit* and was prescribed psychotropic medication. On the day of the incident, the Youth had an identified disability. Accommodations included access to a *Staff Assistant*. Additional accommodations included allowing extra time for completing tasks as well as discussing and simplifying new vocabulary. In school and during District testing, accommodations included use of a calculator.

Mental Health and Disability Status Youth B

The Youth presented with a *Mental Health Designation*, resided on an *Intensive Behavior Treatment Unit* and was prescribed psychotropic medication. On the day of the incident, the Youth was not identified as having a disability.

Use of Force Review Project

X. Accountability

Observation Two: Progressive Discipline

10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.

Crisis Prevention Support Plan Youth A

According to the plan, Youth A was prescribed psychotropic medications. Youth A presented with a history of a brain injury sustained from a car accident at age five years. The plan stated that Youth A seemed childlike and had difficulty processing information. Youth A was described as reading and writing at the second grade level. Youth A was viewed as having strong family support; his primary connection being to his mother. Youth A had received multiple Behavior Reports for verbal and written harassment, as well as for disruptive behaviors. Youth A was described as easily frustrated and known to use verbally threatening behaviors toward staff members. De-escalation techniques included using simple and easily understood instructions. Also, Youth A had learned the ABCs of the *Anger Control Chain*. Using physical cues, Youth A was able to recognize the triggers of his anger and had learned to apply de-escalation techniques such as deep breathing or taking a timeout. Youth A was viewed as needing space away from a negative incident for a cool down period. Individual counseling was viewed as beneficial. When Youth A did not respond and security measures needed to be taken, chemical agents were seen as effective.

Crisis Prevention Support Plan Youth B

According to the plan, Youth B exhibited extreme mood swings. Youth B was prescribed psychotropic medication but was viewed as amendable to changes in medication. The plan stated it was good to have a Psychiatrist available for Youth B. The Youth was described as a *Parole Violator* who was hyper and disrespectful, with difficulty controlling his anger. Since returning to the *Living Unit*, Youth B had focused much of his anger toward Youth Correctional Counselor [Insert name]. The plan recommended that since Youth B had already threatened to assault the Counselor with a broomstick in his hand, if possible, the Counselor should be removed from any situation in which Youth B was irrationally focused upon her. In all of his acting out incidents, several staff members had to assist in de-escalating Youth B to a manageable level. Further, Youth B was known to incite other Youth into acting out with him. Youth B was viewed as very impulsive, quickly reacting to new information. The plan stated that challenging the behaviors of Youth B would escalate his behavior.

Prior Warning

Two Youth were involved in a verbal argument. One of the Youth took a seat while the other Youth was pacing around the dayroom and “talking aggressively” to the other Youth. Words were exchanged.

Intervention

One Youth Correctional Counselor observed the event unfolding. Other than instructing the Youth to stop bickering and separate, no other effort was made to intervene. A few moments later, both Youth were seen standing in a fight stance and then exchanged closed fist punches toward one another. The force incident may have been avoided had staff members taken more proactive actions to de-escalate the interaction.

Custody Response

Two Youth Correctional Counselors were at the scene and one of the Youth Correctional Counselors applied MK-4 Pepper Spray toward one of the Youth. The chemical agents made contact with the upper back of the Youth; both Youth separated from one another.

Use of Force Review Project

X. Accountability

Observation Two: Progressive Discipline

10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.

Decontamination Shower

Both Youth refused a decontamination shower.

Medical Treatment

Both Youth refused medical treatment or to be seen by a nurse.

Mental Health Intervention

The incident occurred on a weekend when no Mental Health Clinician was on duty. There is no indication a Mental Health Clinician intervened post incident.

Debriefing

No debriefing was held after the force incident.

Force Review Committee Findings

1. Staff actions prior to and during the force incident were found to be in compliance with policy, procedures, and training.
2. Staff actions following the force incident were not found in compliance with policy, procedures, and training. Specific findings included:
 - Failure to document a verbal warning and alarm activation. There was no indication as to how the *Force Review Committee* determined that the staff member had actually issued a chemical warning but failed to document it. If the staff member did not issue a chemical warning, staff actions prior to the force incident would not have been in compliance with policy.
 - Time discrepancies between different sections of the reports.

Force Review Committee Actions

1. Two Youth Correctional Counselors were issued *Advisory Memorandums* for failure to document verbal warnings and alarm activation.
2. The Lieutenant serving as the Watch Commander and one Youth Correctional Officer were issued *Advisory Memorandums* for time discrepancies cited in reports.

COMMENTS

Force Review Committee Actions

Despite the fact that the facility where these incidents occurred reported having a tracking system for *Advisory Memorandums* related to force, there was no indication that when assessing the need for corrective actions, the *Force Review Committee* considered the prior history of any of the staff members who had violated policy.

Use of Force Review Project

X. Accountability

Observation Two: Progressive Discipline

10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.

Policy, Practice and Training Recommendation

Amend the *Crisis Prevention and Management Policy* to include a standardized process for implementing employee training, corrective action and discipline related to force incidents that is in line with the *Department Operations Manual*; as necessary, deliver refresher training to managers and supervisors on the *Progressive Discipline Policy* and the revised *Crisis Prevention and Management Policy*.

