GENERAL CORRECTIONS REVIEW OF THE CALIFORNIA YOUTH AUTHORITY

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BACKGROUND

This review was completed at the request of the California Attorney General (AG) and the Youth Authority (YA). Issues to be examined were cited in federal and state court lawsuits filed by the Prison Law Office (PLO). My charge was to answer a set of specific questions, and to make recommendations for improvements as needed. The areas covered in this report are the following:

- Ward Classification
- Access to Lawyers and Ward's Rights
- Use of Force and Ward Safety
- Restricted Programs, including Special Management Programs and Temporary Detention
- Access to Religious Services

To complete this study, I reviewed current and draft YA policies in each of these areas, as well the entire manual for the Institutions and Camps Branch. Also examined were the content of YA training materials in the relevant areas. I reviewed statistical data provided by a broad range of YA staff. The effort to identify and assemble these data was greatly facilitated by Stephen Stenoski and Van Kamberian, as well as from several staff in the Central Office such as Sterling O'Ran, Tammy McGuire, Mark Blazer, Mark Gantt, Larry Miranda, Delores Lozano, Lisa Lester, and the YA Ombudspersons, Carrie Womack and Sherry Ellis. Data were also provided by institutional staff at many YA institutions. Few of these data were readily available and

required special data collection and analysis from YA staff. The support and cooperation of YA staff in this effort was extraordinary. It is obvious to the outsider that most YA staff are extremely qualified professionals and are very committed to the agency's mission. Also examined was a large amount of materials assembled by the PLO and the AG's staff that was highly referent to the issues listed above. YA made available for my review, copies of a random sample of videotaped extractions of wards from secure areas. In no instance was I denied access to any reports or documents, nor was I prevented from talking on a confidential basis with any staff or wards.

Besides paper reviews and analysis of statistical data, I conducted intensive visits to the following YA institutions: The N.A. Chaderjian Youth Correctional Facility, the Heman G. Stark Youth Correctional Facility, the Fred C. Nelles Youth Correctional Facility, the Preston Youth Correctional Facility, the El Paso De Robles Youth Correctional Facility, and the Ventura Youth Correctional Facility. During these site visits I was usually accompanied by staff from the AG's Office and Youth Authority Central Office Staff, Stephen Stenoski and Van Kamberian. These onsite visits were generally three days in duration. Over the course of the visit, I toured each institution and inspected all the restrictive housing units, as well as a cross section of regular living units.

Interviews with institutional staff usually involved individual one-hour sessions with the Superintendent, the Parole Agent III, the Chief of Security, the Ward's Rights Coordinator, the Risk Manager, the Chaplains, and other staff. I also attended regular scheduled meetings of the Use of Force Review Committees, Institutional Classification Committees, Special Management Program(SMP) Reviews, and the Suicide Prevention Committees. In the course of my facility tours, I had unlimited opportunities to talk with line staff, both Youth Correctional Counselors (YCCs) and Youth Correctional Officers (YCOs).

Most important, I was able to conduct completely private and confidential interviews with nearly 100 wards at the facilities that I visited. Wards were chosen at random across all living units, and represented different "phases" or behavioral ratings in each living unit. Wards, including those in SMP and TD units, were brought to a interview room for these conversations. Usually ward interview lasted from 30-45 minutes. I told them that I was talking to them in connection with pending lawsuits filed by the PLO, and that my role was as a neutral fact-finder. I was neither an employee of the YA or the PLO. They were free to participate in the interviews if they wished (only a few selected wards declined to be interviewed). I took notes but assured the wards that they would not be directly quoted. I was looking for general patterns and not specific allegations. My intention was to keep their responses confidential, but I promised to report their concerns to the facility superintendents or Central Office staff if they wanted me to address specific issues. Many of the wards sought my help in getting answers to questions that they had on a wide range of issues. I made it clear that I would report circumstances in which I believed that they or other wards were in danger.

