U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

October 31, 2008

Ms. Yvonne B. Burke, Chairperson
Los Angeles County Board of Supervisors
500 West Temple Street, Suite 856
Los Angeles, CA 90012

Re: Investigation of the Los Angeles County Probation Camps

Dear Ms. Burke:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Los Angeles County Probation Camps ("the Camps"). On November 9, 2006, we notified you of our intent to conduct an investigation of the Camps pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). We informed you that our investigation of the Camps would focus on whether youth were adequately protected from harm. As we noted, both CRIPA and Section 14141 give the Department of Justice ("the Department") authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions.

Prior to the investigatory tours, the Department and Los Angeles County ("the County") agreed that the Department would tour a sample of the Camps, and that the Department's inspection of the sample would stand as representative of all of the Camps.[1] On January 22-26, February 5-8, and March 5-8, 2007, we conducted on-site inspections of Camp Vernon Kilpatrick ("Camp Kilpatrick"), Camp Joseph Scott ("Camp Scott"), and Camp Karl Holton ("Camp Holton"), as well as five of the camps at the Challenger Memorial Youth Center ("Challenger" or "the Challenger Camps"). We toured with expert consultants in juvenile justice

[1] The Los Angeles County Probation Camps include 19 juvenile justice facilities. The Department toured eight of them.

administration and, at the Challenger Camps, an expert consultant in mental health. Before, during, and after our visit, we reviewed an extensive number of documents including, but not limited to, policies and procedures, incident reports, housing logs, and orientation materials. However, the County refused to provide us access to all child abuse investigations and to some medical records and logs.[2] Additionally, in conducting our on-site investigations, we interviewed administrators, professionals, staff, and youth. We observed the youth in a variety of settings, including on their living units, while dining, in classrooms, and during recreation.

Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we conducted exit conferences at each facility we visited upon the conclusion of the tour, during which our expert consultants conveyed their initial impressions and concerns.

Under the leadership of Robert Taylor, Chief Probation Officer of the Los Angeles County Probation Department ("Probation Department"), the County has unequivocally indicated its clear desire to improve the facilities. We commend the Probation Department staff for their helpful, courteous, and professional conduct throughout the course of this investigation. We hope to continue to work with the County and facility staff in the same cooperative manner going forward.

Consistent with our statutory obligation under CRIPA, we set forth below the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described below, we conclude that youth confined at the Los Angeles Juvenile Camps suffer harm or the risk of harm from constitutional deficiencies, specifically in the areas of protection from harm and mental health care. Notwithstanding the

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[2] By law, our investigation must proceed regardless of whether County officials choose to cooperate fully. Indeed, when CRIPA was enacted, lawmakers considered the possibility that State and local officials might not cooperate in our federal investigations. See H.R. Conf. Rep. 96-897, at 12 (1980), reprinted in 1980 U.S.S.C.A.N. 832, 836. As we informed the County's attorney, the County's decision to deny us access to these records permits us to draw negative inferences about their contents. We have drawn negative inferences with respect to the adequacy of abuse investigations and the adequacy of the discipline for staff who violate the rights of youth.

foregoing, we are pleased that the County informed us of some preliminary steps it intends to take to remedy deficiencies we reported during our exit conferences.

I. BACKGROUND

A. Description of the Facilities

The Los Angeles County Probation Department operates 19 detention camps. Approximately 2,200 post-adjudicated youth are housed in the Camps, which provide an intermediate sanction between community supervision and detention in the secure facilities operated by the California Department of Corrections and Rehabilitation, Division of Juvenile Justice. The Probation Department also operates the Los Angeles County Juvenile Halls ("Juvenile Halls"), which house approximately 1,500 to 1,800 youth who generally range in age from 11 to 19 and are awaiting adjudication.[3] Many youth from the Halls are transferred to the Camps following adjudication.

1. THE CHALLENGER CAMPS

The Challenger Camps are six separate camps located on 44 acres in the town of Lancaster in Los Angeles County's Antelope Valley. In January 2007, one of the six camps, Camp Onizuka, which housed girls, was closed. The remaining five camps - Jarvis, McNair, Resnick, Scobee and Smith - have the capacity to house 110 youth each.

Each camp is a large, concrete, single-story facility, configured in a semi-circle, divided in half by a continuous line of classrooms. The classrooms divide the facility into two identical halves, each with a large grass field area in its center. There are three camps on each side of the facility's divide. Although all youth in each camp move to school and to outdoor recreation together, programming and meals are conducted separately in the dayrooms of each side of each camp.

Youth housed at the Challenger Camps tend to include those with histories of violence and/or escape. All youth with medical and mental health needs are housed in the Challenger Camps. A significant percentage of the population is prescribed

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[3] On August 26, 2004, the Department, Los Angeles County, and the Los Angeles County Office of Education entered into an agreement to resolve the Department's investigation regarding conditions of confinement at the Juvenile Halls.

psychotropic medication. Youth housed at the Challenger Camps range in age from 14 to 18 and most are fulfilling commitments of three, six, or nine months.

There is also a 60-bed disciplinary unit called a Special Housing Unit ("SHU") that operates as a separate program at the Challenger Camps. The SHU also serves as a local detention facility for up to 10 youth arrested by police in the community immediately surrounding the Challenger Camps.

2. CAMP SCOTT

Camp Scott is a secure facility for girls located in the rural Santa Clarita community of Los Angeles County. Camp Scott is configured as a semi-circle of single story buildings. Camp Scott has a rated capacity of 125 youth, although the population on the first day of our visit was 79 youth. The girls, who range in age from 12 to 18, sleep in a single dorm designed to house up to 113 youth. Girls are generally committed to Camp Scott for periods of three, six, or nine months. The newest building on the campus is an Assessment Center (which also functions as a disciplinary housing unit), with a capacity of 12 youth housed in single cells. All of the camp's buildings open onto the main grass field and recreation area. Girls are able to walk the short distances from their dorm to the school, culinary unit, administration building, assessment center, and other buildings on the campus.

3. CAMP HOLTON

Camp Holton is located in the rural Sylmar community of Los Angeles County. This secure, all male facility is constructed largely of cinderblock with a single dorm used as living quarters for all youth. Although the facility can house up to 119 youth, 77 were assigned to the facility on the first day of our tour. Youth are typically committed to the camp for three, six, or nine months, with an average length of stay reported to be approximately 90 days. The single dorm is divided into four sections, each with approximately 25 bunks. The sections are separated by a low, cinderblock wall running down the center of the dorm with a control center located in the middle of the dorm. Youth ages 13 and under tend to be housed in one quadrant of the dorm while honors youth occupy another and general population youth occupy the remaining two quadrants.[4] The various buildings

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[4] At the time of our visit, it appears that the youngest youth housed in the camps we toured was 12 years old.

that make up the facility - - the school, administrative area, culinary unit, Special Housing Unit and a gym - - are arranged in a fully enclosed, semi-circle around a large, open area with basketball courts, a track, and a grass field for recreation. Youth walk the relatively short distances from building to building.

4. CAMP KILPATRICK

Camp Kilpatrick is a secure facility for boys built in 1964 in the hills of Los Angeles County's Malibu community. The facility is unique among the Camps because of its focus on sports; Kilpatrick is a certified high school and its sports teams compete with area high schools in football, basketball, baseball, and soccer, at both the junior varsity and varsity levels. Built mostly of cinderblock, the facility is in a general state of physical and cosmetic disrepair. For example, the gymnasium was rendered structurally unsound after an earthquake in 1994 and has not been usable since.

Kilpatrick is configured in a fully enclosed, semi-circular fashion around a large dirt field and basketball courts. The facility's rated capacity is 112 youth, although only 91 were assigned on the first day of our tour. The youth ranged in age from 13 to 18 years old. Youth are assigned to one of two identical dorms, based largely on programming preferences. Each dorm houses approximately 45 youth in single bunks arranged in four rows with a control center in the middle of each dorm. The various buildings that make up the facility - - the school, culinary unit, administration building, and Special Housing Unit - - open on to the field and recreational space and each is within easy walking distance to the dorms. Youth at Kilpatrick are typically committed for periods of three, six, or nine months, with three-month commitments being the most common. Camp Kilpatrick is next to Camp Miller, with which it shares kitchen facilities and its Special Housing Unit, although the camps operate as two separate and distinct camp programs.

B. Legal Background

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional rights and the federal statutory rights of juveniles in juvenile justice facilities. 42 U.S.C. § 1997. Section 14141 of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, makes it unlawful for any governmental authority with responsibility for the incarceration of juveniles to engage in a pattern or practice of conduct that

deprives incarcerated juveniles of constitutional or federal statutory rights. Section 14141 grants the Attorney General authority to file a civil action to eliminate the pattern or practice.

The Due Process clause of the Fourteenth Amendment to the U.S. Constitution governs the standards for conditions of confinement of juvenile offenders who have not been convicted of a crime. Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987); Jones v. Blanas, 393 F.3d 918, 931 (9th Cir. 2004). Confinement of youth in conditions that amount to punishment, or in conditions that represent a substantial departure from generally accepted professional standards, violates the Due Process clause. Youngberg v. Romeo, 457 U.S. 307 (1982); Bell v. Wolfish, 441 U.S. 520 (1979); Alexander S. v. Boyd, 876 F. Supp. 773, 796-799 (D.S.C. 1995), aff'd in part and rev'd in part on other grounds, 113 F.3d 1373 (4th Cir. 1997). The Fourteenth Amendment prohibits imposing on incarcerated persons who have not been convicted of crimes conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. at 539-540.

The County has an obligation to assure the reasonable health, safety, and freedom from undue restraint of the youth in its custody. See Youngberg v. Romeo, 457 U.S. 307 (1982); Gary H. v. Hegstrom, 831 F.2d 1430 (9th Cir. 1987); Alexander S. v. Boyd, 876 F. Supp. at 786-7; Santana v. Collazo, 793 F.2d 41 (1st Cir. 1984); D.B. v. Tewksbury, 545 F. Supp. 896 (D. Or. 1982). Confined juveniles must receive adequate medical treatment, including adequate mental health treatment and suicide prevention measures. See Youngberg, 457 U.S. at 323-24 & n.30; Oregon Advocacy Ctr. v. Mink, 322 F.3d 1101, 1120 (9th Cir. 2003); Gibson v. County of Washoe, 290 F.3d 1175, 1187 (9th Cir. 2002); Carnell v. Grimm, 74 F.3d 977, 978-79 (9th Cir. 1996); Cabrales v. County of Los Angeles, 864 F.2d 1454 (9th Cir. 1988), vacated and remanded, 490 U.S. 1087 (1989), reinstated, 886 F.2d 235 (9th Cir. 1989); Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994); Gordon v. Kidd, 971 F.2d 1087, 1094 (4th Cir. 1992).

II. FINDINGS

Youth residing in Los Angeles County's Camps are not adequately protected from harm. Further, the County fails to provide adequate suicide prevention and mental health care to youth.

A. Failure to Protect Youth From Harm

Youth housed at the Camps are subjected to harm and risk of harm as a result of the following failures by the County: (1) failure to protect youth from harm by staff, including failure to protect youth from use of excessive force by staff, excessive and inappropriate use of Oleoresin Capsicum ("OC") spray, and staff misconduct at Camp Holton; (2) failure to protect youth from harm by other youth; (3) failure to provide adequate staffing; (4) failure to provide adequate staff training; (5) failure to adequately investigate allegations of abuse; (6) failure to provide an adequate classification system; and (7) failure to provide an adequate grievance process.

1. Failure to Protect Youth From Harm by Staff

a. Use of Excessive Force by Staff

Youth at the Camps have a right to be free from unnecessary restraint and the use of excessive force. Youngberg, 457 U.S. at 315-16. With the noteworthy exception of Camp Kilpatrick, our investigation uncovered systemic physical abuse of youth by staff. We found a disturbing consistency in the youth's accounts of the use of unnecessary physical restraint and excessive force by staff at the Camps. Most of the youth we interviewed reported staff abuse they had received themselves or had witnessed. Youth repeatedly corroborated each other's allegations in separate interviews, with no opportunity to discuss the allegations between interviews. In each instance, we attempted to track down whether the abuse had been reported (by reviewing the Suspected Child Abuse Report ("SCAR") forms we received from the County), or a grievance had been filed. Some allegations had been reported to or discovered by the County. Others, for various reasons, were reported to us in the first instance, suggesting both that youth lack trust in the County to report abuse and that the County systemically fails to detect abuse occurring at the Camps.

i. The Five Challenger Camps

At the Challenger Camps, many of the youth we interviewed reported several allegations of mistreatment at the hands of staff. Other youth witnesses corroborated the original youth's accounts of these events. In two instances that we describe below, staff knew about the incidents, yet did not take the required steps to report them to the Los Angeles Department of Children and Family Services ("DCFS") or initiate an

investigation. Generally, we found that staff did not understand their responsibilities as mandatory child abuse reporters or know what procedures to follow when receiving an allegation of abuse. As a result, the protections that would have been afforded by DCFS involvement were never accessed, and youth reported that they did not feel safe enough to voice their concerns about mistreatment directly to staff. Consider the following illustrative examples:

- B.P.[5] reported that a Camp McNair probation officer, while attempting to restrain L.N., slammed L.N. to the ground and dislocated the youth's shoulder. L.N. reported that the incident occurred in December 2006 in the dining hall after another youth threatened to spit in his food. He stated that he got mad and started fighting the youth. L.N. reported that staff ordered the youth to stop fighting and that L.N. complied by backing away from the other youth. Nevertheless, the officer grabbed him and slammed him to the floor on his shoulder.[6] (We observed a bone sticking out of L.N.'s shoulder. He told us that he was seen by camp medical staff and told that he would have to see a bone specialist).