Use of Force Review Project

STAFFING

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

11.2 Mental Health Clinicians were not available to act as equal partners with custody staff when intervening in conflicts or force incidents during all shifts, including weekends and holidays.

Use of Force Review Project

XI. Staffing

Observation One: Shifting Staff Members

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

Authority

According to the *Institutions and Camps Manual*:

Superintendents may assign staff to any duties consistent with their classifications, including participation on treatment teams. Management has the right to change an employee's job assignment, shift assignment, working hours or job location without permission from the State Personnel Board or departmental administration.

According to the *Agreement Between State of California and California Correctional Peace Officers Association Covering Bargaining Unit 6 (Corrections)*:

- A. There shall be seventy percent (70%) of the YCC post assignments in CYA allotted according to seniority. Once a YCC successfully bids for a seniority assignment, he/she shall not be eligible to bid again for a twelve (12) month period of time.*
- B. In order to remain in the post assignment of choice, the senior employee must maintain a satisfactory level of performance.*

If there is no interest in the vacant "seniority" post assignment, management shall fill the assignment by existing rules, policies, and practices. For those post assignments retained by management, existing rules, policies, and practices, with regard to filling vacancies, shall remain in effect.

Management shall have the discretion to review and re-designate the selected post assignments. Nothing in this section shall diminish management's right to carry out departmental goals and objectives ...or interfere with management's rights to meet operational needs in making post assignments. The afore-stated will not be done in an arbitrary or capricious manner.

CYA agrees not to alter existing "day off" patterns, unless the local Chapter President and the Appointing Authority mutually agree to do so.

- C. If the local CCPOA Chief Job Steward is a YCC, the Department will hold one (1) seniority second watch assignment with Saturdays and Sundays vacant for that Chief Job Steward or the Chief Job Steward may use "super seniority" to bid upon any available post. In the event the Chief Job Steward uses "super seniority" to bid upon an available post, the second watch assignment with Saturdays and Sundays off held vacant will revert to conditional bid.*

Use of Force Review Project

XI. Staffing

Observation One: Shifting Staff Members

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

According to the Agreement Between State of California and California Correctional Peace Officers Association Covering Bargaining Unit 6 (Corrections) [Continued]:

D. In the event the employer has a legitimate reason to change a seniority bid, the following will occur:

- 1. The local Chief Job Steward and the impacted employee must be notified in writing prior to the change as to the specific reasons for the change.*
- 2. The impacted employee may either: (a) remain in the position, (b) bid to a vacant seniority bid position, or (c) request placement and be placed in a management position with the same RDO(s) [Regular Days Off] and substantially similar start and stop times as the employee's original bid position. In this latter case, the employee may not remain in the management position longer than twelve (12) months without prior management approval.*

Quantitative Analysis

1. In the sample of 245 cases, 46 or 19% of incidents involved a single Youth who was not engaged in assaultive behavior and potentially, was amenable to intervention by a trusted staff member.
 - Thirty-three (33) cases involved a single, non-compliant Youth.
 - Eight (8) cases involved a single Youth engaging in self-injurious behavior.
 - Two (2) cases involved a single Youth demonstrating suicidal gestures.
 - Two (2) cases involved a single Youth engaging in destructive behavior.
 - One (1) case involved a single Youth attempting to escape.
2. In the sample of 245 cases, 5 or 2% of incidents involved a *Youth on a Staff Assault*.
 - Five (5) of 5 or 100 % of *Youth on Staff Assaults* involved a single Youth.
 - One (1) of 5 or 20% involved use of chemical agents; 4 of 5 or 80% involved physical force.
3. In the sample of 245 cases, 1 or less than 1% of incidents involved an *Attempted Youth on Staff Assault*.

Two (2) Youth were involved in the incident; chemical agents were applied to 1 of the 2 Youth.
4. In the sample of 245 cases, 21 or 9% of incidents involved a *Youth on Youth Assault*.

Fifty-six (56) Youth were involved in the 21 incidents that involved a *Youth on Youth Assault*; chemical agents were applied to 39 of the 56 Youth.

Use of Force Review Project

XI. Staffing

Observation One: Shifting Staff Members

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

Quantitative Analysis [Continued]

5. In the sample of 245 cases, 3 or 1% of incidents involved an *Attempted Youth on Youth Assault*.

Five (5) Youth were involved in the 3 incidents; chemical agents were applied to 4 of the 5 Youth.

Qualitative Analysis

In the 100 qualitatively reviewed cases, 26 or 26% of incidents involved a single Youth who was not engaged in assaultive behavior and potentially, was amenable to intervention by a trusted staff member.

- Seventeen (17) cases involved a single, non-compliant Youth.
- Seven (7) cases involved a single Youth engaging in self-injurious behavior.
- One (1) case involved a single Youth demonstrating suicidal gestures.
- One (1) case involved a single Youth engaging in destructive behavior.

Case Snapshot

The following case snapshot describes an incident where there was a possibility that staff members who had rapport with a Youth might have been able to intervene effectively and avoid an attempted staff assault and the subsequent use of force.

[Additional case examples included: 1, 2, 4, 7, 8, 27, 32, 35, 36, 42, 45, 62, 66, 67, 70, 71, 72, 75, 76, 81, 82, 86, 87, 88, 91, 92, 94, 96, 98 and 99.]