These ward interviews were conversational in style, covering their views on the specific topics of my review, but I also asked about how they were doing in school, what were their plans for the future, how their families were doing, as well as any concerns that they might have about visiting, mail, and telephone privileges. I always asked about their medical care. The interview also probed whether they felt safe in their current living unit. I would always end the interview with open-ended questions about "the hardest thing for you personally about being in the YA," and any "good or positive things that were happening because they were in YA." The wards were very open and candid in their comments. They usually thanked me profusely for "just listening to them." Several of the wards would show me injuries that they claimed were the result of attacks by other wards or were the result of use of force by staff.

At the end of each site visit I conducted a one-hour debriefing with the institution's superintendent in the presence of staff from YA Central Office and, sometimes, staff from the AG's office. These meetings were intended to give some of my key observations, and to clarify areas of confusion. I wanted to have no surprises, and I wanted to let institutional staff correct any errors in my data collection or perceptions, as needed.

As to professional standards in the pertinent areas of my review, I examined YA policies, standards available from the United Nations, the Welfare and Institutions Code, the American Correctional Association, the Council of Juvenile Correctional Administrators, and the National Institute of Corrections. In some instances, I will be referring to standards that have been applied by federal courts to other youth correctional systems. My report is organized by the questions posed in the original charge to me by the AG's staff.

I. CLASSIFICATION

- ***Does the Youth Authority have an appropriate classification system for the purposes of security and programming?***

There is a growing professional consensus that effective classification systems are central to the safe and efficient operation of correctional systems. In the 1970s, the Federal Bureau of Prisons and the California Department of Corrections pioneered the use of objective classification systems to manage offender populations. Almost all prison systems and most large jail systems now employ objective criteria that are statistically associated with serious inmate misconduct to assign offenders to appropriate custody and security levels within these correctional systems (Laurel Rans, ed., 1982; Austin, Hardyman, and Brown, 2001). Correctional classification systems are designed to reduce threats to the public and to increase the safety of

inmates and staff. Objective classification approaches can also be used to plan for new facilities. One lesson learned from objective classification systems is that large proportions of inmates can be housed in lower levels of custody without endangering inmate, staff, or public safety. This means that systems can realize substantial savings in operational and capital construction costs.

Formal systems of classification are less common in juvenile corrections. One reason for this is that most states have only one long-term juvenile correctional facility. Further, juvenile corrections systems have been more focused on assessing treatment needs rather than on custody and security concerns. It is worth noting that many prison systems are starting to incorporate treatment needs as part of their formal classification systems. The pressure to include non-security issues in prison classification systems has stemmed from litigation requiring that adult corrections systems do a better job of identifying inmates in need of mental health or medical services, including those offenders who pose a high risk of committing suicide.

The Youth Authority invests a substantial amount of staff time and resources collecting detailed information about its wards, but these data are not organized into an effective system to guide either security or custody needs. Typically wards are given a very thorough assessment at one of the YA Reception Centers during their initial commitment to YA or after return due to parole violation. This assessment covers the initial parole consideration date, the maximum confinement time, and the maximum jurisdictional date in the YA, and any special program requirements set by the Youth Offender Parole Board. Reception Center staff utilize data provided by the committing county, but also conduct an extensive series of medical, psychological, educational, and social case histories. The YA Reception Center also conducts detailed interviews with the wards to determine the nature and extent of their gang participation. The reports completed by Reception Center staff are very comprehensive, and potentially of great value in determining institutional placements and treatment planning. It is unclear,

however, whether this excellent diagnostic and assessment effort is readily and routinely utilized by those YA staff who supervise the wards on a daily basis. Further, the YA continues to cling to its traditional mission of providing treatment and training. This is an admirable goal, but YA staff also acknowledge that the ward population has become more violent and difficult to manage. It does not appear that the YA has developed a coherent strategy that integrates security and treatment concerns. Fear of violence, and especially of gang behavior dominates the thinking of many staff in living units. Staff seem confused as to how to maintain the safety of staff and wards, while still meeting the rehabilitative mission of YA. Without a clear and consistent correctional philosophy, and lacking a structured classification process, most decisions about wards are made on an ad hoc basis—with less than ideal results.