- One youth described being given what he believed was a new jacket by a member of the staff, but learned later that the jacket actually belonged to another youth in the camp. The other youth demanded that his jacket be returned. The reporting youth refused. The two youth fought soon thereafter. The staff member who had given

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[5] The initials used to refer to youth are pseudonyms to protect their privacy. We will provide a key to the youth's real names to the County under separate cover.

[6] Youth reported that staff "slam" youth in the following manner: Youth are either slammed against the wall, or staff grab youth, lift them in the air, and forcibly take them to the ground. In some cases, officers land on top of youth, injuring both the youth and the officers involved in the process. As discussed below, staff at all of the Camps consistently reported to us that the Probation Department did not have a use of force continuum and that staff had received no additional training on use of force techniques after their initial new hire training. Abusive practices such as "slamming" are the predictable consequences of a systemic lack of adequate training on the use of force.

the jacket to the first youth intervened by physically taking one youth to the ground. The youth reported that, during this contact, he suffered a broken jaw. Facility administrators reported that although staff knew about this incident, they had not investigated the veracity of any complaints of excessive force or that the staff had purposefully instigated the incident. With our urging, the Probation Department's Special Investigations Unit ("SIU") was notified of this incident.

- V.T. reportedly observed staff physically restrain a youth in the dining hall because the youth continued to talk after being instructed to be quiet. After the restraint, V.T. reported that he observed the youth with a bloody mouth and a "knot" on his forehead.

- A.K. reported that two Camp Resnick probation officers allegedly punched, kicked, and sprayed a youth with OC while he was handcuffed.

Youth reported the following incidents at Camp Smith:

- L.O. alleged that he was grabbed, slammed, and dragged across the control center steps in Camp Smith because he refused to exercise with the dorm.

- Youth reported observing staff break a youth's jaw and beat him while restraining him (the youth purportedly suffered a broken jaw after staff allegedly "slammed" the youth to the ground).

- C.R. reported that he observed staff beat a youth who had assumed the "OC [Oleoresin Capsicum spray] position"[7] on the ground.

We received additional noteworthy reports of staff-on-youth assaults at Camp McNair, such as the following:

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[7] Staff order youth to assume the "OC position" as a means of gaining control of the youth, meaning that the youth must immediately lie down on the floor in the prone position with his eyes shut.

- N.T. alleged that in December 2006, a Camp McNair probation officer caught two youth "locking legs."[8] The officer "slammed them," sprayed them with OC, and kicked them.

- J.I. allegedly witnessed staff members using excessive force on V.T. J.I. observed that, following the use of force, V.T. had a bloody mouth and a big knot on his forehead.

- F.D. alleged that he was physically assaulted by staff for no reason. The youth is visibly physically disabled, and of short stature. He reported suffering from a bone weakening disease that causes his bones to be fragile and undeveloped. Staff allegedly dragged F.D. across the recreation field, causing severe injury to his knee. The County began an investigation of this incident after we brought it to the County's attention. The County preliminarily reported after our exit conference that F.D. was suspected of drug possession. The County agreed, however, that regardless of the youth's offense, the staff should have handled the incident differently.

The allegations described above had indicia of credibility and we did not receive any documents refuting these accounts. More generally, allegations like these, both founded and unfounded, are not uncommon in secure facilities such as the Camps. It is therefore essential, for the protection of the youth and the staff, that such allegations be promptly and properly reported, and thoroughly investigated. For this to occur, staff must understand their legal obligations in this regard and must know the formal steps required to properly report incidents of alleged child abuse.

ii. Camp Holton

We also uncovered abusive practices at Camp Holton. Youth reported that some staff verbally and physically mistreated youth when their drill performance fell below expectations. Youth

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[8] "Locking legs" is a discreet method of fighting where youth sit on the ground or on a bunk facing each other and interlock their legs at the knee so only a few inches separate them. They then begin to hit each other. The loser is determined, in part, by which youth first "unlocks" his or her legs and moves away.

revealed that some staff become agitated and impatient with youth when "facing movements" (a method of lining up youth in formation and moving them safely and efficiently from building to building) and when other required regimens are not carried out in a swift and organized manner.

Additionally, we uncovered a number of disturbing allegations of staff assault. These allegations include:

- One 15-year-old youth stated that staff kicked him twice in the ribs during his first week at Camp Holton. He explained that while he was in the dorm during shower time, staff allegedly directed him and others to line up. Because he did not line up quickly enough, staff allegedly directed him to come to the control center area. Upon arriving at the control area, which is a slightly elevated staff observation area surrounded by a wall standing approximately four feet in height, staff directed the youth to sit in a chair against the wall. This positioning made it difficult for other youth in the dorm or the video surveillance system to observe the youth. While seated, the youth reported that a staff member kicked him twice in the ribs and slapped him once on the back of his head with an open hand.

- Another youth reported that in February 2007, a staff member reportedly told him, "I can do whatever I want," and pushed him with both hands on the youth's chest, tackled him to the concrete floor, and twisted his arm and leg behind his back.

- K.Z. reported that in January 2007, after an argument with staff, staff bumped into the youth but claimed that the youth hit the staff. Using this as cause to restrain the youth, staff reportedly grabbed the youth's arm and foot, causing the youth to fall forward. Once on the ground, staff pushed the youth's head to the floor. Another youth corroborated this incident and stated that he heard the youth scream. The following day, the Director reported this incident to law enforcement; two days later, a deputy responded to the facility to interview the youth involved. We do not know the results of the investigation.

- D.B. reported that staff pushed him against a wall and put his arm behind his back in a painful hammer lock allegedly because he was moving too slowly. He

reported that staff then placed him on the floor and put their knees to his head and against his ribs. He suffered scratches on his leg and neck and swelling around his eye as a result of this incident. Another youth corroborated this story, stating that the alleged victim told him he had been beaten up by staff. Although a mental health professional completed a Suspected Child Abuse Report ("SCAR") about the alleged incident, the incident was not reported to DCFS or law enforcement at that time. The Camp Director filed a report with law enforcement four days later, on January 21, 2007, but law enforcement had yet to respond at the time of our initial tour.

- Another youth, whose arm was in a sling as a result of a fractured clavicle, reported that, in December 2006, two staff who had been escorting him had taken him forcefully to the ground.[9] He further reported that one of the officers drove his knee into the youth's shoulder and pulled the youth's arm up behind his back, causing considerable pain and aggravating the fracture. The youth reported that the officers then lifted him to his feet and slammed him into the wall twice. He complained about excessive pain to his injured arm but reported that medical staff did not see him until the following day. He reported the incident to his case manager, who had him complete an affidavit. A police report was filed, but staff from the SIU interviewed the youth. We do not know the results of the SIU's investigation.[10]

Additionally, youth reported that Holton staff order youth to go to the Command Center ("CC") and assume the "bob sled position" (meaning that youth are made to sit on the ground with their knees close to their chests and their arms interlocked around their knees). Youth reported that by "assuming the bob sled position" in the CC, "no one can see what is happening to you." One youth reported that staff also turn the lights off and kick the youth when they are forced to assume the bob sled position. The youth reported that this practice occurs as often

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[9] We believe that the youth's clavicle was broken prior to the incident, but we cannot confirm or deny this belief because we were denied access to the youth's medical files.

[10] As discussed later in the report, the County refused to provide us with any of their child abuse investigations.

as two to three times per week. S.C. reported that he had been forced to assume the bob sled position twice. P.S. reported that youth sit in the bob sled position out of camera range where "staff can slap and yell at you."

iii. Camp Scott

Youth at Camp Scott repeatedly reported that staff twist youth's arms behind their backs to control their behavior, and one staff person in particular was mentioned repeatedly as using inappropriate force by tackling youth, twisting their arms behind their backs, and slamming them to the ground.

Staff at Camp Scott also lack of knowledge of both the proper thresholds for reporting allegations of abuse and the authorities to whom to report such allegations. These inadequacies are clearly evident in the way in which recent allegations of staff abuse have been handled. Although supervisors and administrators took some action in most of the situations described later in this letter, their actions stopped far short of a formal report to the proper authority, and fell substantially below generally accepted professional standards.

iv. Camp Kilpatrick

We are very pleased to report that we did not uncover any reports of staff abuse at Camp Kilpatrick. Although staff training on the use of force is inadequate at all of the Camps, including Kilpatrick (as discussed below), youth interviews and documents consistently indicated that staff at Camp Kilpatrick exercise a continuum of non-physical interventions prior to using physical force. Moreover, although proper medical documentation was not available for review, the documents we did review indicated that staff intervention in altercations did not cause or exacerbate injuries to youth. Youth at Camp Kilpatrick also consistently reported that they could talk to staff about their problems or concerns without fear of retaliation.

b. Excessive and Inappropriate Use of OC Spray at Challenger

Probation officers throughout the Challenger Camps are using OC spray excessively. See <u>Alexander S. v. Boyd</u>, 876 F. Supp. at 786 (finding that the use of CS gas (a form of tear gas) in a juvenile justice facility for purposes other than the protection of staff or other juveniles, or where there is a threat of serious bodily harm, is unconstitutional). Probation Department policy on the use of chemical agents in the Camps appropriately

requires that such agents be used only as a last resort. The policy requires that staff follow a use of force continuum and attempt to de-escalate a situation before deploying OC spray. The Probation Department fails to comply with this policy.

For example, N.T. reported that a probation officer at Camp McNair (one of the Challenger Camps) slams youth into a prone position on the ground, sprays them with OC spray, and then kicks them. A number of youth similarly reported excessive uses of OC spray at Camp Smith. L.O. allegedly observed a youth sprayed with OC while the youth was restrained on the ground. C.R. reportedly observed a youth sprayed in the face for no apparent reason as he entered the dorm. At Camp Resnick, J.I. alleged that he observed a probation officer empty a can of OC spray on two youth who had been fighting but had complied with his order to get on the ground. As previously mentioned, A.K. alleged that probation officers punched, kicked, and sprayed a handcuffed juvenile at Camp Resnick.

Further, a probation officer told us about an incident in which OC spray was used in the SHU in April 2006. Allegedly, several Camp McNair youth were sent to the SHU after a disturbance. Many of the youth were yelling and banging on their cell doors for hours. Another supervisor identified a couple of youth who were banging especially hard. That supervisor and an officer moved to one of the cells and opened the door. They gave a verbal OC warning. The youth jumped back in what the officers perceived to be a threatening manner. A probation officer then sprayed the youth and quickly closed and locked the door to the youth’s cell. The probation officer and the supervisor then moved to two other cells, where they sprayed one of the two youth inside.

Probation Department policy also appropriately prohibits the use of OC spray on youth who suffer from medical or respiratory conditions such as asthma, youth who are on psychotropic medication, obese youth, and youth with mental health disorders.

As a mental health director reported, nearly half the youth at the Challenger Camps are being actively seen by mental health staff, and roughly one-third are on at least one psychotropic medication. We were repeatedly told during our tours that youth with mental health needs, and particularly troubled youth, are sent to one of the Challenger Camps. Yet, we were told that the Challenger Camps are, paradoxically, the only camps at which staff are authorized to carry OC spray. One supervisor told us that he believed that allowing staff to carry and use OC spray made sense given the “mental health population” at the Challenger

Camps. This rationale not only contradicts policy, but also generally accepted professional standards.

In addition to adequate policies, the County must also have clear procedures guiding the use of OC spray to ensure that youth who have the disqualifying conditions listed above are not sprayed. The probation officers with whom we spoke alleged that they were not provided with this information. Indeed, we received varying answers from staff regarding the types of youth on whom it is impermissible to use OC spray. When asked, probation officers were unable to identify the conditions that should prevent the use of OC spray, except for asthma or some other respiratory disorder. Some staff could list a few youth who had asthma, but most answered our inquiries about who could be sprayed by saying, "I assume that all of them can." Further, officers offered a variety of explanations as to precisely how they would identify a youth as having one or more of the disqualifying conditions. Some officers stated that they simply have no way of knowing whether a youth should not be sprayed, others reported that youth with excluded conditions wear green t-shirts bearing the letters "MED," while others told us that different colored wrist bands were used to indicate the prohibited condition status of a youth.

We interviewed several youth who had been sprayed with OC in the three months prior to our tour; several of them reportedly had one of the disqualifying conditions listed above. For example:

- W.G. reported having asthma. Although he reported to us that he was not on any psychotropic medications, he reported earlier spending two months at the Dorothy Kirby Center (the County's psychiatric residential treatment center), suggesting that he has a mental health diagnosis that would prohibit him from being sprayed.

- G.R. was sprayed in mid-January 2007 and reported having been sprayed on at least one other occasion. He reported taking psychotropic medications.

- E.V. was sprayed in January 2007 after he and two other youth were involved in a fight over a chair in the dorm. He reported taking psychotropic medication.

Failing to inform staff about which youth have disqualifying conditions for the use of OC spray is not only negligent, but

also amounts to a gross deviation from generally accepted professional standards.

Further, no one at the Challenger Camps or in the leadership ranks of the Probation Department has recognized that the use of OC spray at the Challenger Camps is a problem. The Superintendent at the Challenger Camps reported that she had heard of improper uses of OC spray in the past, but believed that these had occurred "a long time ago."