Case 16

In Case 16, a male Youth, 17 years of age, who resided at *Ventura* on the *Monte Vista Living Unit*, attempted to assault an Officer. Chemical agents and physical force were used to subdue the attacker. When the chemicals were dispersed a second male Youth, 17 years of age, who resided at *Ventura* on the *Monte Vista Living Unit*, was impacted by overspray.

Mental Health and Disability Status

At the time of the incident, both of the Youth who were exposed to chemical agents had a *Mental Health Designation* and both were being prescribed psychotropic medication. In addition, both of the Youth had an identified disability. For Youth A, there were no accommodations cited on the *Youth with Disabilities List*. Accommodations for Youth B included access to a *Staff Assistant*, as well as allowing extra time for the completion of tasks, breaking task steps down, using simplified concise language, allowing time to verbally formulate responses, discussing and simplifying new vocabulary and asking for instructions to be paraphrased. In school, accommodations included ensuring attention prior to giving instructions, encouraging questions, allowing for alternative modes of evaluation, utilizing a small group setting, reducing the number of questions or problems per assignment, utilizing preferential seating near the teacher away from distractions and allowing the use of calculator, talking dictionary and thesaurus. The evidence suggested that during the incident interventions were not adjusted to accommodate the individual needs of the Youth in crisis or the Youth trying to assist.

Use of Force Review Project

XI. Staffing

Observation One: Shifting Staff Members

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

Crisis Prevention Support Plan

At the time of the incident, neither Youth had a *Crisis Prevention Support Plan*. Subsequently, a *Crisis Prevention Support Plan* was developed for Youth B; entries in the plan begin on July 9, 2009. According to the plan, Youth B presented with a history of aggression, fighting, and verbal escalation requiring intensive intervention. The plan stated that Youth B was assigned to a *Special Counseling Program* and had been identified as having a disability requiring services. The Youth was viewed as responding well to individual counseling where there were no other distractions, especially from other Youth. The Youth was also viewed as responding well to a contract with accompanying positive reinforcement. In crisis, the plan recommended reminding the Youth to practice anger reducing techniques learned in *Anger Replacement Therapy*. The plan also suggested encouraging the Youth to practice meditation techniques. Further, when the Youth was highly agitated, prior to giving directives, the plan recommended allowing the Youth a cool down period, using a low calm voice and asking the Youth to explain his behavior. When possible, the plan also recommended allowing the Youth ample time to process information. If available, the plan suggested requesting that the Licensed Psychiatric Technician provide *Crisis Intervention*. Before implementing any high level of force, the plan recommended using clear and easily understood dialogue.

Custody Response

Youth A asked Youth Correctional Counselor One why he had been “booked.” Counselor One explained that he had searched all the rooms on the hallway and that Youth A had been “booked” for having graffiti on his door and gang writings in his room. Counselor One then directed Youth A to continue to his room. In response, the Youth uttered profanities at Counselor One. At this time, Youth B attempted to peer counsel the Youth in crisis but Counselor One directed Youth B into the dayroom. However, Youth B refused to follow instructions. At this time, Counselor One, along with a second Counselor, escorted Youth A to his room. Youth A then turned around and approached Counselor One in an aggressive manner with closed fists. Counselor One who was about six feet away then issued clear instructions for Youth A to stand by his door or chemical agents would be used. Youth A continued to approach Counselor One with closed fists. In response, Counselor One dispersed chemical agents to the facial area of Youth A. Counselor Two then opened the room door, placed his hand on the back of Youth A and guided him into his room. Counselor Two then closed and secured the room door. Youth B who was in the hallway received overspray from the chemical agents. Two Youth Correctional Officers escorted Youth A and Youth B to the *Outpatient Housing Unit*. Both Youth were seen by a nurse. In the *Nursing Report* the face of Youth A was described as red; eyes as teary and closed. In the *Nursing Report* Youth B was described with eyes clear and dry.

Use of Force Review Project

XI. Staffing

Observation One: Shifting Staff Members

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

Youth Experience

According to the *Patient's Description of the Occurrence and Injury* in the *Nursing Report* for Youth A,

"YCC [Insert Name] was coming up at me. I flinched at him; and he maced me. He's lucky that he is staff. I am not hurt. I have no pain."

According to the *Patient's Description of the Occurrence and Injury* in the *Nursing Report* for Youth B,

"I was in the hallway when [Insert Name] got sprayed; I felt like I took in a lot of fumes. I feel better now; I don't want to be seen."

COMMENTS

Rapport

Youth A felt threatened and on the defensive throughout the incident. Youth A was not given a chance to express his feelings about being "booked." Youth A was denied the support of his peer. By being escorted to his room, Youth A experienced what may have felt like disrespect or a personal attack. Being denied expression of his feelings and the support of his peer, along with feeling disrespected by the escort are three times when a staff member who had rapport with Youth A might have intervened differently to de-escalate the incident. For example, a staff member who had rapport with Youth A might have predicted that he would feel upset about being "booked." An alternative way of responding might have been to validate the feelings of Youth A and to encourage the use of previously identified coping skills. Rapport, however, requires consistent contact, a condition that is impossible to meet with rotating staff members.