The YA does employ one security classification form that screens for those youths who can be safely placed in Camps or Forestry programs. This security risk classification points to each ward who might potentially qualify for placement in a minimum security Camp setting. The criteria on this form have not been subject to a validation study, so YA does not really know if this risk assessment effectively selects those wards who will function best in a Camp setting. Recently a ward assigned to a fire fighting detail assaulted his supervisor from the Department of Forestry. This led to a shut down on all Camp programs until the YA could investigate the matter. While most youths assigned to Camps perform quite well, it is unclear if the formal screening process assists in making these placement decisions. I repeatedly heard from staff that score on this classification instrument could be over-ridden, i.e., the ward who appeared to be Camp eligible was denied this option at the discretion of staff, or wards who did not appear to qualify for Camp placements were given waivers and assigned to minimum custody settings.

This screening form is filled out on virtually all new YA admissions, but it is not used to make assignments to any YA institutions other than the Camps. A YA working group led by

Sterling O'Ran has explored expanding this risk screening for making advisory decisions for institutional placements. This group did not arrive at a consensus for action, and YA still does not possess an organized risk classification process.

Reception Center staff make recommendations for institutional placements. Typically there are three placements options that are offered, these recommendations are prioritized by the Clinic staff, but sometimes only one placement option is given. Because of legal requirements to separate juveniles from adults, there are often very limited options to be recommended. Further, not every institution has a full range of programmatic options such as formalized drug treatment programs, intensive treatment units, or sex offender treatment programs, thus, the choices available to the Reception Center staff are even more limited. Moreover, the YA has had shifting strategies of not placing certain gang members in certain institutions. This further limits the range of placement options. Once the recommendations by Reception Center staff are made, these are forwarded to the Population Management Unit, which essentially checks to see if a bed in the chosen institutions is available. The ward is then assigned to a given institution.

As part of this review, I looked at a random sample of approximately 20 files that had been processed by the Population Management Unit. This review included examining the case file, the Reception Center reports, and the scores on the Camp Screening tool. I could find little rhyme or reason to the recommendations for specific institutional placements. Recommendations were not based on the severity of the commitment offense or the ward's prior criminal history. Since many of the wards had been in the YA before, and were returning on parole revocations, it was common that prior DDMS records were referenced in this placement reports. The allegation that a youth might be a sex offender was often decisive in making a placement determination, although there were unclear guidelines as to what constituted sex offending behavior, which could run the gamut from aggressive sexual assaults, more passive sexual contacts, to

masturbation. The ward's age was generally the most important factor, followed by alleged gang affiliations, and other geographic considerations (wanting to generally keep Southern California wards in Southern facilities, and other youths at the Preston facility or the Stockton complex).

The Central classification process does not recommend the specific living unit to which the ward will be assigned. This determination is made at the institutional level and is typically staffed by the PA III. The process includes review of the YOPB orders. It was reported by the PA III at the Heman G. Stark (HGS) facility that sometimes these orders were in conflict with the law. Judges would set sentencing parameters for specific offenses that were incorrect, but were often missed by the YOPB. In these cases the YA needs to communicate with the sentencing authority and get the situation corrected. This means that some wards are kept longer that the law permits—opening the YA to serious exposure on issues of habeas corpus violations and false imprisonment. The PA III at HGS told us that this was especially a problem for wards who moved to several YA facilities, because the new institutions did not recheck all of these factors. It is clear that this problem must be addressed and that clarifying the correct sentence must be a YA Central office responsibility and not delegated to PA IIIs at the various facilities. It is too easy for cases to "fall between the cracks." While we were told that this problem had been periodically found at HGS, other PA IIIs confirmed that they sometimes found similar discrepancies.