Finally, the facilities do not have adequate procedures and documentation governing the issuance of OC spray canisters to officers, nor do they have any procedures to weigh OC canisters on a regular basis to detect the unauthorized discharge of spray. After our tour, the Probation Department started to establish a "Use of Force Review" to assess the extent to which policies surrounding the use of OC spray have been followed. Although we have not had an opportunity to assess the implementation and adequacy of this reform, it is evident that the use of force review will not be meaningful until these policies are clearly articulated and staff have been adequately trained on them.

c. Inappropriate Staff Conduct at Camp Holton

We found the treatment of youth at Camp Holton by some of the staff who work there particularly troubling. We conducted a second, follow-up tour on March 7 and 8, 2007, to investigate newly arising allegations of mistreatment and intimidation of youth by Camp Holton staff, as well as reports that some staff maintained and consumed alcohol on the facility premises during the course of their 56-hour shifts. The implications of these allegations were so troubling that we modified our previously established plans and revisited Camp Holton to interview youth, staff, and Camp administrators, and to re-tour portions of the facility.

Youth reported on our follow-up tour that during our initial visit in January 2007, staff allegedly warned them not to "embarrass" staff by reporting mistreatment. We also learned of alleged remarks by staff during our second tour that were clearly intended to intimidate youth and prevent them from reporting staff misbehavior to us. A number of youth reported that one evening after we conducted interviews, staff purportedly made comments like, "We're going to have cheese sent up from the kitchen for the rats." Or, "C Dorm is still waiting for cheese from the kitchen." We heard numerous and serious allegations of staff physically mistreating youth and intimidating them by threatening physical harm or administrative sanctions if youth

cooperated with our investigation. Youth repeatedly named three staff and one former staff member as staff who threatened, intimidated, and put their hands on youth in a violent manner.

Additionally, on our second visit to Camp Holton, we discovered two bottles of alcoholic beverages in some of the staff's sleeping quarters.[11] The use or possession of alcoholic beverages by staff while on shift is expressly forbidden in policy, and foments a serious and unnecessary risk of harm to youth and staff in a secure institutionalized setting. It is also our understanding that Camp Holton leadership may allegedly have been aware of allegations of mistreatment and alcohol consumption by some of these staff.

We commend the County for taking immediate steps to address the serious concerns raised as a result of this tour by ensuring that the youth and staff who spoke with us were protected, and conducting an extensive follow up investigation. We understand that the County is also discussing this matter with the Probation Officers' union. We do not know the current status of the investigation or the discussions, but believe that appropriate

exit interviews.

2. Failure to Protect Youth from Harm by Other Youth

The high incidence of youth-on-youth assaults, particularly at the Challenger Camps and at Camp Scott, evidences another failure of the County to keep youth safe. At the Challenger Camps, youth reported that fights occur daily in the dorms. A review of the logbooks confirmed these reports. Youth reported that movement from the five camps to school - where groups of 90 or more youth are escorted by approximately seven staff - was perhaps the most likely time for a fight to break out. The combination of large numbers of youth and relatively few staff was cited by several youth as being a factor in fights occurring during movement. We learned that fights occur not only within the staff's field of supervision, but many occur out of staff's line of sight, in places that could not be well supervised given the small number of staff.

Youth are aware of the severe shortage of staff and describe two primary "types" of fights - those that occur in the open and are seen and responded to by staff, and those that are conducted

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[11] Staff who are in the sleeping quarters are still on duty.

in a more discreet fashion without staff becoming aware. The more discreet method of fighting is called "locking legs," as described above. This form of fighting generally occurs in the back of the dorm room where large fans obscure the sound, and other youth obscure the vision of officers. At Camp Scott, girls reported "locking legs" in the back of the dorm area and stated that such fights occur daily. Although youth reported that staff seldom noticed these fights, some youth believed that staff were aware of the fights and allowed them to take place.

At Camp Scott, fights also typically occur undetected in the laundry room and shower area. For example, two youth fought undetected in the laundry room of the dorm. Staff did not see them until after the fight had ended, when a staff person noticed that one of the girls appeared to be injured. The girl required emergency medical treatment for a concussion sustained when the other girl repeatedly shoved her head against the wall. Another girl, H.N., alleged that she was repeatedly punched and stomped in the face and head in the laundry room. A third girl had to intervene to stop the fight because staff were not around. H.N. alleged that she had to be taken to the hospital as a result of her injuries and was purportedly told by a probation officer that if the officer gets into trouble due to the incident, "I'm filing a 'triple-seven'[12] on both of you." In another incident of youth-on-youth assault, two girls engaged in a premeditated fight outdoors, out of the view of staff. Later, while the girls were working on kitchen duty, kitchen staff noticed their injuries as the girls washed their blood away in the sink.

Fights that occur in full view of staff are referred to as "going live."[13] Youth know that when they "go live" they will probably be caught and punished. Some youth alleged that staff have encouraged youth occasionally to "go live."

Fights are not the only evidence of the County's failure to adequately protect youth from harm. Many youth at the Challenger Camps also reported being "stressed" about other youth tampering

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[12] A "777" refers to a formal probation violation filed with the judge who retains jurisdiction in a youth's case. Such filings can and, according to both staff and youth, often do, result in additional time in custody for the subject youth.

[13] Many of the fights that occur at the Camps are concealed, i.e., youth lock legs or fight in some other manner that is undetected by staff. "Going live" means that caution is abandoned and the fight occurs in plain view of staff and others.

with their food, stealing their personal property, spitting on their beds, filling neoprene gloves with urine and throwing them, filling soap cups in the shower with urine, as well as engaging in gang-related conflicts. In several interviews, youth noted that their stress levels interfered with their ability to sleep and that they had sought and received medication to aid them in this area. Several youth expressed fear that they would not be able to "make it" at the Challenger Camps.

Each of these concerns from youth point, in part, to a need for enhanced staff supervision. Youth described the common practice of staff congregating for long periods in the command center area of the dorms, rather than circulating through the dorms as required. Some staff believed that other staff, particularly new staff, were afraid of the youth. This fear of the youth by some staff reportedly resulted in those staff either turning a blind eye to inappropriate activities or in a tendency to keep their distance from youth, typically remaining in the units' command center areas.

Increasing staff-to-youth ratios and ensuring that the youth remain under supervision at all times would likely reduce youth's stress, decrease staff apprehension, and lessen youth-on-youth violence at all of the Camps.

Additionally, the lack of an adequate behavior management system at the Camps contributes to youth-on-youth violence and the staff's inability to keep youth safe. If staff had a range of options with youth rather than either, generally, the threat of a "triple-seven" or sending the youth to the SHU for an infraction, and were provided with clear guidelines on the use of positive as well as negative incentives, the level of safety in the Camps would increase.

3. Inadequate Staffing

The biggest factor preventing the Camps from keeping youth safe is the lack of sufficient staff to adequately supervise youth. Without adequate numbers of trained staff, it is impossible to respond in a safe and timely manner when violence and other crises occur. Staff themselves discussed the stress they experience when a violent altercation breaks out in their dorm, and they must choose between intervening in a fight or ensuring that other youth do not become involved in it. Moreover, without adequate numbers of qualified staff, probation officers do not have the time to build the relationships with

youth that are necessary to identify potential conflicts, prevent incidents from occurring, and engage youth in meaningful rehabilitation.

Adequate numbers of staff must be deployed to supervise youth during waking and sleeping hours in order to protect youth from harm. The number of staff available to supervise youth is directly relevant to nearly all of the measures designed to protect youth from harm. For example, each housing unit is staffed with a combination of supervisory and line probation officers. Although seven staff may be assigned to a dorm holding 100 youth, at any given time, only four of them are assigned primary supervision duties, with two on one side of the dorm, and two on the other side of the dorm. The requirement that they attend to the needs of so many youth prevents staff from being able to de-escalate tensions effectively. This has serious repercussions as some staff purportedly may not intervene in fights immediately, choosing instead to await the arrival of backup staff, which creates the potential for youth to inflict more serious injuries during physical altercations.

Because staff at the Camps work 56-hour shifts (16 hours on, eight hours off, 16 hours on, eight hours off, and a final eight hours on shift before departing for four days off), they are given regular breaks throughout each of these stretches on duty. We observed several meal periods during which only two staff were present to supervise approximately 50 youth lining up, receiving food, sitting down to eat, and cleaning up. The other staff were either on break or doing casework (e.g., preparing court reports, contacting the youth's families, etc.). When the youth were on the housing unit, only two line staff were assigned to each side, resulting in a 1:27 ratio, at best. All staff assigned to the unit are deployed to assist with movement to and from school, which may bring the ratio down to 1:15 if seven staff are assigned to the dorm. When interviewed, however, staff indicated that they are frequently required to operate with fewer than seven staff.[14] In any event, a ratio of 1:15 during waking hours substantially departs from the generally accepted professional standard, which is 1:8/10 during the day.

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[14] The definition of "direct care staff" is inconsistent across the Camps' facility administrators and Probation Department policy. The generally accepted practice is to count only those staff whose primary duty is youth supervision, and to exclude those who are assigned as administrative, supervisory, and office staff.

a. Challenger Camps

Inadequate staffing during school hours at the Challenger Camps is a major concern. The youth in each camp are distributed across five classrooms allocated to that camp (youth from various camps do not mix in the school setting, except in special education classes). During school hours, only one staff from each camp was assigned as the School Liaison, which translates to a dangerous 1:110 ratio during the school day. The School Liaison sits in "the bubble" (the equivalent of a control center at the school) and watches a monitor which, when functioning, provides a three-second glimpse of each classroom in rotation. Each classroom has a telephone and a stationary panic button that the teachers are to use when an incident begins. Over the six months prior to our tour, the panic buttons were inoperable for long stretches of time, resulting in one instance where a teacher was unable to summon help when several students assaulted him in his classroom. Although other staff assigned to the dorm reportedly will respond when the School Liaison summons them on the radio, those staff are often coming from far across campus and therefore are not immediately available to assist. Teachers also complained that the phone was often busy when they tried to call the bubble to request assistance from the assigned officer. The Superintendent at the Challenger Camps stated that the School Liaison is required to patrol the corridor outside the classrooms and to check in on each class periodically. Neither teachers nor probation officers reported that this occurs with any regularity.

The Probation Department's Regional Director indicated that the Challenger Camps had recently received additional staffing, sufficient to bring the waking hours ratio in all camps but Jarvis up to generally accepted standards. Although 62 new positions had been funded, 47 of these were vacant and the remainder were in pre-service training. Thus, the enriched staffing had yet to be put into place within the Camps during our tour. In addition, the facility had 18 staff on worker's compensation leave, meaning that they were on leave after having been injured on the job. Moreover, the filling of vacancies in the recent past reportedly came, at least in part, at the expense of filled case worker positions. According to the Regional Director, 70% of case workers have returned to line staff positions, leaving significant vacancies in the case worker staff.

The failure to meet generally accepted staffing levels at the Challenger Camps results in significant and tangible harm to youth. As discussed earlier, physical altercations between youth are very common. As detailed above, some of these fights

occurred within the staff's field of supervision but many occurred out of the line of sight, in places that could not be well supervised given the small number of staff.

At the Challenger Camps, directors and the Superintendent were seldom observed circulating in the dorms or other common areas where youth could see them. Youth commonly said that they did not know who the Camp Directors were. The lack of a high-level staff presence at the Challenger Camps seems particularly unwise given the camps' large number of new staff and generally challenging population.

b. Camp Holton

Camp Holton also lacks sufficient staff to adequately protect youth housed there. Exacerbating the risk of harm presented to youth by chronic understaffing at Camp Holton is an apparent lack of oversight and supervision. As previously mentioned, youth repeatedly identified a specific group of staff as particularly abusive. Also as noted, the leadership at Camp Holton allegedly was aware of some of the allegations concerning abuse, threats, intimidation, and alcohol, and we could not find evidence that adequate steps had been taken to address these serious allegations. For example, during our January 2007 tour, we expressed concern regarding the presence of alcohol at the camp. In response to this concern, the Camp Director reportedly issued a memorandum to all staff regarding the bringing of contraband items into the camp. Nonetheless, when we returned to Camp Holton in March 2007, we found alcohol on site.

c. Camp Scott

We also found inadequate staffing at Camp Scott. A review of staff schedules revealed that overtime is used extensively, but the lack of staff greatly affected facility operations. In February 2007, for example, the facility could not find additional overtime staff to cover several shifts. A review of the supervisor's log revealed that, on one night, staffing fell dangerously low, to only two staff from 10pm to 6am for populations of 76 and 106 youth, respectively.

Inadequate staffing has led to staff being pulled from the orientation/isolation unit (the Assessment Unit ("AU")) at Camp Scott. A minimum of two staff is needed to keep this unit operational. When the staffing complement is insufficient, the unit is closed. A review of this unit's Movement Log revealed that the unit was closed on 10 of 63 days between January 1 and March 4, 2007, because of staff shortages. Thus, the essential

functions of new resident orientation, small group counseling, and disciplinary isolation were not available on those days.

Many youth corroborated that they either did not receive orientation or were not sent to isolation as a result of the lack of staff. In fact, during the several weeks prior to our visit, new girls moved almost immediately into the dorms without receiving the benefit of proper camp orientation. One girl we interviewed had been at Camp Scott for one week without having had orientation and without having been assigned to a caseworker. As a result of not having been assigned a case worker, she was at a loss for how to access mental health services, gain access to personal items that family members brought to the facility for her, file a grievance, access medical care, or become familiar with the behavior management system. She reported feeling depressed and wanting to speak to someone from mental health, but she did not know how to access mental health services, believing all girls were expected to make such requests through their caseworker. Camp staff and administrators informed us that the chronic staffing shortages have forced them to rely on youth who fill “leadership” positions to perform orientation and other duties more appropriately performed by staff.

d. Camp Kilpatrick

Camp Kilpatrick also suffers from the lack of adequate staff. At the time of our visit, seven assigned staff were unable to report to work because of worker’s compensation leave, family leave, or sick leave. Two other staff positions were vacant. These nine slots accounted for about one-quarter of the facility’s 38 line staff positions. Although extra staff have been budgeted to ease some of this difficulty (i.e., staffing relief factor), the significant number of staff who are unable to report to work presents a significant burden for remaining staff.