Crisis Prevention Support Plan

Although not in place at the time of the incident, entries in the *Crisis Prevention Support Plan* began just one month later and indicated some familiarity with Youth B. If the plan had been in place prior to the incident, the staff members could have accessed communication strategies that might have facilitated a more positive outcome. At the time of the incident, if rapport had been established based upon past shared experience, staff members might have been able to intervene with Youth B using strategies similar to those later identified in the plan. Clearly, if the communication strategies used during the incident had been more effective in convincing Youth B to move to the dayroom, the overspray from the chemical agents could have been avoided. Consistent interaction with familiar staff members is essential for establishing rapport, especially with Youth who have special needs.

Use of Force Review Project

XI. Staffing

Observation One: Shifting Staff Members

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

COMMENTS [Continued]

Mental Health and Custody Collaboration

A Mental Health Clinician was not involved before, during or following the incident. A Mental Health Clinician could have provided direct intervention and/or coached the custody staff members intervening with the Youth. Adjusting interventions and using alternatives to chemical agents to accommodate individual needs requires familiarity with the Youth which is accomplished via rapport. Routinely adjusting interventions to accommodate Youth with special needs can be supported through the active involvement of Mental Health Clinicians. When Mental Health Clinicians are viewed as strong, effective partners, their active involvement in force incidents is more likely. Effective collaborations are diminished when rotation of staff members interferes with building strong partnerships.

Chemical Agents and Psychotropic Medication

Both Youth A and Youth B had a *Mental Health Designation* and an identified disability, yet neither was recognized as such; during the incident it does not appear that interventions were adjusted to accommodate the individual needs of Youth A or Youth B. For example, both Youth were prescribed psychotropic medication but both Youth were also the recipients of chemical agents. Per the *Crisis Prevention and Management Policy*, chemical agents are to be used at a minimum on Youth with a *Mental Health Designation*. Adjusting interventions to accommodate individual needs is achieved more easily when staff members have consistent contact with the Youth and opportunities to build rapport; a condition that is impossible to meet with staff members rotating and changing assignments.

Use of Force Review Project

XI. Staffing

Observation One: Shifting Staff Members

11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.

Policy, Practice and Training Recommendations

1. Eliminate the shift and bid process at each facility.
2. Maintain stable and consistent staffing on every living unit at each facility.

Use of Force Review Project

XI. Staffing

Observation Two: Mental Health Coverage

11.2 Mental Health Clinicians were not available to act as equal partners with custody staff when intervening in conflicts or force incidents during all shifts, including weekends and holidays.

Authority

According to the Crisis Prevention and Management Policy:

Prevention techniques should be used prior, during, and after the point in which force measures become necessary. All prevention and de-escalation measures, such as the use of Conflict Resolution Teams, Psychologists, Teachers, Interns, Clergy, Nurses, Recreation Therapists, ADA Coordinators, and other staff should be considered and utilized when possible and practical. Reasonable efforts to de-escalate and prevent force should be made.

Prevention strategies include, but are not limited to...Follow-up or Debriefing Strategies: The following strategies, when used correctly, can assist staff in reducing the re-occurrence of a crisis situation. Staff should consider using the strategies listed below following a crisis situation...Communication with the Youth's Treatment Team...

In a controlled use of force situation, if the time needed does not create an additional safety and security issue or significantly interfere with the operations of the facility, Correctional Peace Officers shall consult with a licensed Health Care / Mental Health Professional regarding the mental and physical impairments of a Youth with disabilities prior to using force.

Principles of Mental Health Assessment and Treatment Policy [In Process]

According to the Agreement Between State of California and American Federation of State, County, and Municipal Employees Covering Bargaining Unit 19 (Health and Social Services/Professional):

FLSA-exempt employees are expected to work the hours necessary to accomplish their assignments or fulfill their responsibilities. Their work load will normally average forty (40) hours per week over a twelve (12) month period. However, inherent in their job is the responsibility and expectation that work weeks of longer duration may be necessary.

Management can require FLSA-exempt employees to work specified hours. However, subject to prior notification and approval, FLSA-exempt employees have the flexibility to alter their daily and weekly work schedules.

Use of Force Review Project

XI. Staffing

Observation Two: Mental Health Coverage

11.2 Mental Health Clinicians were not available to act as equal partners with custody staff when intervening in conflicts or force incidents during all shifts, including weekends and holidays.

Quantitative Analysis

1. In the sample of 245 cases, 177 or 72% involved at least one (1) Youth with a *Mental Health Designation*.
2. Out of those 177 cases identified above, 96 or 54% involved at least one (1) Youth residing on a *Mental Health Living Unit*, while 81 or 46% involved Youth who did not reside on a *Mental Health Living Unit*.
3. In the total sample of 245 cases, 118 or 48% involved incidents that occurred outside of the typical working hours for Mental Health Clinicians which are Monday through Friday, 0800 to 1800.

Qualitative Analysis

1. In the sample of 100 qualitatively reviewed cases, the evidence for involvement of Mental Health Clinicians in force incidents was limited to 6 or 6%.
2. In the sample of 100 qualitatively reviewed cases, 76 or 76% involved at least one (1) Youth with a *Mental Health Designation*.
3. During the review period of March 2009 through May 2010, one (1) Youth with a *Mental Health Designation* and an identified disability requiring accommodations was involved in 40 different force incidents.

Case Snapshot

The following case snapshot describes an incident in which Mental Health Clinicians and Correctional Peace Officers did not partner effectively to de-escalate and manage a non-compliant Youth.