In making decisions or requests to transfer youths to more restrictive settings, or to recommend facility transfers, the Institutional Classification Committee review large and cumbersome files for each ward. These files are not well organized and are not user-friendly. There are no summary sheets that concisely list the main risk and treatment factors. Often the ICC needs to puzzle over when and where certain events, such as attempted suicides, took place. This process is pretty informal and often is influenced by an ICC member who reports that he

knows something about the ward, or by the Gang Coordinator who may have pertinent information. Also discussed is the ward's behavior while temporarily housed at the Reception Center or in orientation or intake unit of the facility. It is not uncommon that the ICC asks the ward their suggestions on where they should be housed. Placement in special mental health units requires the concurrence of facility clinical staff. This group makes an initial living unit assignment and transfers the ward from the intake or orientation unit to a regular living unit. There appeared to be significant variability in how the ICC process was accomplished from institution to institution. The growing ward files are then sent to the units as the ward is assigned to a specific Youth Correctional Counselor (YCC). The living unit staff must wade through this small mountain of paper to develop their treatment plans. The PA IIIs conduct periodic audits of the YCC treatment plans to ensure that they are being completed and followed, but there is significant variation among individual institutions in terms of how carefully the treatment plans are monitored.

Wards are reviewed by the ICC at a maximum of every 120 days or if a transfer to another living unit or facility seems warranted. This reassessment process is also handled slightly differently at each facility, and the process is conducted in an informal manner. The ICC comes up with a preliminary recommendation that is usually presented by the ward's parole agent. Typically the ward is invited to these meetings and asked to give input into placement decisions. The ICC members sign a form that shows they concur or disagree with the group's decision. No formalized instruments addressing risks or treatment needs are employed as part of this process. The ward is asked to sign a form indicating that he or she understand the decisions, and that he or she has the right to appeal that decision to the institution's superintendent.

There is also an informal and traditional arrangement that allows superintendents to request the transfer of a ward who poses a danger to others or who is in acute danger from other

wards. Usually this is accomplished via telephone conferences between the superintendents of the sending and receiving facilities. The Central Office Population Management Unit is informed once these agreements have been reached. There is generally no Central Office review of these or other assignments to living units unless a formal complaint is lodged by the ward. These complaints are generally in the form of letters to the Director of the YA, who in turn will send these matters to the I&C Branch for review.

The absence of a classification system is further complicated by the recent closures of many living units within the YA. Put simply, there are fewer real placement options within each facility. Some facilities may not have Intensive Treatment (ITP) Units, and so these wards are usually transferred to other facilities that have ITP units. Other facilities lack formalized sex offender or drug treatment facilities. Although the YA tries to match wards with specifically identified treatment needs to living units that might provide for those needs, this is often not possible.

Another major problem for classification is that, unlike the Department of Corrections, the YA does not rate its institutions by security or custody levels. With the exception of the Camps, all the other YA institutions are treated as if they are equivalent in security and custody levels. It is generally understood that Chad and HGS handle more difficult wards and thus operate with a higher concern on security issues when compared with Ventura or DeWitt Nelson and Preston. Nelles and El Paso De Robles are viewed as more security conscious than OH Close, but these are informal understandings and are not formalized in policy or practice. Whereas the ITPs have enriched clinical resources, presently the YA does not assign differing levels of staffing to living units based on custody and security risks posed by the wards assigned to those living units. Most of the YA facilities possess a mix of single locked rooms, open dorms, and unlocked rooms in some of the dorm units. Due to the shrinking population of the YA, most

of the rooms hold single wards, but there have been times in the recent past when many of these rooms were double-bunked. Even the single rooms are not necessarily appropriate for secure confinement. For example, at Ventura and some of the other living units, the rooms have electrical outlets, and wards are permitted to have televisions, radios, or other electrical devices in their rooms. The potential for these electrical outlets to facilitate suicide attempts, fire setting, and other security problems is significant.