During our initial tour of Camp Kilpatrick, we entered a housing unit at approximately 6:00 pm where only one staff person was present, providing supervision from a position in the command center. At the time, approximately 35 youth were involved in varying activities the dorm. Camp Kilpatrick’s staff-to-youth ratios often fell below generally accepted standards. The disparity was particularly notable on the night shift, when a single staff member was commonly assigned to dorms housing as many as 56 youth. During our visit, the ratio was approximately 1:45. The generally accepted standard for staff-to-youth ratios at night is 1:16/20.

4. Inadequate Staff Training

Not only must the facilities have an adequate number of staff, but these staff must also be well trained to manage youth behavior appropriately, to de-escalate tensions and intervene effectively in crises, and to use force appropriately when less restrictive means have failed. The gross lack of staff training exacerbates all of the problems associated with the lack of staffing at the Camps with respect to keeping youth safe. The gross lack of training available to staff, coupled with the lack of adequate staff, means that staff are ill-equipped to ensure that fights between youth are stopped quickly, appropriately, and safely.

The County has no policy regarding staff training, when it is required, its content, or how staff skills and knowledge will be assessed. Staff at the Camps do not receive adequate training to perform critical job functions such as protecting youth from harm. For example, staff at the Challenger Camps reported that they do not receive sufficient guidance, either through formal training or on-the-job mentoring and supervision, on how to properly restrain youth.

The lack of staff training is particularly problematic at the Challenger Camps. Given the characteristics of these camps' population as described by the facility Superintendent -- that is, youth who are on various forms of medication for mental health reasons, who have violent offense histories, who have medical concerns, and who are generally considered to be "high risk" -- staff training is essential to the safe operation of these facilities. This training is sorely lacking in all critical areas, and was noted by many staff as being among the greatest unmet needs at the Challenger Camps. One supervisor noted that this is particularly important given the large number of new staff at the facilities. This supervisor noted that some staff lacked basic knowledge about how to perform their jobs and conduct themselves in a safe and professional manner. Specifically, the supervisor mentioned staff understanding of proper use of force techniques, as well as a wide range of unprofessional conduct, including staff use of foul language and talking on cell phones while on duty, as priority training areas.

Training on the use of force should have, as its foundation, a set of detailed policies governing the use of physical, mechanical, and chemical restraints. The paucity of information in formal policy relevant to the use of force and the lack of a Probation Department-approved use of force curriculum illustrate the lack of standardization and attention to this issue.

Training documentation revealed that only 14% of Challenger staff had received formal training in the use of force since January 2006, while an additional 20% had received training at some point earlier in their careers. At Holton, only 10% had received training in the use of force since January 2006, and 24%, at some point earlier in their careers. At Camp Kilpatrick, only 9% percent of staff had received formal training in the use of force since January 2006, and only an additional 9% had such training at some point earlier in their careers. Two-thirds of staff at both Challenger (66%) and Camp Holton (67%), had <u>never</u> received formal training in the safe use of physical restraint measures; more than three-quarters of Camp Kilpatrick staff (82%) had <u>never</u> had formal training in such techniques. Undoubtedly related to this gross lack of training, as detailed above, youth uniformly reported the widespread use of slamming and other inappropriate uses of force by staff at virtually all the Camps.

Staff interviews at all of the camps that we toured confirmed that no Probation Department-approved use of force continuum exists, nor could staff name or demonstrate any specific physical restraint techniques that were approved for use. Except for two individuals who were recently hired or recently transferred to the Challenger Camps from one of the County's Juvenile Halls, none of the staff had received any training in the use of force since their initial training after being hired. For some staff, this meant that they had not received any use of force training in more than 10 years. Several staff indicated that they were not paid to attend training that was scheduled outside of their normal shifts, and they therefore refused to attend.

Staff's lack of knowledge and the lack of a standardized curriculum was highlighted in the incident reports we reviewed, nearly all of which lacked details about the specific ways in which staff intervened in fights between youth, what restraint was used, and which staff participated in the restraint. Most often, the incident report indicated that the youth was "*assisted to the ground*" or "*placed on the ground*," but no details were given as to how this was accomplished. (Emphasis added).

It is critical that training in the proper use of physical restraint to break up a fight between youth be given to Camp staff. Youth and staff consistently reported a high number of youth-on-youth assaults throughout the Camps. Many youth reportedly sustained injuries during these fights (although the rate of injury could not be determined because the County denied us access to the youth's medical charts despite our repeated requests). Youth and staff also reported a high number of staff

injuries as a result of attempts to intervene in the fights. The lack of training available to staff, coupled with the lack of adequate numbers of staff discussed previously, mean that staff are ill-equipped to ensure that fights between youth are stopped quickly, appropriately, and safely. Of the 47 staff injured on the job in 2006, nearly half (48%) were injured during the course of a restraint.

Further, our observations and reports from youth demonstrate that staff are not properly trained to de-escalate conflict between youth. Rather than using the typical methods of de-escalation (e.g., calm tone of voice, clear directions, providing opportunities for youth to express themselves), some staff reportedly instigate, antagonize, and otherwise encourage youth to assault each other. For instance, one youth reported that in response to a brewing altercation between him and another youth, the staff allegedly said, "Come on, you motherfuckers, I haven't seen anyone 'go live' in months." These, and other statements like them reported by several youth, escalate, rather than de-escalate, conflict. Many youth described unprofessional behavior by staff and offered graphic examples of improper uses of force. Youth described staff provoking youth, ridiculing youth in front of their peers, swearing at youth, calling them stupid, using sexual innuendos, fostering racial tension among youth, punishing large numbers of youth for the behavior of one, and using excessive force. Youth also stated that some staff even engaged in "gang talk" with them. A youth from Camp Resnick (a Challenger Camp) indicated that a staff refused to let another youth use the restroom after the youth stated that he felt ill. The youth, in fact, vomited and the staff antagonized the youth by saying, "Stop acting like a bitch! Suck it up! Stop being a pussy!" The reporting youth filed a grievance regarding this incident and received a response two weeks later, stating that the youth and staff had been "counseled."

Staff also are inadequately trained on procedures and safe practices regarding the use of OC spray. The County's OC Spray policy fails to include a use of force continuum that would serve as a guide to its officers on when it is appropriate to use OC spray. The policy also does not comment on the training and certification requirements for staff. We were also told that the training officers received upon hiring was inconsistent regarding the proper use of OC spray, and that Challenger staff received a separate training on the topic from a member of the Challenger staff who also maintained all staff training records on this topic. We were unable to verify this because, according to the Superintendent, the training records were lost. Although we were informed that efforts were underway to re-establish both OC spray

training and a record system to track the training, we were provided with no documents reflecting the status of these efforts.

5. Inadequate Investigation of Abuse Allegations

a. Failure to Report Abuse

When an allegation of abuse is made, it must be reported to the proper authorities to investigate the veracity of the allegation. Generally accepted professional standards require that all staff working at a juvenile justice facility be mandated child abuse reporters. As such, they must report all instances of alleged abuse, no matter how credible, to the state Child Protective Services agency. The allegations or information must be reported without filtering or making subjective decisions about which are serious or credible enough to be reported. Disturbingly, most of the staff we interviewed at the Camps were unaware of their duties to report.

At all of the Camps, three separate agencies have been designated to handle allegations of abuse - the Department of Child and Family Services ("DCFS"), local law enforcement, and the SIU. Staff uniformly reported that they were responsible for reporting allegations they received to their supervisors, but had no knowledge of their responsibility to make an independent report to any agency. Indeed, none of the administrators or Probation Department officials knew what the staff's obligations were in this regard.

At Camp Holton, two of four abuse allegations that were reported to staff in the six months prior to our tour were not passed on to DCFS in a timely manner. In November 2006, a youth made an allegation of abuse to an officer and to a member of the mental health staff. Neither of these individuals made a DCFS Suspected Child Abuse Report (SCAR), choosing instead to wait for the Camp Director to return from vacation two weeks later to find out how to handle the allegation. In January 2007, another youth reported an allegation to a member of the mental health staff, yet that staff person also failed to make a SCAR report. The Camp Director made the report four days later. The failure to make a SCAR report is of great concern and severely threatens the integrity of the process for protecting youth from harm by staff. It does not appear that any of these staff were held accountable for their failure to take required suspected child abuse reporting actions.

Staff at the Camps reported that they had not received any training on child abuse reporting in the previous year prior to our tour. Training documentation revealed that only 16% of Challenger staff had received formal training in child abuse reporting since January 2006. An additional 38% had received this training at some point earlier in their career. None of Camp Holton's staff had received formal training in child abuse reporting since January 2006, but two-thirds (67%) had received training at some point earlier in their careers. Only 4% of Camp Scott staff had received formal training in child abuse prevention and reporting since January 2006; 49% had received such training at some point earlier in their careers.

Alarmingly, nearly half (46%) of Challenger staff had never received formal training in child abuse reporting. One-third (33%) of Camp Holton staff had never received formal training in child abuse reporting, and nearly one-half of Camp Scott staff (47%) have never received any kind of training in child abuse reporting.

At Camp Scott, the lack of knowledge surrounding the proper thresholds and authorities for reporting allegations of abuse is apparent in the way in which allegations of abuse have been handled. Although supervisors and administrators took some action in most situations, their actions stopped short of a formal report to the proper authority. For example:

- In November 2006, a youth provided a written statement recounting an event that had allegedly occurred in August 2006: "[staff] pushed me down on the control center and literally put his knee on top of my chest, holding my breath out/in, while his other hand was around my neck choking me for at least 5-10 seconds. I black [sic] out for about 2 seconds and woke up." The youth stated that she told the Administrator on Duty who replied that the staff was doing his job and that the youth needed to calm herself down. The Licensed Clinical Social Worker ("LCSW") receiving this complaint, completed a written report, and gave it to the Camp Director. The Camp Director, however, failed to report the allegation to the appropriate authorities.

- A youth alleged an inappropriate relationship between another youth and a staff member at Camp Scott in January 2006. Although the youth's statement named the staff member, the facility never reported the alleged inappropriate relationship to DCFS. The facility

administrator reported to us that the SIU had investigated this matter, but stated that she did not have a copy of the resulting report. Of particular concern, the same staff person involved in this incident was implicated in two other allegations of misconduct in August and December 2005. Even if the staff member's behavior had not amounted to "abuse," it certainly should have been evaluated for compliance with the Probation Department's policies surrounding appropriate professional boundaries.

- In November 2006, a youth's written statement clearly alleged excessive force and verbal abuse by a staff person: "[staff] grabbed my thumb and bent it back" and also called her a derogatory name. This youth's statement was never reported to or investigated by any of the three agencies (DCFS, law enforcement, or SIU).

Camp Scott's failure to promptly report allegations of abuse to the proper authorities substantially departs from generally accepted practice and the Probation Department's own regulations.

At Camp Kilpatrick, although there have been complaints of verbal abuse, there had been no allegations of physical abuse or mistreatment in the six months prior to our visit. Nevertheless, it is of concern that staff reported they had not received any training in child abuse reporting, and some were not aware of their duties in this regard. Training documentation revealed that none of Camp Kilpatrick's staff have received child abuse training since January 2006. Approximately two-thirds (68%) had received training at some point earlier in their careers. About one-third (32%) had never received formal training in child abuse reporting.

b. Failure to Take Adequate Investigatory Actions Once Abuse is Reported

Once an allegation of abuse has been made, proper investigation is required to protect youth from staff abuse by collecting evidence to verify or disprove the allegation. These investigations are essential to identify staff in need of training and/or termination, as well as to clear staff who have been wrongfully accused. The investigation process must have reasonable integrity, preserve all physical evidence (e.g., videotape footage, documentation and photographs of injuries, clothing, etc.), obtain statements from all youth and staff involved in the incident and those who witnessed the incident, and utilize other sources of information to corroborate or refute

the allegation (e.g., logbooks, other sources of facility documentation).

i. Failure to document medical treatment following a use of force

The integrity of the investigative process includes documenting the youth's injuries. Generally accepted professional standards require that youth subject to a use of force be seen and treated, if necessary, by a medical professional. Medical staff can also be an avenue for youth to report abuse or mistreatment. Further, even when youth do not report abuse or mistreatment, under generally accepted professional standards, medical staff are mandated reporters of child abuse if abuse is suspected. Oftentimes, the nature of a youth's injury would lead a medical professional to suspect abuse.

Staff and County officials repeatedly claimed that if medical attention was received, it would be documented on the incident report. The documentation provided by the County did not suggest that medical attention is automatically provided to youth involved in uses of force. At Camp Holton, the medical portion of the incident reports we reviewed was left blank in nearly all instances; only two of the 30 incident reports included any documentation by a medical professional. Thus, in the event that the youth actually did receive treatment and the error was one of documentation, we requested access to the medical charts of the youth involved in the undocumented incidents. This request was denied, and therefore no evidence was provided that indicated youth receive medical treatment by licensed medical staff following their involvement in a use of force.

At Camp Scott, the available documentation also did not substantiate that medical attention was automatically given to youth involved in uses of force. Of the 27 incident reports reviewed, 18 recounted events that required some form of medical attention (e.g., fights, uses of force, suicide gestures, etc.). Of these 18, only five provided evidence to verify that the youth involved received prompt medical attention. Several others provided documentation for only one of the youth involved, and several revealed long delays in obtaining medical attention, even during times when the nurse was at the facility.[15] Six incident

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[15] At some of the Camps, nurses are not on duty after certain hours or on weekends.

reports did not include any documentation that the youth had been seen by a nurse following his involvement in the incident. Once again, we were unable to review the medical files to determine if this was simply a failure of documentation or practice.