[Additional case examples included: 32, 42, 62, 70, 86 and 88.]

Use of Force Review Project

XI. Staffing

Observation Two: Mental Health Coverage

11.2 Mental Health Clinicians were not available to act as equal partners with custody staff when intervening in conflicts or force incidents during all shifts, including weekends and holidays.

Case 8

A male Youth, 16 years of age, who resided at *N.A. Chaderjian*, on the *Sacramento Living Unit*, refused to uncover his room window. Chemical agents were used to gain compliance with a lawful order and to effect custody.

Mental Health and Disability Status

At the time of the incident, the Youth had a *Mental Health Designation* and was on *Suicide Risk Reduction* status. In addition, the Youth had an identified disability; accommodations cited on the *Youth with Disabilities List* included access to a *Staff Assistant* as well as allowing extra time for the completion of tasks, use of simplified concise language and allowing time to formulate responses. In school, accommodations included discussing and simplifying new vocabulary, allowing use of an electronic speller or dictionary and a calculator. The evidence suggested that during the incident, interventions were not adjusted to accommodate the individual needs of the Youth in crisis.

Crisis Prevention Support Plan

At the time of the incident, the Youth did not have a *Crisis Prevention Support Plan*. However, subsequently, a *Crisis Prevention Support Plan* was developed; entries in the plan begin on July 14, 2009. According to the plan, the Youth had a history of assaultive behavior toward others and tended to become argumentative and disregard instruction when in crisis. Effective strategies for staff members attempting to prevent and de-escalate crises included accessing staff members with whom the Youth had good rapport, validating his feelings, actively listening, minimizing external stimuli, reinforcing progress in his program, providing one-on-one counseling that identified behavior patterns, refocusing the Youth on his goals and overall well-being, providing a temporary timeout in his room and allowing the Youth to call his Godfather. It was also noted that attending to verbal cues, such as when the Youth requested to be alone and letting staff members know when he was ready to talk, could be beneficial. Finally, it was noted that the Youth would resist physical force, especially if used prior to chemical agents.

Time and Day of the Incident

The incident occurred on a Sunday at 2140 hours, outside of the typical working hours for Mental Health Clinicians.

Custody Response

*Two Youth were covering their room windows and not allowing a proper visual. The responding Officers attempted dialogue to get the Youth to uncover their windows. Through the tray slot, both Youth were observed to have t-shirts tied around their heads with blankets covering their heads and bodies. When the Youth did not comply with instructions to uncover the windows, the Lieutenant placed the safety chain around both door handles. Dialogue continued to be ineffective in getting the Youth to uncover the windows.

**This Case Snapshot is focused on one of the two Youth.*

Use of Force Review Project

XI. Staffing

Observation Two: Mental Health Coverage

11.2 Mental Health Clinicians were not available to act as equal partners with custody staff when intervening in conflicts or force incidents during all shifts, including weekends and holidays.

Custody Response [Continued]

Youth Correctional Officer One then reached through the tray slot and attempted to clear off the window in one of the rooms. At the same time, the Youth inside kicked the door barely missing the arm of Officer. The Youth then used his blanket to again cover the window. After a struggle with the Youth, Officer One was able to grab and remove the blanket from the room. The Youth then began kicking the door and tray slot area. The Youth also grabbed another blanket and covered himself from head to toe.

At this point, the Lieutenant informed the Youth to stay away from the door so the window could be cleared. Youth Correctional Officer Two then issued a verbal command for the Youth to stay away from the door or chemical agents would be used. The Lieutenant then opened the room door. Youth Correctional Officer Three then reached into the room to remove the window covering. At the same time as he reached into uncover the window, the Youth ran at the door attempting to strike or grab the arm of Officer Three. In response, Officer Two dispersed chemical agents.

For a moment the Youth backed away from the door. Officer One took this opportunity to again attempt to remove the window covering. In response, the Youth again ran at the door and the arm of Officer One. In response, Officer Two deployed a second burst of chemical agents. The window was then successfully cleared; and the Youth lay on the floor in a prone position stating, "I'm done, I'm done."

Mental Health Response

No Mental Health Clinician was involved before, during or following the incident. During the incident both Youth stated, "Mace us, we want to be maced." In addition, the Youth stated, "spray us, we are not going out, you're gunna have to come get us." After the incident, the Youth experienced a calming effect from the chemical agents having been dispersed. Possibly, if a Mental Health Clinician had been available and partnered effectively with the responding Officers, the use of chemical agents could have been avoided. Undoubtedly, there were power and control dynamics underlying the interactions between the Youth and the Officers. A Mental Health Clinician could have pointed this out and coached the Officers on ways to intervene that did not involve chemical agents, which were clearly reinforcing to the Youth. Additionally, after the chemical agents were dispersed, a Mental Health Clinician could have elucidated the soothing effect the chemical agents had on the Youth and assisted in identifying better ways to intervene in the future. Surely, there were more appropriate ways for the Youth to relieve anxiety and achieve a calmer state of mind than winning a power struggle and being sprayed with chemicals; many of which were imbedded within the accommodations identified for the Youth and or contained in the *Crisis Prevention Support Plan*.