Summary and Recommendations

The YA employs an exemplary assessment approach that invests significant staff time and resources in knowing many aspects about the wards. Unfortunately, there is not an effective system to ensure that these data are incorporated in day-to-day custody, treatment, and training decisions. While the YA seems to do a good job at monitoring the development and delivery of individual case plans, it is not at all clear that the YA case work process is grounded in the extensive casework process that begins at the Reception Centers. More important, the detailed information on wards is not systematically utilized for assignments to living units or facilities. YA has become more focused on program assignments of wards to formalized drug treatment units, Intensive Treatment Programs, and Specialized Counseling Programs. It is still unclear how many wards that ought to be placed in these special programs are currently housed in other units.

Assessment data is not simply translated or summarized for those staff who supervise the ward on current living units. There is virtually no passing on of these assessment data to YA parole staff who prepare the youth for return home, or to those field staff who must supervise the ward on release. Because the detailed Reception Center assessments are not routinely repeated,

there are concerns expressed that these data are badly outdated for those youths who remain in the YA for substantial terms. Adolescence is a time of rapid change and development in a young person's psycho-social development, thus, the value of the excellent work at the Reception Centers is of diminished utility as time goes on. In particular, parole staff find these initial assessments of limited value, and perhaps misleading.

The current assessment process is not very helpful in making custody decisions, with the exception of cases with dramatic psychiatric problems or immediate past histories of gang-related violence. While other juvenile correctional systems have been slow to embrace a custody-focused classification system, it is very common that prisons and jail systems across the nation have adopted the sort of objective classification approach advocated by the National Institute of Corrections. There is no inherent reason why custody classification would be in conflict with the primary mission of the YA—to provide high quality treatment and educational services within a safe environment. Indeed it is impossible to imagine how an effective rehabilitative program could be provided in unsafe and often chaotic living units. Custody classification creates a "platform" on which good treatment and education can take place.

Achieving an NIC model of classification for the YA is very desirable for short-term ward management and long-term institutional planning. This is a complex process that needs to have unequivocal support from top management, especially from the I&C Branch. There are many materials available from NIC that could be used by YA to move toward an objective classification process.

Let me outline some of the critical tasks that must be accomplished by the YA to achieve this objective. The YA should establish a high-level management group to implement an effective custody classification system. This group needs to come up with standardized criteria for categorizing each living unit in the YA according to different levels of security and custody,

similar to the classification system now being employed by the CDC. With the possible exceptions of Chad and HGS, all other institutions will have various custody levels within the facility. Next, YA needs to develop a research-validated security classification instrument that can be scored for each ward. This instrument should classify youths into differing levels of risk in terms of escape and serious institutional misconduct, especially assaults on staff and other wards.

The YA should examine the current security of the ward's current housing assignment, as compared with the presumptive placement of the youth based on the validated risk instrument. This process will reveal the mismatch between actual security and custody needs and current YA resources and options. These data can be used to argue for additional facility renovation or replacement that is more in synch with ward security needs. Further, the YA should consider developing new staffing ratios that are tied directly to the security and custody needs of the wards under supervision. Further, the YA should implement a full set of policies and procedures that cover initial security classification and reclassification.

Some YA staff have expressed concerns that a focus on security and custody classification would undermine the traditional focus on treatment and rehabilitation. This is a "red herring." Effective treatment and training cannot occur in environments that are perceived by staff and wards as unsafe. Moreover, it is entirely feasible to implement a system of treatment needs assessment that is appropriate for youths in every security classification. Juvenile correctional systems tend to break down when security and treatment considerations are not attended to with equal weight. Staff in such systems are given conflicting messages, and wards experience these confused systems as examples of arbitrary and capricious decision-making.