Efforts should also be made to increase the involvement of medical staff as an avenue to uncover information about youth mistreatment. The nurses can conduct confidential interviews with the youth to gather information about the incidents.

ii. Failure to take adequate action following an allegation of staff abuse

Youth we interviewed reported several allegations of mistreatment at the hands of staff. Pending the outcome of the investigation of these allegations, generally accepted professional standards require that these staff be placed in non-contact positions. Most of the staff we interviewed reported that accused staff are "usually" moved to security, where they are deployed to the key room, office, or other positions where they do not have contact with youth. However, staff were also aware of other accused staff who continued to work directly with youth. One staff reported that he, himself, had been accused of mistreating a youth, but was simply transferred to another unit, rather than to a non-contact position. By moving accused staff to a position in which they do not have direct contact with youth, the facility protects youth from the risk of harm and protects itself from liability if the staff person were to commit additional misconduct pending the outcome of the initial investigation.

Obviously, because some allegations are unfounded, it is vital that child abuse investigations be completed in a timely manner so that wrongly accused staff can be can return to their normal post. All of the Challenger Camp staff with whom we spoke voiced a concern regarding the length of time required for the investigation process to clear staff, if the allegation was not substantiated. Reports of investigations pending for over a year were not uncommon. The length of time required for this process contributes to the generally low morale reported by many staff, who feel unsupported in doing their work.

At Camp Scott, the Director stated that accused staff are assigned to non-contact positions at Camp Headquarters pending the outcome of the investigation. However, as discussed above, several of the allegations of abuse occurring over the past 12 months were administratively screened out and not reported to the proper authorities. In one of the cases discussed above, the

same individual was implicated in three separate incidents (all alleged misconduct). None of the accused staff were removed from direct supervision. Failures to report allegations of abuse and to move staff into non-contact positions place youth at Camp Scott at significant risk of harm.

According to Camp Holton's Director, staff at the camp are not automatically placed in non-contact positions pending the outcome of an abuse investigation. The reasons for this practice are not clear, although it is likely influenced by the impact on facility staffing levels. Indeed, a total of 11 staff were involved in child abuse allegations from November 2006 to the time of our tours, representing approximately one-quarter of the facility's staff. If all were to be placed on non-contact status, the facility would have a very difficult time covering each shift. Although difficult operationally, the responsibility to protect youth from harm is paramount, and thus transfer to non-contact status is essential. The SCARs discussed above, along with several other youth and one staff, made repeated references to a small core group of staff at Camp Holton who allegedly abuse and terrorize youth. Indeed, these are the same staff who the youth we spoke with described as being heavy-handed during the course of restraint. Camp Holton's failure to place these staff on non-contact status at the first allegation of abuse not only created an opportunity for additional allegations of abuse to occur, but also led to the sentiment among both staff and youth that staff are not held accountable for their behavior. This lack of accountability leads directly to the culture of fear and intimidation that pervades youth's experiences at Camp Holton.

Normally, our site inspection protocol includes a careful review of the investigations of each allegation of abuse occurring over the past 12 months. However, we were denied access to these documents. The reason for the denial provided by the County was the staff's right to privacy. This was despite our repeated offers to ensure confidentiality and privacy, including our offer to sign a confidentiality agreement. Without these documents, we are unable to verify that the County adequately protects youth from abuse by staff because we are unable to make any finding regarding the actual existence of such investigations or their quality. Accordingly, we draw negative inferences and find that the investigations are inadequate.

Our site inspection protocol also includes a review of all disciplinary action taken against staff found to be guilty of misconduct or abuse. We were also denied access to these records, and therefore cannot verify that the County protects

youth from abuse by appropriately disciplining staff. Accordingly, we draw a negative inference and find that discipline of staff who violate the rights of youth is inadequate.

c. Failure to Provide Safe Avenues to Report Threats and Intimidation at Camp Holton

Avenues for youth to report abuse at Camp Holton are ineffective due to the culture of fear that pervades the facility and the failure to hold staff accountable for mistreating youth. As previously mentioned, of great concern during both tours at Camp Holton were reports that youth were threatened and intimidated by staff in an effort to prevent youth from speaking with us. During the first tour, we had difficulty locating several youth who were supposed to have been confined at Camp Holton. These youth, it turned out, had been recently transferred to Barry J. Nidorf Juvenile Hall ("Barry J."). Facility staff were not able to tell us the time of return to Camp Holton so that they could be interviewed by members of our team. Our subsequent efforts to contact some of these youth at Barry J. were unsuccessful because, by the time we visited Barry J., they had been transferred back to Camp Holton. Additionally, as previously mentioned, during our second tour, youth reported that staff made public announcements suggesting that the youth who cooperated with our interviews were "rats." Other youth reported that staff warned youth "not to embarrass [them]" by talking candidly with our team. The various avenues for youth to report mistreatment, no matter how well designed, are rendered ineffective in a facility that permits staff to threaten and intimidate youth to prevent them from exercising their right to discuss their conditions of confinement with federal investigators.

6. Inadequate Classification System

The absence of an adequate classification system also contributes to the County's inability to keep youth safe. Generally accepted professional standards require that youth be housed and supervised based on a reliable classification system which includes the following considerations: a youth's age, charged offense, history of violence and escape, gang membership or affiliation, health and mental health concerns, and institutional history.

The youth at the Camps are, at best, classified in an ad hoc manner, rendering it impossible to safely house youth. Compounding the problem of inadequate placement criteria is the

physical structure of the housing units and lack of adequate numbers of staff. At the Challenger Camps, the facility Superintendent indicated that initial camp placements are loosely based on the programmatic focus at the camp. However, we did not find this to be the case. The Challenger Camps do not utilize a structured decision-making tool to make housing decisions within each camp. Instead, they rely on the subjective assessments of staff, none of whom have received classification training. Youth who are considered to be "at risk" are reportedly assigned bunks in the front of each dorm. However, staff were not consistent in their definition of "at risk." Most often, youth were judged to be at risk due to a particular medical condition. None of the staff included youth who were vulnerable (due to age, size, etc.), had serious mental health issues, or who were at risk of self-harming behavior. Occasionally, staff discussed the need to separate members of rival gangs, but there was no method for doing so.

Similar to the practice at the Challenger Camps, at Camp Holton, youth who are considered "at risk" are reportedly assigned bunks close to the command center. However, this practice appeared to be applied with questionable consistency. At Camp Holton, our findings rest almost exclusively on reports from staff and administrators. We were unable to verify whether, in fact, at risk youth are placed in beds closer to the command center because they did not maintain adequate records of bed assignments. We requested the bed charts for one of the dorms for 20 randomly selected days, but staff were able to produce only four of them. Not only are these records important to determine whether any classification system has been properly implemented, but they are essential when investigating serious incidents or child abuse allegations that occur in the dorm.

At Camp Kilpatrick, youth are separated into two dorms, with one dorm reserved for those participating in the sports program and the other dorm housing everyone else. Youth considered by staff to be "at risk" are assigned bunks closest to the control center within each dorm. But we found no definition of the term "at risk," and staff are left to interpret its meaning. Youth who misbehave as well as vulnerable youth and youth with medical conditions are all considered at risk at Camp Kilpatrick. Although an at-risk determination certainly is appropriate for each of these groups, not separating violent and non-violent youth is contrary to generally accepted practice.

The primary form of classification at Camp Scott is to place youth into one of four platoons: one for dorm leadership, one for youth with jobs, one for recently admitted youth, and one for

general population. These distinctions bear little relationship to protecting youth from harm or improving outcomes for youth in the facility, which are the intended purposes of classification. The platoon assignments do not account for a youth's particular vulnerabilities, interpersonal conflicts, or past involvement in institutional misconduct. Similarly, the concentration of those holding leadership positions into a single platoon limits the ability of these youth to serve effectively as role models for other youth, which was noted by staff and administrators as being a primary role of leadership.

One of the problems plaguing Camp Scott on an episodic basis is the involvement of youth in consensual sexual activity. A review of relevant incident reports indicate that, although staff attempt to note and address the behavior from a variety of angles, the use of a formal classification strategy was not among them. Youth found to be involved in this type of behavior are often assigned to the bunks farthest from the control center, and have opportunities to manipulate the environment to provide cover for their activities. The use of a structured classification system to guide housing decisions would accurately identify youth involved in these behaviors.

The current classification process in the Camps does not adequately address known risk factors for institutional misconduct, and could lead to the proximal housing of youth who should be separated in order to adequately protect them from harm. The Regional Director for the Camps reports that each of the Camps will have an entirely different focus as a result of Camp Redesign, an ongoing 14-point project aimed at a variety of improvements throughout the Camps.[16] In the meantime, however, the Camps' method of classification does not ensure that youth are protected from harm, and substantially departs from generally accepted professional standards.

7. Inadequate Grievance Process

Youth at the Camps are not provided with adequate access to a grievance system designed to address their complaints regarding their treatment at the facilities. Generally accepted professional standards mandate that youth should have readily available access to a grievance process. Where courts have considered this, they have uniformly found that detained youth have a constitutional right to file grievances with facility

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[16] The project is protected to continue at least through the end of 2008, if not far beyond.

administrators regarding their treatment. Bradley v. Hall, 64 F.3d 1276, 1279 (9th Cir. 1995); D.B. v. Tewksbury, 545 F. Supp. 896, 905 (D. Or. 1982); Morales v. Turman, 364 F. Supp. 166, 175 (E.D. Tex. 1973). An objective grievance system should be well known and easily accessible. Grievances also provide an important quality-control mechanism by which camp administrators can monitor whether facility staff are adhering to policies and procedures.

Youth at the Challenger Camps knew of the existence of a grievance process, but very few had pursued it as a remedy for concerns or complaints. Most youth interviewed had no confidence in the grievance process as a useful avenue for addressing concerns about staff or camp conditions. Of the relatively few youth who had raised issues regarding staff directly with supervisors or via the grievance process, it was reported that such actions resulted in staff calling them "snitches." During the tours of all the facilities, we noticed grievance forms and boxes in the housing units. Staff reported that the boxes had been installed just prior to our visit. The procedure previously had inappropriately required youth to submit their completed grievance forms to a staff member. The availability of the submission boxes appropriately increases the confidentiality afforded to youth.

Although they did not have great confidence in the grievance system, youth did use it to address some of their concerns about their treatment at the Challenger Camps. We reviewed approximately 75 grievances from all five Challenger Camps between January 2006 and January 2007. Approximately 20 of the grievances complained about food, maintenance issues, and personal products. Approximately 25 grievances complained about the denial of medical care or tensions between staff and youth. Approximately 15 grievances alleged verbal abuse or mistreatment by staff. For example, a youth from Camp Resnick alleged that a staff had cursed at the youth repeatedly and made fun of him for being gay. This grievance was never responded to or resolved. A large number of other grievances alleged mistreatment by this same staff person.

Approximately six of the grievances alleged physical abuse or the excessive use of force by staff. For example:

- In June 2006, a youth from Camp McNair alleged that a staff used OC spray on him without cause, stating that he (the youth) had assumed the "OC position" to indicate he was not involved in the incident. The

response to the grievance was only: "I will speak to [the staff] about the incident."

- In January 2006, a youth from Camp Resnick alleged that he was physically restrained by a staff for five or 10 minutes after an incident occurred. The disposition on the grievance form inappropriately concluded that the grievance was "resolved" because the youth was transferred to another camp. It does not appear that the youth requested the transfer.

- In June 2006, another Camp Resnick youth alleged that he was threatened by a staff who later grabbed the youth by the neck and pushed his face into the ground. Again, the grievance was "resolved" when the youth was transferred to another camp.

- In June 2006, a youth from Camp Scobee alleged that a teacher kicked him. There was no response or apparent resolution of the grievance.

Although a few of the grievances pertaining to maintenance, hygiene, and access to medical care appear to have been appropriately resolved, in many situations, releasing the youth to the community or transferring him to another camp led to the determination that an issue had been "resolve[d]." All of these complaints were about conditions at the facilities that would not change in any meaningful way simply because the youth was no longer there. Although the youth made the effort to address the issue, the staff responsible for resolving the matter chose not to do so. Further, many of the grievances took an inordinate amount of time to resolve, and many others did not have a date of receipt or date of resolution written on them, making their compliance with required timelines impossible to ascertain. One youth marked his grievance "urgent" and went on to explain his desire to be placed in protective custody. After 16 days, the grievance was considered "resolved" because the youth had been transferred to another camp.

Thus, although a grievance system exists at the Challenger Camps, it lacks many of the components needed for it to be a viable avenue for youth to state their concerns. For the grievance system to meet generally accepted standards, the timeliness and thoroughness of the responses must be improved and those indicating mistreatment or abuse by staff must follow the required procedures for child abuse reporting. Finally, whether or not the youth is transferred to another camp or released to

the community, the underlying issues for all grievances must be appropriately addressed.

The grievance system at Camps Holton and Scott is similarly inadequate. At Camp Holton, only two grievances had been submitted between approximately July 2006 and January 2007. One alleged abuse by staff and was properly reported to DCFS, but not before the receiving staff member replied: "Denied. If you followed instructions and did not resist, nothing would have happened." The other protested a disciplinary write-up, and was resolved in the youth's favor. The system lacks a set of local policies to identify responsible parties, timelines, and required investigatory procedures. Further, contrary to policy, no grievance log is maintained at either Camp Holton or Camp Scott.