Use of Force Review Project

XI. Staffing

Observation Two: Mental Health Coverage

11.2 Mental Health Clinicians were not available to act as equal partners with custody staff when intervening in conflicts or force incidents during all shifts, including weekends and holidays.

Policy, Practice and Training Recommendations

1. Require that the primary work location for a Mental Health Clinician be on a living unit at a facility.
2. Require that at least one Mental Health Clinician be at the facility during the hours of 0600 through 2200 on weekdays, weekends and holidays.
3. Require that any Mental Health Clinician involved with an incident that commences but does not end prior to 2200 hours, sees the intervention through completion via working late and/or transitioning care to another Mental Health Clinician.
4. Require that a Mental Health Clinician be on-call and available over the telephone and in person during the hours of 2200 through 0600 on weekdays, weekends and holidays.



May 5, 2011

Nancy Campbell,
Office of the Special Master, *Farrell v. Cate*
56 East Road
Tacoma, WA 98406, CA 90002

Dear Ms. Campbell:

The Division of Juvenile Justice (DJJ) recently released a Use of Force Subcommittee Report dated March 17, 2011. DJJ convened a multi-disciplinary committee and subcommittee to review use of force incidents within DJJ. At the request of the Office of the Special Master in *Farrell v. Cate*, the Office of the Inspector General (OIG) provided technical support and served in the traditional capacity of an oversight agency.

Along those lines, a Special Assistant Inspector General (SAIG) from the OIG's Bureau of Independent Review (BIR) monitored the processes and case reviews conducted by the DJJ subject experts for objectivity, fairness, and thoroughness. The SAIG reviewed the cases and engaged in the discussions with the DJJ experts, but it was done in the BIR's traditional role as a monitor not as a workgroup member. The case reviews conducted by the DJJ experts appeared thorough, critical, and objective. The experts' discussions regarding the use of force incidents were robust and candid.

The OIG did not review the report to validate the observations or comments, nor to offer an opinion as to whether any particular recommendation constitutes the best policy or practice for DJJ. We can, however, verify that the observations, comments and opinions contained in the report appear to accurately reflect the observations, comments and opinions expressed by the experts during the review process.

Sincerely,

A handwritten signature in cursive script that reads "Bruce A. Monfross".

for BRUCE A. MONFROSS
Inspector General (A)

Nancy Campbell, Office of the Special Master, *Farrell v. Cate*

Re: Division of Juvenile Justice (DJJ) 2011 Use of Force Subcommittee Report

May 5, 2011

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cc: John Chen, Office of the Special Master *Farrell v. Cate*
Rachel Rios, Chief Deputy Secretary (A), Division of Juvenile Justice,
California Department of Corrections and Rehabilitation,
Michael Brady, Assistant Secretary (A), Division of Juvenile Justice,
California Department of Corrections and Rehabilitation,
Don Specter, Prison Law Office
Barry Krisberg, Court Expert *Farrell v. Cate*
Logan Hopper, Court Expert *Farrell v. Cate*
William Kwong, Deputy Attorney General, Office of the Attorney General
Van Kamberian, Deputy Attorney General, Office of the Attorney General
Julie Bole, Staff Counsel,
California Department of Corrections Office of Legal Affairs

Use of Force in DJJ and Mental Health Youth

Supplemental Report by Barry Krisberg and Logan Hopper

Introduction / Summary

This report is intended to be a supplement to the original report with the same title, dated April 26, 2010, prepared by a panel of Court Experts consisting of Barry Krisberg, Terry Lee, Eric Trupin, and Logan Hopper (a copy of which is attached to this report). The original report examined to what extent there were problems prevalent at that time in the use of force on youth on the mental health caseload within DJJ, and it provided recommendations on actions deemed appropriate to begin to address the problems that were identified. This report followed a similar report in 2009 written by Barry Krisberg about the unnecessary use of force with girls at Ventura; a DJJ task force found that his findings were correct and suggested that these problems might go on in other DJJ facilities. After submission of the Experts' report to the OSM and the parties in June, 2010, it was agreed by the parties that DJJ would undertake a study to examine the same issues raised in the original Expert's Report. The two remaining Court Experts served as advisors to the subcommittee charged with undertaking the examinations and the drafting of DJJ's report, although we were not a member of that subcommittee. DJJ's final report was released on April 17, 2011. We have reviewed DJJ's final report in detail, and are submitting this supplemental report to the OSM and the parties to respond formally and to give our opinions regarding the adequacy and likely overall effectiveness of the report in managing the findings and issues raised.

At the outset, we would like to commend the five members of the subcommittee (also called the *ad hoc* work group in the report) for their exceptional efforts in undertaking a detailed review of the extensive data and in analyzing the issues at hand. Nevertheless, despite their outstanding efforts, we cannot fully endorse the report committee's as it is currently written, and feel that additional actions requiring more extensive changes and proactive policies than those recommended in the report need to be implemented immediately to counteract the ongoing trend of excessive use of force, both upon youth with mental health conditions and other disabilities and upon the general youth population.

The subcommittee summarized numerous "observations" related to departmental policies and/or usual practices leading to excessive use of force, and we concur with those observations and feel that the subcommittee did an excellent job in describing current conditions. It is clear that the subcommittee analyzed the available data effectively and arrived at the appropriate findings regarding what was occurring with respect to use of force. It should be noted that their findings almost completely coincide with the conclusions reached by the Court Experts in our original report, with the most telling findings being (1) that a youth with a mental health disability is over twice as likely to be subjected to excessive use of force than a non-disabled youth (this statistic should actually be the reverse), and (2) that almost 80% of all use of force incidents involve a youth with a mental health or other disability.