The changes outlined above will be difficult and potentially costly to implement. The CDC spent several years to fully operationalize their system of custody classification. In the

interim the YA should consider a more moderate approach that systematically collects data on ward security and treatment needs and attempts to make placement decisions that are more aligned with the observed needs. Until staffing and physical plant deficiencies can be rectified, the YA could train its living unit staff on improved offender management techniques that have been demonstrated to reduce violence among high-risk inmates. One place to look is the Prison Management Classification system that was tested by the Washington DOC and evaluated by NCCD under a grant from the National Institute of Justice. The Washington approach showed reductions in serious institutional infractions in one prison in which staff were trained in improved inmate supervision techniques compared to another prison that housed very similar inmates. YA staff generally lack sufficient training in managing different types of offenders, and there are living units that clearly could benefit from increased levels of staffing. The preliminary results from the YA pilot project, in which the number of wards assigned to a living unit were decreased, and staffing ratios were increased, suggest that YA needs to explore a more complete implementation of this approach. An effective custody classification system would be the best way to actualize this new approach on a system wide basis.

As noted earlier, the excellent assessment data compiled at the Reception Centers are not available to line staff in a "user friendly" format. These data are not routinely summarized and incorporated into institutional or system-wide management, budgeting, or planning. A new classification system should be supported by a management information system that could better support a wide range of YA functions and activities. For example, institutional classification data on security and treatment needs should be seamlessly passed on to the Parole Division to strengthen reentry efforts. No such system currently exists. Many of the problems that are discussed below about issues of staff and ward safety, the use of SMPs and ward's rights could be, at least partially, moderated if YA possessed a competent correctional classification system.

II. PHYSICAL SAFETY OF WARDS

On a system-wide level:

- ***Is the use of physical force against wards by CYA staff excessive?***
- ***Are chemical agents used in an inappropriate manner?***
- ***Do CYA staff receive appropriate training in the use of force?***
- ***Are ward-on-ward assaults, including sexual assaults and harassment, problem?***
- ***Are episodes of excessive use of force by CYA staff appropriately reported, investigated, and disciplined?***
- ***Is staff-on-ward harassment, including sexual harassment, a problem?***
- ***Does the CYA appropriately house wards who are vulnerable to sexual assaults and harassment?***
- ***Does the CYA appropriately investigate reports of assaults and harassment from other wards and staff?***
- ***Do CYA staff receive appropriate training in monitoring and investigating assaults and harassment?***
- ***Does the CYA appropriately protect wards from gang violence?***
- ***Does the CYA have appropriate policies and procedures for protecting wards from staff and inmate assaults and harassment?***

Because these multiple questions are highly inter-related, I will attempt to answer them in a coordinated fashion in the paragraphs below. At the root, these questions address the concern of

whether the CYA is a safe place, and if the organization is doing all that it could be doing to ensure the safety of wards and staff.

It is abundantly clear from a range of data that I collected as part of this review, that the YA is a very dangerous place, and that neither staff nor wards feel safe in its facilities. One might easily conclude that an intense climate of fear permeates California'a state youth corrections facilities. While the YA Director Jerry Harper has taken important steps to rectify this situation, the organization has a very long road to travel. Let me summarize some of the data and my observations, assessing the steps that YA is taking to alleviate these safety concerns.

Virtually all of the chiefs of security (COS) at the institutions that I visited expressed concerns that these facilities possessed serious physical design issues that made security a difficult problem. Most YA facilities are 40-years old or older; even the newer living units were built over a generation ago. Whereas the CDC has been given substantial funding from the legislature to build new facilities and to enhance the security of existing institutions, capital expenditures that have been approved for the YA have been minimal. As one chief of security told me, "these places were not designed to be safe." He went on to point out myriads of "blind spots" in which assaults could take place without staff being able to witness these attacks. This same COS showed me buildings in which broken windows and other readily available materials could easily be fashioned into lethal weapons. Living units had many areas in which security staff could not see what the wards were doing. While there were cameras installed in many of the living units, I observed that the on-duty staff did not know how to operate this equipment—i.e., how to have the cameras get close-up views of individual rooms. In one instance, the staff could not even find the remote control needed to work the cameras. Staff attempt to house those youths who are at highest risk of suicide nearest to the central security station, and they reported that

viewing the activities in the back of living units was especially problematic. Even camera rooms were less than desirable, because in-room cameras were often vandalized by the occupants, or covered with cloth towels, clothing, paper, human waste, or dirt.