At Camp Scott, a new staff had been appointed to serve as the Grievance Coordinator. In this new role, the Grievance Coordinator noted that he checks the grievance boxes daily and tries to respond to each grievance within 48 hours, and to resolve each within five working days. These efforts to strengthen the grievance process, however, have yet to take root. Most of the youth interviewed were familiar with the grievance process, but the process is used very rarely. Although under development, the system as it currently exists lacks a clear set of policies to identify responsible parties, timelines, and required investigatory procedures. The absence of a consistent and fully developed orientation program, during which new youth should be adequately informed of the grievance process, may also contribute to the limited usage of the grievance system. Some of the girls interviewed acknowledged using the grievance system, or at least considering it as one means of formally expressing a complaint. Others expressed a total lack of confidence in the system, stating that they had complained previously about broken windows and clogged air vents in the dorm, to no avail.

B. Inadequate Suicide Prevention and Mental Health Care

The Constitution requires that confined juveniles receive adequate medical treatment, including adequate mental health treatment and suicide prevention measures. See Youngberg, 457 U.S. at 323-24 & n.30; Oregon Advocacy Ctr. v. Mink, 322 F.3d 1101, 1120 (9th Cir. 2003); Gibson v. County of Washoe, 290 F.3d 1175, 1187 (9th Cir. 2002); Carnell v. Grimm, 74 F.3d 977, 978-79 (9th Cir. 1996); Cabrales v. County of Los Angeles, 864 F.2d 1454 (9th Cir. 1988) vacated and remanded, 490 U.S. 1087 (1989), reinstated, 886 F.2d 235 (9th Cir. 1989); Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994); Gordon v. Kidd, 971 F.2d 1087, 1094 (4th Cir. 1992). The Camps fail to meet

these constitutionally minimal standards. Below, we describe deficiencies in the areas of suicide and self-harm prevention; mental health screening and identification; clinical assessment, treatment planning, and case management; medication management practices; mental health counseling and other rehabilitative services; and quality assurance programs.

1. Inadequate Suicide Prevention Plan

Juvenile institutions are required to adequately protect youth from self harm. Generally accepted professional standards require juvenile facilities to have a well-established suicide prevention plan. The plan should be implemented on a systematic basis and all staff members should understand it. The plan should include procedures for the placement of youth under varying levels of enhanced supervision, immediate evaluation by a mental health professional, and, if necessary, safe transfer to a psychiatric facility better capable of handling a psychiatric emergency. Staff members must be well trained on an ongoing basis in identifying and preventing youth suicides, and the facility should have a system for providing ongoing follow up to youth who have expressed suicidal ideations while in detention. The Camps fail to protect youth from self harm in the following ways: (i) staff fail to adequately assess youth for risk of suicide; (ii) the Camps fail to provide sufficient mental health services to youth on suicide precautions; (iii) staff fail to supervise youth on suicide precautions and in seclusion sufficiently; and (iv) staff lack preparation and training to respond appropriately to suicide attempts.

As an initial matter, it is critical to note that Camps Kilpatrick, Scott, and Holton have absolutely no formal suicide prevention plan in place. And the Challenger Camps' policies, practices, and training regarding suicide prevention are grossly inadequate. These deficiencies at all of the Camps place youth at grave risk of harm.

a. Insufficient Suicide Risk Assessment

A formal screening for suicide risk is necessary for all youth upon entry to the Camps. This screening should be conducted using a validated suicide risk assessment instrument. Contrary to these generally accepted practices, the Camps fail to adequately assess youth's risk for suicide upon admission, thereby exposing youth to grave risk of harm.

Not one of the Camps has procedures in place to screen youth for suicide risk upon admission. Nor does any Camp actually

provide such screening. Instead, staff and administrators reported that youth are screened at the Juvenile Halls, prior to their arrival at the Camps. The lack of screening upon entry to the Camps is troubling for a variety of reasons. First, the screening at Juvenile Halls may take place months prior to a youth's arrival at one of the Camps. A youth's risk of self harm could drastically change during that time, particularly in light of the stress and change the youth experiences as he or she transitions from the Juvenile Halls to the Camps. Second, a youth's mental health case file often does not accompany him/her from the Juvenile Halls, so relevant historical indicators and even suicide attempts may go unnoticed. Finally, the screening conducted at the Juvenile Halls provides no protection for youth transferred to the Camps from other facilities or from an extended stay elsewhere.

b. Insufficient Mental Health Services for Youth on Suicide Precautions

Youth on suicide precautions should receive appropriate follow-up care from mental health staff to assess the need for ongoing restrictions associated with such precautions and to provide treatment. In addition, a qualified mental health professional must be available for consultation during hours when staff are not scheduled to be at the facility, and this professional should be able to respond promptly when a youth requires crisis evaluation. The Camps fail to provide sufficient mental health services to youth on suicide precautions, exposing youth to grave risk of harm.

When a youth is transported to a Special Housing Unit ("SHU") on suicide precautions, the generally accepted practice is to place him on the highest level of supervision, one-to-one, until a qualified mental health professional can make an adequate risk assessment and assign an appropriate level of supervision. Contrary to this generally accepted practice, at the Challenger Camps, when youth are transported to the SHU, non-mental health professionals - individuals who are <u>not</u> trained in conducting such assessments - make the initial determinations of risk level and required level of supervision. For example, we encountered one youth whose level of supervision changed frequently, apparently as a result of determinations of risk assessment by line staff. Troublingly, this youth was never seen by mental health staff while in the SHU. In general, the role of mental health professionals in addressing the risk of self harm among youth was largely unknown to line staff.

At the Challenger Camps, we encountered numerous instances where youth at obvious risk of self harm were not seen by mental health staff within a reasonable time. For example:

- One youth was referred to mental health on 11/30/06. He was seen 11 days later, on 12/11/06. The day after he was seen, the youth made a self-harm gesture. Contrary to stated policy and practice, the youth was not transported to the SHU following this gesture. And, he was not seen by mental health staff for another three days.

- Another youth was referred to mental health on 9/23/06 and again three days later. He was not seen until 10/9/06 - more than two weeks later. Just over a month later, the youth made a suicidal gesture and was placed in the SHU. He was not seen by mental health staff at all while he was in the SHU. And, he was not seen by mental health again until 12/27/06 - more than *seven* weeks after his self-harm gesture.

- Another youth, who had a history of self-harming behavior while in a Juvenile Hall, was referred to mental health at a Challenger Camp on 12/8/06. He was not seen by mental health until 12/28/06 -- a troubling 20 days after his initial referral, and 22 hours after he had engaged in another self-harming behavior at the Challenger Camp.

- Another youth was sent to the SHU at 9:30 a.m. on 2/4/07, after he had cut his wrist during the night with a piece of metal from his wristband. Another youth on the unit had alerted the nurse to this behavior. The troubled youth was sent to the SHU with a notation indicating "recent cutting, verbalizes SI [suicidal ideation]." The youth was not seen by a mental health or a medical professional until 7:30 a.m. the following day - 22 hours after he had been sent to the SHU.

- In another incident, two youth who were brought to the SHU the previous evening on suicide precautions were not seen the next morning. When we asked mental health staff why the youth had received no mental health care, the psychiatrist stated "I forgot."

Once placed on suicide precautions, youth at the Challenger Camps receive inconsistent follow-up care. Despite a Probation

Department policy requiring that youth on suicide precautions be seen daily by mental health staff for the first five days, as previously noted, youth often spend days in the SHU without the benefit of regular clinical contact. Moreover, none of the staff with whom we spoke knew the requirements for monitoring youth pending an assessment by a mental health professional. Staff at the Challenger Camps also do not help youth learn skills to reduce their suicidal ideations or behaviors.

Like the Challenger Camps, Camps Kilpatrick, Holton, and Scott fail to provide adequate mental health services to youth on suicide precautions. As noted above, none of these camps has a formal suicide prevention plan in place. Instead, staff are simply instructed to send youth either back to a Juvenile Hall, to a psychiatric hospital, and/or to the Challenger Camps if a chronic condition persists or a risk of self-harm develops. In the interim, however, not one of these camps has formal procedures in place to protect youth from self-harm as they await transfer to a more appropriate setting. Procedures appear to be ad-hoc in nature and not guided by formal policy and procedures.

Moreover, although staff at Camps Holton, Kilpatrick, and Scott stated that they would fill out a mental health assessment form if they felt a youth was particularly vulnerable, we found the benefits of filling out such a form to be questionable at best. At Camp Holton, the time frame within which the form would be received and a mental health professional would see the youth was unknown. At Camp Kilpatrick, as noted above, the psychologist is available only part-time and is assigned to at least two other facilities; he therefore cannot be relied upon for timely availability to youth. And, although Scott appeared to have a good practice for referring, monitoring, and transferring vulnerable youth so they could obtain mental health services, the camp does not document this practice, so it could not be verified.

c. Inadequate Supervision of Youth on Suicide Precautions and in Seclusion

Generally accepted professional standards require adequate supervision of youth on suicide precautions and in disciplinary seclusion. Staff who conduct periodic checks of such youth should document their observations and the times of their checks. Safety checks should be conducted at random intervals at least four times per hour for lower risk youth, and more often for youth at higher risk. Per the Camps' policy, a sheet is to be displayed on the door of each occupied cell with a notation of the time the youth was last visibly observed, along with the

initials of the staff member who conducted the observation. In addition, prior to their admission to the unit, youth and the room in which they will be placed should be searched to ensure that no hazards or other materials that could be used in a self harm attempt are available.

We observed a number of disturbing practices regarding supervision of youth on suicide precautions and in seclusion; these practices expose youth to grave risk of harm. Of particular concern was the falsification of Observation Forms and logs - critical papers that document the facility's supervision (or lack thereof) of youth who have been placed in the SHU and may be at risk of self harm. Specifically, at the Challenger Camps, we observed that staff certified on forms that they had conducted checks at times that had not yet arrived (for example, noting at 9:30 a.m. that a check had been done at 10:15 a.m.). We observed a similar practice on at least one form at Camp Scott. Moreover, at both the Challenger Camps and at Camp Holton, we observed logs that had times pre-printed on them; staff thus again were failing to record the actual times when safety checks had occurred. At the Challenger Camps, we also observed staff filling in the logs by writing in observation times after we noticed that the log was blank or had not included an observation time within the last hour.

Because these forms are to be completed when an actual visual check has been conducted, pre-completed forms suggest that staff assigned to these high-risk youth are actually not monitoring them in accordance with safe practices. This falsification of records calls into question the reliability of supervision for youth on such special security status, and suggests that supervision is insufficient to ensure that staff uphold these serious responsibilities. Moreover, pre-printing of set times on forms does not allow for checks of youth at random times, as dictated by generally accepted professional standards.

Despite questions about the validity of the Observation Forms in light of the disturbing falsification we observed, we requested random samplings of Observation Forms for youth in the SHU at the Challenger Camps, Camp Holton, and Camp Kilpatrick, and the Assessment Unit log for youth at Scott. At the Challenger Camps, Camp Holton, and Camp Kilpatrick, only a handful of the forms we requested could even be located. Our review of the forms revealed multiple additional failures to follow generally accepted practices to protect youth on suicide precautions or in disciplinary seclusion from self harm. Deficiencies included the following:

- Safety checks were not being conducted randomly at least four times per hour (the Challenger Camps, Camp Scott, Camps Kilpatrick).
- Many of the forms revealed gaps of 30 minutes to several hours during which youth were not monitored at all (Camp Holton).
- Forms contained no documentation of visits by medical or mental health staff (Camp Holton, Camp Kilpatrick). At both camps, youth reported having seen the nurse, but said they did not see mental health staff.
- Instead of using individual forms for each youth, checks were documented for the entire hall on a single sheet (Challenger Camps, Camp Scott).
- Staff did not document the condition of the youth at the time of observation (e.g., sleeping, crying, eating, etc.) (Challenger Camps).
- The forms did not evidence any supervisory review (Challenger Camps, Camp Scott).
- The location (Dorm or Assessment Unit) was not marked (Camp Scott).
- The length of time in confinement indicated in the Observation Logs did not match the time in confinement indicated in the movement log (Camp Holton).

Apart from the serious issues evidenced in our review of the Observation Forms and Assessment Unit logs, at the Challenger Camps, we observed multiple additional troubling instances where staff failed to adequately supervise youth in the SHU, in direct contravention to Probation Department policies. For example, although Probation Department policy requires that the level of enhanced monitoring be gradually decreased over time as the youth's level of risk of self-harm decreases, we found three separate instances where youth were returned from the SHU to the general population without any gradual decrease in supervision. Moreover, direct care staff had placed one of these youth in a room providing only supervision by camera upon his entry to the SHU, in direct contravention of the policy prohibiting the camera room from substituting for direct care staff observation. Although the youth was later placed on one-to-one supervision after a mental health assessment, one-to-one supervision should have been the default level upon his placement in the SHU. In

another instance, a staff member providing one-to-one supervision to a youth did not have any information as to what behavior prompted the high level of supervision; the staff member reported being told only to make sure the youth's hands were visible at all times. Yet another staff member was performing one-to-one supervision while he had a novel on the chair next to him. It is inappropriate for staff to do anything other than observe a youth who is placed on one-to-one supervision. Such failures to supervise youth in the SHU put already vulnerable youth at risk of grave harm.