The subcommittee also proposed over 90 separate recommendations for remedial actions and/or changes in policy, intended to bring about improvements in excessive or ineffective use of force.

The vast majority of their recommendations are extremely thoughtful, innovative, and potentially productive. However, when we evaluate specific recommended actions, it is these recommendations that do not allow us to endorse DJJ's Use of Force Committee's Report in its entirety. In particular, the report is deficient in the following major issues: (1) recommendations to curb the excessive and oppressive use of chemical agents as a daily management tool for "controlling" youth, (2) inadequacies of the current policy and descriptions of "immediate" vs. "controlled" use of force and security personnel's propensity for misjudging the "immediacy" of many common management situations, and (3) the inability of all facility staff to effectively interact with youth with mental health disabilities and to understand the underlying bases for these youth's behavior. This supplemental report is intended to focus on the lack of recommendations in these areas and to supplement more effective recommendations for immediate action.

Process

As stated above, we commend the subcommittee members for their excellent work, particularly the organizing efforts of John Chen, Deputy Special Master, who was largely responsible for project management and scheduling. With that being said, we must also state that the overall process took too long. When we were approached in June, 2010, with the idea of DJJ following up our Expert Report with its own internal study and report, we were assured that the study would take about two months, not almost the full year that has transpired. There were many reasons for the delays, many of which were certainly not the fault of the subcommittee, who met almost daily to review the data. For example, many UOF reports from facilities were not provided, with SYCRCC being unable to locate numerous applicable reports, a fact that the DJJ report does not fully describe or attribute to being a major problem. Our perspective was that the current report was to be largely a "qualitative" analysis by very experienced DJJ staff, and that is the way the subcommittee (correctly) went about their tasks.

Nevertheless, it is not the intent of the above comments to interject negativity or place any blame on the process, and again, in general, the process yielded suitable results in terms of observations and many recommendations. Our major reason for discussing the process in this report is to point out that a long period has transpired since our original findings and recommendations, and that further delays in taking decisive actions are unacceptable. In our opinion, some of the time frames suggested for implementation are too long; there is no need for further study, as that was supposed to be the work of this committee.

Positive Subcommittee Recommendations

Before we propose additional recommendations on some of the major issues, we again want to acknowledge that the subcommittee's report contains many positive and productive aspects that we wholeheartedly endorse. Some of these issues include the following:

1. The Crisis Prevention Support Plan (Section I, Observation 1.1) recommendations will greatly improve individualized approaches to reducing use of force on the most problematic and/or troubled youth, and we endorse these recommendations. Since it is recommended that these be completed within 30 days for mental health and disabled youth, we would hope that these are in the process of being developed at the present time.
2. The discussions and recommendations (Sections I, Observations 1.2, 3.1, & 3.4) to improve living unit staff's and security personnel's recognition of antecedents and

proximate events are well thought out, and close scrutiny of these recommendations will greatly help staff to reverse current tendencies of neglecting to consider root causes of violence and use of force. These recommendations are even more crucial for dealing with the high percentage of mental health and disabled youth involved in these instances.

3. The discussions regarding improving the role of mental health clinicians (Sections II & XI, Observations 2.1 and 11.2) are necessary components of a successful program, and we endorse these recommendations. However, during full committee meetings, it appeared that those involved with mental health programs were less enthusiastic about these proposals than subcommittee members, and the ability to adequately identify youth with mental health issues and to properly place these youth into mental health units was called into question. We would hope that such misgivings would not supersede the immediate implementation of the recommended best practices related to mental health clinicians' involvement in potential use of force incidents.
4. Observations and recommendations (Section V, Observation 5.1) regarding improving health care services related to use of force appear to be proactive and effective (although it is unknown if these have been reviewed by the Health Care Experts).

Major Concerns Regarding Subcommittee Recommendations

As stated above, we cannot endorse the final Committee report, mainly because of unresolved and inadequate recommended actions on the following topics:

Prohibition / Reduction of the Use of Chemical Restraints

This topic remains our primary concern, because of the following issues:

1. We are certainly in agreement with what appears to be the subcommittee's intent to prohibit the use of chemical agents on youths involved in single-youth incidents (or incidents where a single youth can be effectively isolated from other youth in multiple-youth incidents, although that intent is not specifically listed in the report). This was indeed a major component of our original report from over a year ago. However, the report's wording seems evasive when it states "Within 30 days, *issue an official statement* (emphasis added) that chemical agents shall not be utilized in situations involving a single non-compliant youth. Also, it is unclear why a statement such as "Within 30 days, require that the Director of Juvenile Facilities conduct a special review and report to the Chief Deputy Secretary any deviation from policy regarding a single noncompliant Youth, with consideration given to those rare incidents involving serious assault on a staff member, use of a deadly weapon and escape" is included. This appears to counteract the concept that chemical agents must not be used, period. The qualitative reviews showed that staff do not effectively make such a determination. Also, the recommendation "Within 30 days, issue an official statement that when intervening with a Youth with a *Mental Health Designation* or an identified disability, chemical agents should not be used as a daily management tool; provide training and coaching" is very weak, and does not provide definitive guidance. We feel that the prohibition on chemical agents on single youth, without any qualifications, must be implemented immediately, and if necessary, by departmental order from the Secretary, Chief Deputy Secretary, or by judicial review.