The Ventura facility had many rooms with electrical outlets in the rooms. I was told that this was a common design feature of many YA single rooms (although not the newer units). The potential for electrical outlets to be used to start fires or to facilitate ward attempts to injure themselves ought to concern the YA. It was not uncommon that wards in some living units were permitted to have televisions, radios, and other electrical devices in these single rooms. Some of these appliances can easily be used to fashion weapons, or can become part of an underground facility bartering system among the wards.

The COS staff also complained about "dead spots" in fences that were supposed to be monitored via cameras or by alarms. No COS felt that they possessed adequate staffing to achieve a desired level of institutional security. While very proud of the professionalism of their staff, virtually all of the COS staff asked that more training be made available to staff, especially in the area of the use of force.

Some living units, such as the "270" units, are more supportive of security than the open dorms or older lock-up units, but COS and other staff repeatedly complained that there were serious design flaws even in the newer units that made effective ward supervision very difficult. Often entry ways to outdoor recreation areas created "blind spots," and the general disrepair of concrete floors, steps, and fences appeared to me to create potentially hazardous conditions for both wards and staff

Because most of the YA institutions are so antiquated and in a general state of disrepair due to budgetary priorities, many of the units lacked safe and effective methods of feeding wards

who were confined to their rooms. Staff complained about the risks of "gassing," in which wards would throw an unknown and potentially toxic substance at staff who needed to enter the rooms to deliver food or other materials. In the older living units, one could see a variety of staff attempts to reduce the risks of "gassing" via the use of duct tape, temporary fixes involving wooden or metal strips attached to the doors, and other non-standardized security methods. One wonders if these "patches" create additional health and safety issues for both the wards and the staff.

Perimeter security was a major issue at every facility that I visited. Some of the facilities, such as HGS and Chad, once had security checkpoints as one entered the grounds, but these posts were abandoned to consolidate security staff within the institutions. At other facilities the visitor drives right into a parking lot near the front entrance. Once at the facility, the visitor goes through a sally port and must provide a valid ID to the security. Never once was I asked if I had any weapons with me, nor was my briefcase or computer searched by YA staff. Apparently having a photo ID that corresponds to a name on the approved visitors list is sufficient to avoid a search. I never passed through a metal detector of any type at the six YA facilities that I visited. Put simply, I was subject to greater security screenings at airports as I flew to YA facilities than at the facilities themselves. While I was told by staff that approved visitors for the wards were subject to higher levels of searches for contraband, however, I was unable to witness this myself. Moreover, I wonder if other visitors, including volunteers, workmen, and vendors, are examined any more closely than I was. This policy needs to be reviewed carefully by the YA. Certainly the CDC imposes a much higher security standard in admitting visitors.

More generally, I found that YA security policies were unevenly followed, if at all. For example, it is YA policy that all staff and visitors entering an SMP or TD unit put on protective

vests. The only time that I was asked to put on a vest was at the SMP in Ventura. No similar requests were made of me at other lock-up units at facilities that housed wards with more extensive histories of violence or assaults on staff. Another troubling observation occurred during the times that I was interviewing wards at the various institutions. The security staff would bring all of the wards at the same time to the building in which the interviews were taking place. This often created a situation in which a group of wards were sitting together in a small waiting area as I was conducting the interviews. According to staff, many of these wards belonged to rival groups and were supervised by one YCO. The staff would ask these wards if they were "cool" with being together. If the wards answered affirmatively, they were allowed to remain together.

YA practices with respect to wards having personal items in their individual rooms or lockers seemed inconsistent. I observed ward rooms that were filled with a range of materials that might be regarded as contraband, or could be used to make weapons. Periodically, facility administrators would become concerned about the amount of personal items in the possession of the wards. In these cases, with little advance warnings, the security staff would conduct room searches and confiscate large amounts of ward possessions. The wards were very resentful of these "raids" and were doubtful that their confiscated personal items (including family photographs) would ever be returned to them. While it is abundantly clear that correctional agencies have the right and duty to monitor the personal items held by inmates in their rooms or living units, the patently inconsistent and ever changing nature of institutional policies and practices is not desirable.