Finally, the Camps fail to adequately supervise youth at the outset of their placement in the SHU. At the Challenger Camps, although youth's general population clothes are shaken out and youth are required to put on a SHU uniform, youth are not routinely searched prior to placement in the SHU. Similarly, youth are not routinely searched prior to admission to Holton's SHU. A youth thus could conceal a weapon or other contraband on his or her person and bring it to the SHU. Indeed, at Camp Scott, a youth gave herself a tattoo while confined to that camp's assessment unit. This strongly suggests that search procedures prior to her admission were inadequate. Moreover, the Challenger Camps require a youth to search his own SHU room to ensure that the youth is not unfairly accused of property damage in the room. Staff - not youth - should be responsible for all searches so that the Camps can ensure that youth do not have access to contraband and potential self-harm items.

d. Lack of Preparedness for Suicide Attempts and Other Self Harm

Staff training in suicide prevention measures at the Camps also departs from generally accepted professional standards. Because the risk for suicide may be present at admission or may develop during incarceration, it is critical at each juncture that staff who interact with potentially suicidal youth be trained to detect, assess, and if necessary, intervene to prevent a suicide. The generally accepted practice is for all staff to receive suicide prevention training as part of both pre-service and annual training. The Camps fail in this regard, exposing youth to grave risk of harm.

The Camps' training statistics are alarming. Half of all staff at Camp Kilpatrick, and one-third or more of all staff at the Challenger Camps, Camp Holton, and Camp Scott have never received formal training in suicide prevention. Yet, these staff are responsible for the safety of vulnerable, potentially suicidal youth on a daily basis.

Annual suicide prevention training at the Camps is nearly non-existent. As of our visits in early 2007, since January 2006, no staff at Camp Holton had received refresher suicide prevention training; only 5% had received it at Camp Kilpatrick; just 18% had received such training at the Challenger Camps; and only 33% at Camp Scott. Even when the training statistics are expanded to encompass the entire course of a staff member's career, the numbers continue to paint a dismal picture: only an additional 33% of Scott staff had ever received suicide prevention training, only an additional 45% had received it at Camp Kilpatrick and the Challenger Camps, and just an additional 67% had received training at Camp Holton.

Based on the training statistics, it is not surprising that staff at all of the Camps lack knowledge and strategies for de-escalating youth who engage in self-harming behaviors. For example, at the Challenger Camps, even staff assigned to monitor youth on the highest level of suicide precautions have no guidance as to how to respond to youth who make statements indicating they are considering self harm. Indeed, Challenger staff gave widely conflicting accounts as to the Camps' policy and practice for safely managing youth who exhibit suicidal ideations. In one of the most egregious examples, one staff member stated that OC spray should be used to stop a suicide attempt in progress.

Additionally, at all of the Camps, many staff were frighteningly unaware of how to intervene appropriately in the event of an actual suicide attempt. For example, staff did not know how to relieve pressure on the neck in the event of a hanging or how to use the cut-down tool. In fact, at the Challenger Camps, although most staff were aware that cut-down tools had recently been placed in a lockbox in the control center of each dorm, none had received any training or instruction on how to use the tool. Indeed, when asked to open the box and remove the cut-down tool, the supervisor of the SHU was unable to do so; his key did not appear to fit the lock. At Camp Scott, staff also had received no formal training in the proper use of the cut-down tool.

Staff at Camp Holton also were unaware of any formal criteria used to determine the appropriate level of monitoring by staff (e.g., 15-minute checks versus constant observation), or even of any formal procedures for notifying mental health staff or anyone else in the event a youth expressed suicidality. Staff at Camp Scott likewise were unaware of procedures for monitoring youth who had expressed intent to harm themselves. In addition, at both Camp Scott and Camp Kilpatrick, staff lacked awareness of

the ways in which depression manifests itself in adolescents (e.g., fighting, failing to follow instructions, or letting others take advantage of them).

Finally, we found that emergency intervention measures at the Challenger Camps were wholly inadequate. For example, first aid kits and rescue tools (e.g., blades to cut ligature from around a hanging victim's neck) were not available. These failures to have emergency equipment readily available to trained staff can mean the difference between life and death to youth at the Camps.

2. Inadequate Mental Health Care

Because youth who have the most serious mental health needs are sent to the Challenger Camps, those camps are largely the focus of the mental health care deficiencies in this letter. Nonetheless, it is important to note that none of the Camps provides adequate mental health services to youth. The Camps' deficiencies include: (1) inadequate mental health screening and identification; (2) inadequate clinical assessment, treatment planning, and case management; (3) inadequate medication management practices; (4) inadequate mental health counseling and other rehabilitative services; and (5) inadequate quality assurance programs.

As an initial matter, many of the deficiencies described below are attributable to staffing shortages. Specifically, the Challenger Camps have only one full-time psychiatrist, and a new part-time psychiatrist. In addition, they have three full-time clinicians, two half-time clinicians and two interns (who are present on Fridays and Saturdays), along with two primarily administrative positions of Clinical Program Manager and Clinical Supervisor. Having only five and a half full-time equivalent clinicians for a population of more than 400 youth with serious mental health needs is clearly inadequate.

Of similar concern is the lack of adequate mental health staffing at Camp Kilpatrick. Camp Kilpatrick's licensed psychologist - the camp's only mental health professional - valiantly divides his time between Camp Kilpatrick and at least two other facilities. In doing so, he keeps no set schedule; rather, he sets his time at the facility based on staff referrals of youth to him. Indeed, none of the youth on the psychologist's caseload were self-referred, and he is not notified about youth placed in the Special Housing Unit in any systematic way. Moreover, he has not even been provided office space on site; consequently, he is forced to carry his notes and files with him

at all times and is at the mercy of other staff and the facility's schedule when he needs to find suitable private spaces where he can meet with youth. In the psychologist's professional opinion, the youth at Camp Kilpatrick are not being served properly with regard to mental health treatment. At Camp Kilpatrick (and at the Challenger Camps), interventions consist of "crisis management," where the psychologist acts more like a social worker than a psychologist. Camp Kilpatrick's psychologist sees individual youth for approximately eight hours per week, a length of time he believes is insufficient to meet their needs. He sees about 10 youth at the camp on a regular basis, but stated that, because of staffing constraints, he is unable to provide ongoing psychotherapy. He also is unable systematically to contact family members of youth to engage family in support of treatment. Although he has attempted to enlist the assistance of interns to expand mental health access at the camp, administrative obstacles have prevented him from being able to do so.

These staffing limitations inevitably affect the quality of mental health care and place these already vulnerable youth at significant risk of harm.

a. Inadequate Intake Screening and Identification

Generally accepted professional standards require that all youth entering secure facilities receive a reliable, valid, and confidential initial screening and assessment to identify psychiatric, medical, substance abuse, developmental, and learning disorders, as well as suicide risks as discussed above. The assessment should include assessment of suicide and homicide risk factors and past behaviors. Based on this screening and assessment, staff should refer youth for any required care. To do this, staff must gather available information, such as a youth's previous records from past admissions, and gather important information needed to care for and treat the youth. The information must be communicated to appropriate personnel so that each youth's needs are appropriately and timely addressed.

We find the efforts to identify youth with mental health disorders at the Challenger Camps significantly lacking. Not only do the Challenger Camps fail to screen youth for suicide risk, as described above, but they also fail to screen youth for other mental health issues at intake and fail to review youth's previous records. As with suicide risk screening, to the extent <u>any</u> mental health screening is performed, it is done only at the time the youth is admitted to the Juvenile Halls. Of additional concern, there is no protocol to ensure that mental health charts

and information are transmitted from the Juvenile Halls to the Challenger Camps. Thus, mental health screening information generated at the Juvenile Halls often does not follow a youth to the Challenger Camps. Consequently, the mental health team at the Challenger Camps often has no way of knowing a youth's mental health history and current medication needs or history. If documentation does not follow the youth to the Challenger Camps, and a current mental health screening is not performed upon a youth's arrival, it is impossible to identify and appropriately address a youth's mental health needs.

The intake process at the Challenger Camps consists merely of noting in a youth's medical chart those youth who come in on psychotropic medication and then scheduling a future appointment with the psychiatrist. Our observations, interviews with youth, and the facilities' own documentation indicate that a significant number of youth who manifest mental health disorders are not being identified, and thus are not being treated. These failures expose youth to significant risk of harm.

Moreover, the records provided to us reveal that the facilities have no reliable documentation system in place to actually identify youth who are receiving mental health services. At the time of our visit, the population roster listed 432 youth as living at the Challenger Camps. The mental health services roster of youth currently on the mental health caseload, however, indicated that 433 youth - a number one greater than the then-current population - were receiving mental health services. As reported to us, this suggested that every youth at the Challenger Camps was on the mental health caseload. When we cross-referenced the mental health services roster with the population roster, however, we discovered that only 192 names - fewer than half - matched. Even more disturbing, the mental health staff for the Challenger Camps identified 86 youth who were currently receiving psychotropic medications; of them, seven were not on the population roster and another eight were not on the mental health roster.

Based upon these conflicting figures, it is readily apparent that the Challenger Camps lack any uniform tracking system to identify youth currently at the facilities, youth receiving mental health services, and youth on psychotropic medications. If we rely upon the figures provided, it appears that only 46% of the total population at all of the Challenger Camps is receiving mental health treatment (192 youth plus the additional seven youth receiving psychotropic medications who are not on the mental health caseload). This statistic suggests that the facilities are not identifying and treating all the youth in need

of mental health services, particularly in light of the fact that all youth who have mental health needs are sent to the Challenger Camps and that, statistically, as many as 65-75% of youth in juvenile facilities have a diagnosable psychiatric disorder.[17] The failure of the Challenger Camps to adequately identify youth who have significant mental health disorders is a substantial departure from generally accepted professional standards.

In short, the initial screening and assessment process fails to achieve all of its primary goals: the process does not identify youth who need immediate services, refer them for services in a timely manner, screen out youth who should be hospitalized rather than admitted to the Camps, or gather and disseminate necessary information to share with staff caring for the youth.

b. Inadequate Clinical Assessments, Treatment Plans, and Case Management

Generally accepted professional standards require timely specialized clinical assessments of youth who have potential mental health needs, development of treatment plans to guide youth's care, and implementation of those plans. The Challenger Camps fail to provide adequate clinical assessments, treatment plans, and case management.

i. Inadequate Clinical Assessments

Youth who are identified at intake as exhibiting behaviors associated with mental illness and/or substance abuse disorders must receive a timely assessment that includes the gathering of prior assessments, treatment history, and other information to confirm a diagnosis and determine an effective course of intervention. This process does not occur at the Challenger Camps, and the consequence for youth is haphazard, uncoordinated, and inadequate care.

As a result, some youth with serious immediate needs slip through the cracks and receive services far too late, or never, because of poor documentation and insufficient staffing levels.

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[17] Los Angeles County Juvenile Justice Coordinating Council, Comprehensive Multi-Agency Juvenile Justice Plan, at 57 (Mar. 20, 2001) (stating that both the National Mental Health Association and federal studies generally estimate that as many as 65-75% of incarcerated youth have a mental health disorder, and 20% have a severe disorder).

Other youth who are in need of an assessment are missed entirely because of the lack of screening. And, as described more fully in the medication management section below, even where youth are referred to mental health, they do not consistently receive an assessment.

Moreover, as a general practice at the facilities, it is our understanding that neither the psychiatrist nor any other member of the mental health staff reviews prior treatment records or contacts community therapists, parents, or probation officers for critical developmental and treatment histories. This is not acceptable.

ii. Inadequate Treatment Planning

In order for youth to receive adequate mental health treatment, they must be provided adequate treatment plans that guide their care. Treatment planning requires the identification of symptoms and behaviors that need intervention, and the development of strategies to address them. Such planning is a critical part of generally accepted professional standards and is critical for effective treatment of serious mental illness, ensuring that youth are receiving appropriate services, and allowing for the tracking of the youth's progress.

The Challenger Camps lack any kind of formal treatment planning. Although recommendations for services are listed as part of initial assessments (to the extent such assessments occur at all), no treatment plans are identified. Although case workers write documents called "treatment plans," these are, in reality, generally uniform sets of exercises designed to help youth develop insights about their delinquent acts, their behavior, and their future plans. They are wholly unrelated to mental health treatment planning.

Moreover, we found that, to the extent the Challenger Camps have any unofficial treatment planning, that planning fails to target specific symptoms or articulate meaningful strategies; does not involve important contributors, such as family members, previous therapists or psychiatrists, or any other system of care in which the youth may be treated; and fails to provide for measuring whether the plan is working. The treatment planning also rarely identifies co-occurring substance abuse disorders as primary goals of treatment, even though effective treatment of mentally ill youth with substance abuse disorders must address these issues simultaneously. Particularly troubling, the Challenger Camps have no substance abuse treatment programming, even though staff estimate that 70% of youth at the facilities

meet the criteria for a substance abuse disorder. The lack of such a treatment program grossly departs from generally accepted professional standards. In addition, the Challenger Camps have no system for establishing individual treatment plans or behavioral plans for youth frequently placed in the Special Housing Unit.

The Challenger Camps also fail to adequately involve families in any kind of treatment planning, despite the fact that families are an extremely important source of clinical information and that it is not possible to conduct an adequate overall functional mental health assessment without including current and historical information from families. Challenger staff reported that family meetings/therapy cannot be conducted on a regular basis because no clinicians are available on Sundays, which is the day families are permitted to visit. The resulting lack of assessment of family, social, and developmental history and the lack of family involvement can handicap clinicians in creating appropriate treatment plans.

iii. Inadequate Case Management

Case managers should communicate treatment plans for mentally ill youth to all staff involved in the management of youth in a juvenile justice facility, and should coordinate implementation of the plans. Although all youth at the Challenger Camps are assigned case workers in their residential units, these case workers have no mental health training, and serve as liaisons between the facilities and the probation officer, rather than coordinating care at the facilities for mentally ill youth. As described above, they write documents called "treatment plans," but these documents have nothing to do with mental health treatment.