2. It should be noted that when the subcommittee recommended: “Within 6 months, conduct a pilot project that removes the use of chemical agents on a mental health unit”, this was only a compromise solution that was discussed during our advisory discussions with the subcommittee. It is still our feeling that the use of chemical agents should be completely removed from all mental health units, per the recommendation in our original report.
3. In our original report’s recommendations, we admittedly struggled over DJJ’s overuse and reliance on chemical agents overall, including during multi-youth incidents. We stopped short of recommending an outright prohibition in all cases, and rather recommended further study and definitive clarifications by DJJ on such usage. While we understand the complexities, we are nevertheless disappointed that the Committee report gives little if any detail or guidance on this topic, and one would assume that the subcommittee’s finding that “chemical agents (are) used as a daily management tool”, basically the first option in all potentially volatile situations, will continue. This is unacceptable, and clarifications are needed.
4. Qualitative reviews of the use of chemical agents on females at Ventura, in all cases and whatever the circumstances, clearly showed that such agents are unnecessary and are of little realistic value. We would again recommend elimination of all chemical agents on females housed within DJJ.

Mechanical Restraints

While not as problematic as chemical restraints, the subcommittee’s recommendations give little assistance in clarifying how mechanical restraints are to be used in the future. Prominent issues include:

1. The subcommittee’s recommendations state: “Within 30 days, in an effort to reduce the use of chemical agents, when physical force is a viable force option, encourage the use of physical strengths and holds”. Yet there is no guidance on what type, when, or how these are to be implemented, or how these practices should be modified with respect to mental health or disabled youth (as required by both remedial plans). This needs further study and clarification.
2. The subcommittee’s recommendations state: “Within 6 months, implement an evidence-based policy on management of transitions, transfers and movements, including special provisions for a Youth with a Mental Health Designation or an identified disability”. The subcommittee’s findings documented numerous examples of excessive force in this area, yet the report recommends no specific policies to counteract these practices. For example, the LH lawsuit settlement was very clear when mechanical restraints could be used in bringing youth into hearings; the same type of detailed procedures are needed throughout the system.

Immediate vs. Controlled Force Definitions

In our opinion, this issue serves as the root cause for the majority of excessive use of force incidents. The subcommittee’s qualitative reviews documented numerous circumstances where security staff overreacted to verbal taunts or non-compliant behavior by considering such predictable (though unacceptable) behavior as “immediate”. Part of the reason for this is that policy concerning “controlled” force (for the two or three times it was used during the last year solely for cell extractions) is too convoluted. The subcommittee recommended: “Within 6

months, amend Crisis Prevention and Management Policy to reflect a continuum of interventions. Ensure the amended policy contains an array of interventions; include “Immediate Force” as the most restrictive intervention and other methods, such as time out, loss of privileges, time in safety area or zone as well as “Controlled Force”, as other viable options”. While these statements are all supportable, they do not go far enough to control current tendencies for security staff to feel that “immediate” threats are commonplace, and overact accordingly (including using chemical agents on youth on psychotropic prescriptions, a practice disallowed by the Mental Health Remedial Plan). We would recommend that the entire system of “immediate” force be suspended until appropriate safeguards can be effectively implemented.

Force Reduction Committee / Departmental Force Reduction Committee Practices

The subcommittee did a commendable job in describing problems with these committees’ activities, and Mike Gennaco’s report also evaluated the problems effectively and gave a number of appropriate suggestions. However, we still do not feel that the recommendations from those two reports go far enough to make the review process effective enough to stem the tide of excessive use of force, and therefore, we cannot fully endorse these recommendations. Many of the recommendations relate more to format, procedure, and administrative functions rather than substance. The reality is that other DJJ staff are too hesitant to criticize the actions of facility and security staff’s inappropriate and non-compliant actions, except in the most egregious circumstances, and in the majority of these cases, lower level staff are cited, as opposed to senior level staff who also had (or should have had) control of the situation. While we do not support punitive actions against staff, we feel an objective discourse is necessary to effect change. Detailed recommendations regarding FRC / DFRC activities were beyond the scope of our original report, but we will be glad to provide additional review and recommendations if requested.

The Role of DJJ Leadership

The current report does not fully address the need for top DJJ managers, especially those who are primarily responsible for the care of mentally ill and disabled youth, to state unequivocally the need to reduce the use UOF with these youth. At best, DJJ staff are getting ambiguous messages from top managers. There remains the false assumption that the main problem is “bad behavior” by youth, not the inappropriate response of staff to youth conduct. While it is true that the dramatic decline in the DJJ population has contributed to a drop in the UOF incidents, there remains a major concern of UOF with mentally ill and disabled youth. There has been a focus among DJJ managers to justify the use of force and to argue that almost every UOF event follows DJJ policies. What is needed is a clear commitment to further reduce the UOF with the most troubled and vulnerable youth.

Report Respectfully Submitted,

Dr. Barry Krisberg, Farrell Safety & Welfare Expert

Logan Hopper, Farrell Disabilities Expert