Moreover, staff who come in daily contact with youth must have sufficient information about youth's mental health symptoms so that they can understand and respond appropriately when youth manifest such symptoms. Communication between mental health staff, health staff, custody staff, case managers, teachers, community probation officers, and parents regarding the treatment of youth at the Challenger Camps is grossly inadequate. Mental health staff do not share appropriate information with other personnel who need this information to supervise youth safely and meet their needs. For example, custody staff do not receive guidance about the behaviors that mentally ill youth display that stem from their mental illnesses. As a result, custody staff misconstrue psychiatric symptoms as intentional behaviors, and inappropriately apply ineffective discipline in an attempt to

reduce the troubling behavior. In addition, youth often target other youth who exhibit mental health problems, thereby exacerbating their symptoms.

Further, contrary to generally accepted professional standards of care, the Challenger Camps do not provide aftercare planning discharge summaries to facilitate treatment in future placements. Our review of 31 mental health records revealed that only seven contained some level of aftercare planning, and none were adequate. Although staff reported that aftercare planning is an important part of a youth’s stay at the Challenger Camps and begins at the time of admission, we saw no evidence or documentation of such planning in the records we reviewed. The failure to communicate the goals, successes, and failures of treatments tried at the Camps may compromise future attempts at treatment for youth in other settings.

c. Inadequate Psychotropic Medication Management

Generally accepted professional standards include, where appropriate, the use of psychotropic medications to augment a mental health treatment plan. The care of youth on psychotropic medications requires proper assessment and management by a psychiatrist. Medications prescribed should have a known benefit to treat the symptoms identified, based on a valid diagnosis and understanding of the root causes of the illness, and medication changes should follow documented monitoring of the effects of previous medication choices and reasons for abandoning a previous approach. Youth and their parents or guardians should be informed about the benefits and risks of medications and give informed consent for their use. Careful monitoring through laboratory tests is necessary to ensure that youth do not experience harmful side effects of many psychotropic medications.

Based on our review, the Challenger Camps have serious deficiencies in these areas, exposing youth to risk of grave harm. First, we noted lengthy delays in the initial psychiatric review of youth on psychotropic medications. For example:

- A youth arrived on 11/24/06 with a notation in his chart that he had been taking medications prior to his arrival at the Challenger Camps, and an “ASAP” request for a psychiatric evaluation. No response was noted in his chart. Two more requests for a psychiatric evaluation followed on 12/7/06 and 12/18/06, both also marked “ASAP,” and both had no response noted. The psychiatrist did not see the youth until 12/29/06 - more than a month after the youth arrived at the camp.

- Another youth arrived at a Challenger camp on 1/3/07, and a request for medication evaluation for him was similarly marked “ASAP.” Again, no response was noted. Shortly thereafter, the youth’s mental health services were terminated as a result of his “asking for things and getting angry.” Ironically, it appears that the youth was denied mental health treatment because he was exhibiting possible signs of a mental health disorder.

Instead of promptly evaluating youth who have been prescribed psychotropic medications prior to their admission, the mental health staff at the Challenger Camps automatically continue youth on those medications until they are seen by a facility psychiatrist. This means that rather than verifying the medication and obtaining a verbal order from the camps’ psychiatrist (thus sanctioning the use of the medication until the youth can be seen for an in-person evaluation), medical staff assume that the youth is taking the medication pursuant to a valid prescription, and that the medication is being prescribed for the appropriate reasons. This practice is particularly dangerous because, as discussed above, in many cases, the mental health records do not accompany the youth to the Challenger Camps. We saw many cases where admitted youth had a history of taking psychotropic medications, but had no records to document diagnosis, side effects, or past efficacy of treatment efforts. These youth nonetheless were continued on their medications. Moreover, as described above, we identified seven youth who were prescribed psychotropic medications but were not being seen by mental health staff because they did not appear on the mental health caseload.

For youth who did not enter the facilities already on psychotropic medications, the provision of such medications to youth at the Challenger Camps who need them is inconsistent at best. Some youth are prescribed psychotropic medications without the benefit of appropriate evaluations or systematic physiological monitoring. Other youth are not provided with medications to treat their symptoms at all. Still other youth are referred for psychiatric evaluation for “urgent” medication evaluations because of side effects from the medications or other mental health concerns and either are never seen by the psychiatrist or are seen weeks after the request for referral.

Moreover, where youth are placed or continued on psychotropic medications, the Challenger Camps have no protocols for providing monitoring or periodic reassessment. Specifically, although many of the medications youth at the Challenger Camps are taking require laboratory tests prior to and during the

course of the treatment, we found no protocols for the administration of appropriate tests to monitor the efficacy and side effects of psychotropic medications in accordance with professional medical standards. Additionally, the frequency of psychiatric follow-up depends, in many cases, upon when the psychiatrist has time to evaluate the youth. Often, such evaluation does not occur for months after the youth's arrival. We found a wide range of follow-up frequency, from several weeks to more than 60 days. For example:

- One youth's chart contained an "ASAP" request for medication evaluation dated 1/20/07, as well as a second request on 2/3/07. Despite these repeated urgent requests, as of our tour on 3/7/07, the youth's chart contained no documentation indicating that a psychiatric evaluation had occurred.

- Another youth was referred from another camp on 9/26/06 for an "urgent" medication evaluation because he had been having "severe headaches" and was "very irritable" since stopping his medications. Although he denied suicidal ideation, he made the statement, "I can't make it." He was housed in the Special Housing Unit pending a psychiatric evaluation, which he did not receive for more than a week.

In addition, although the case files reviewed all included signed consent forms for treatment, it does not appear that the Challenger Camps involve families in youth's therapy and treatment, including when the treatment includes psychotropic medications. Families should be involved, where possible.

Finally, as discussed above, youth at the Challenger Camps are discharged from the facilities without aftercare planning, including medication or prescriptions, thus making it likely that their medications will be discontinued precipitously. This can be dangerous. See, e.g., Wakefield v. Thompson, 177 F.3d 1160, 1164 (9th Cir. 1999) (in the context of a prisoner who was receiving psychotropic medication while incarcerated, holding that the State "must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply.").

d. Inadequate Mental Health Counseling and Other Rehabilitative Services

Generally accepted professional standards require that mental health counseling be provided frequently and consistently enough to provide meaningful interventions for youth. Treatment should utilize approaches that generally accepted practices have determined are effective. Youth with mental illness should receive treatment in settings appropriate to their needs.

We have noted previously the lack of adequate mental health counseling and rehabilitative treatment at Camp Kilpatrick. At the Challenger Camps, mental health counseling is also inadequate to meet the needs of mentally ill youth both in frequency and in content. The limited counseling records that exist do not evidence adequate use of effective treatment strategies. Despite the presence of some caring, dedicated counselors, interventions are not structured toward specific goals and do not adequately involve approaches accepted as effective. As discussed above, many youth are prescribed psychotropic medications to manage their behavior, but receive no counseling whatsoever. Indeed, as noted above, the youth with mental health needs are housed at the Challenger Camps; yet, as the Director of Mental Health Services at the Challenger Camps explained to us, mental health services at the Challenger Camps consist of "mostly crisis intervention."

Troublingly, the Challenger Camps fail to provide adequate individual and group therapies. Both types of therapy are critical to effective treatment in detention settings and are required by generally accepted professional standards of practice.

Of equal concern is the lack of a substance abuse treatment program. Staff generally do not examine individual patterns of use, abuse, addiction, or motivation, nor do they instruct youth in alternative stress management or abstinence support techniques. We found similar deficiencies in this area at Camp Holton, as well.

Recordkeeping also is inadequate. Mental health staff must keep records in a manner that allows both mental health and non-mental health staff at the facility, as well as future providers, to track treatment previously provided. Records of prior interventions are critical to guide staff regarding effective methods of crisis intervention. Counseling records at the Challenger Camps are incomplete, as evidenced by the failure to document follow-up to mental health referrals, including those involving requests for treatment, medication side effects,

discontinuation of psychotropic medications, and suicidal thoughts.

The lack of family involvement in treatment is concerning. Counseling staff fail to adequately involve youth's families in therapy and treatment interventions, thus reducing the effectiveness of any attempt at rehabilitation for youth who plan to return to their families following detention.

Additionally, generally accepted professional standards require juvenile facilities to provide opportunities for rehabilitation that include effective behavior management systems. Effective behavior management systems generally involve incentive-based programs for promoting appropriate behaviors throughout the day, and clearly defined guidelines that are consistently applied across each institution. For youth identified as having behavioral health problems, behavior management programs need to be coordinated with a treatment plan. Appropriate rehabilitative programs for youth confined in juvenile justice facilities include programs that address family conflict, substance abuse, anger management, gang affiliation, and other issues youth in a juvenile justice system typically face.

Contrary to these generally accepted professional standards, the Challenger Camps do not have an adequate behavioral management system in place. As a result, the goals of custody staff and mental health providers are not coordinated, and youth do not benefit from the little mental health treatment that is provided.

e. Inadequate Quality Assurance Program

Generally accepted professional standards require juvenile facilities to establish a quality assurance program to continuously evaluate the processes and efficacy of mental health treatment. The Challenger Camps lack any such program. Indeed, they do not even conduct internal audits; at most, the Los Angeles County Department of Mental Health conducts yearly audits. The risk of inadequate treatment without accountability or oversight is extremely high. The lapses in care discussed above should not have to be discovered by outside auditors or agencies. And, they would be less likely to occur in the first instance if adequate internal review processes were in place.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of the youth confined at the Camps, the County should implement, at a minimum, the following measures:

A. Protection of Youth From Harm

1. Ensure that youth are adequately protected from staff abuse and abusive institutional practices such as "slamming," or "assuming the bob sled position."

2. Develop and implement a use of force policy that provides clear guidelines and appropriate limits on the use of force, including OC spray. Ensure that OC spray is used only where there is an imminent risk of serious bodily harm and no other less intrusive restraint is available, and that policies regarding disqualifying conditions for use of OC spray are developed and followed. Ensure that all uses of OC spray or chemical restraints are well-documented and reviewed in a timely manner by senior administrators.

3. Ensure that staff neither threaten or intimidate youth from reporting abuse or mistreatment, nor maintain or

4. Ensure that the facilities maintain sufficient levels of adequately trained direct care staff to supervise youth safely. Provide sufficient staff supervision to keep youth safe from youth-on-youth violence and allow rehabilitative activities to occur successfully in accordance with generally accepted professional standards.

5. Improve orientation to communicate important information to new residents, such as how to access the grievance system, medical care, and mental health services.

6. Ensure that there is an adequate, appropriate, and effective behavior management system in place, and that the system is regularly reviewed and modified in accordance with evidence-based principles.

7. Provide adequate training and supervision to staff in all areas necessary for the safe and effective

performance of job duties, including training in child abuse reporting and training in the safe and appropriate use of force and physical restraint, the use of force continuum, and de-escalation techniques. Routinely provide refresher training as required by generally accepted standards.

8. Ensure that all allegations of child abuse and mistreatment are promptly referred to the appropriate authorities.

9. Ensure that serious incidents, allegations of abuse, and allegations of staff misconduct are adequately and timely investigated.

10. Ensure that the facilities provide adequate protections for youth once abuse has been reported, and safe avenues through which youth may report mistreatment.

11. Ensure that the facilities develop and implement an adequate objective housing classification system to ensure safe and appropriate housing assignments.

12. Ensure that the facilities develop and maintain an adequate youth grievance system that ensures youth access to a functional and responsive grievance process.

B. Suicide Prevention and Mental Health Care

1. Develop and implement an adequate formal suicide prevention policy, procedure, and protocol.

2. Develop policies and procedures to reduce the risk of self harm and suicidal behaviors, to include adequate suicide risk assessments in accordance with generally accepted professional standards.

3. Develop and adhere to specific protocols for mental health involvement for all youth identified as being at risk of suicide.

4. Adequately and effectively monitor all youth who are placed on suicide precautions in accordance with generally accepted professional standards in order to reduce the risk of self harm, and accurately document the frequency of all safety checks.

5. Create and implement a procedure for enacting suicide precautions pending transfer to another facility for assessment.

6. Provide staff with adequate training to identify and supervise youth at risk for suicide, including training on suicide prevention measures such as the proper use of cut down tools, and re-train staff annually to refresh their skills and knowledge of suicide prevention procedures.

7. Provide and maintain adequate mental health care staffing.

8. Provide an adequate, comprehensive, reliable mental health screening and assessment at intake.

9. Develop and implement policies, practices, and procedures for identifying youth receiving mental health services and youth on psychotropic medications.

10. Maintain accurate and complete mental health records; ensure that all relevant records are forwarded from the Juvenile Halls in a timely manner.

11. Provide ongoing training, proper supervision, and reasonable accountability for mental health clinicians in accordance with generally accepted professional standards.

12. Provide timely evaluations to youth referred for mental health services.

13. Establish and maintain adequate formal treatment planning in accordance with generally accepted professional standards.

14. Establish and maintain adequate mental health programming, including substance abuse programming, and the case management thereof.

15. Establish and maintain protocols to monitor youth who are on psychotropic medications in accordance with generally accepted professional standards.

16. Provide aftercare planning discharge summaries to

17. Establish and maintain an effective quality assurance program consisting of established policies and procedures by which to judge the quality and success of treatment.

* * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division’s website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division’s website until 10 calendar days from the date of this letter.

The collaborative approach the parties have taken thus far has been productive. We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns with regard to the Camps. Provided that our cooperative relationship continues, we will forward our expert consultants’ reports under separate cover. These reports are not public documents. Although our expert consultants’ reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical, technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at prompt remediation.

We are obligated by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you.

Accordingly, the lawyers assigned to this matter will be contacting your attorney to discuss next steps in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General

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The Honorable Thomas P. O'Brien
United States Attorney for the
Central District of California