Security practices vary widely across the facilities that I visited. For example, ward movements are rigidly controlled by staff at some institutions, but they are much more relaxed and informal at others. These differing facility policies did not seem to be necessarily related to

the potential dangers posed by individual wards or by rival groups. This is, in part, due to the absence of a clear ward security classification system that might be reflected in different institutional practices. The general YA approach to safety and security appeared to me to be primarily reactive in nature. The principle control device that was used by staff was lockdowns of whole units or institutions, or immediate transfer of certain wards to TD units. There have been documented instances reported by the Office of Inspector General in which institutions, especially Chad and HGS, were in lockdown status for weeks and even months. Stepped up security measures are often geared up to respond to the last problems, e.g., a group disturbance in the chapel, which might not happen frequently. Recently, the YA has instituted the staff position of Risk Managers, who are supposed to compile statistical data about the time and place of security problems, and to identify any patterns. The Risk Managers provide this information to institutional management staff, however, the degree to which these Risk Managers are funded (fully budgeted or just an additional job assignment for existing staff) varies across facilities. Generally, YA administrators seem to lack "early warning" data about potential problems that might be brewing before actual outbreaks occur. Typically, the gang coordinators are relied on to "take the temperature" of rival groups and to anticipate potential outbreaks of violence, but the YA has only recently invested in upgraded training and better Central Office support for the gang coordinators at the individual facilities.

Data on Ward Safety and the Use of Force

YA Director Jerry Harper has been instrumental in starting efforts to collect system-wide data on ward safety and the use of force. These efforts, while laudable, are still in the pilot phase, and there is considerable variability in reporting across the YA institutions, especially on the use

of force. Greater attention is needed on increasing the consistency and quality of reporting in these crucial areas. I will summarize the data that I was able to collect with the able assistance of, Tammy McGuire, Stephen Stenoski, Lisa Lester, and Van Kamberian. These limited data paint an alarming picture of violence issues in the YA.

Perhaps the most conservative measure of violence in the YA comes from data on sustained DDMS level B infractions. These are limited to wards who either admitted to serious violations or were found guilty by the DDMS fact finders. Not included are violent incidents that do not come to the attention of staff, or events in which a lesser DDMS violation is changed. This latter situation might occur in which eye witness accounts are absent, or the evidence is contradictory.

This very conservative measure of violence reveals a stunning amount of violence in the YA. In 2002, the six institutions that I visited accounted for over 4000 sustained Level B infractions for ward on ward assaults and battery—at least 10 such assaults every day.

Level B DDMS Data for 2002

	EPDRYCF	FCNYCF	HGSYCF	NACYCF	PYCF	VYCF
Average Population	598	471	956	651	574	570
Ward/Ward Sexual Act	6	28	8	9	5	0
Ward/Ward Sexual Assault	1	5	3	0	0	0
Ward/Ward Assault/ Battery	921	1123	1164	346	714	48
Sexual Harassment	87	401	203	121	107	6
All Level B's	2159	2459	3159	1465	1532	864
Assaults/Batteries on Staff with Weapon or Vile Substance	4	10	27	13	5	5
Assaults/Batteries on Staff without Weapon or Vile Substance	12	20	27	23	5	7

There were 921 infractions at El Paso De Robles, 1123 at Nelles, 1164 at HGS, 346 at Chad, 714 at Preston, and 48 at Ventura. The different facilities have different rates of assaults per inmate population, however there is no clear explanation that accounts for these differences.

Besides the ward-on-ward assaults and batteries, there were nearly 1000 incidents of sexual harassment, as well a number of sexual assaults by wards on other wards. Also in 2002, there were 84 Level B infractions for wards who committed assaults and batteries on staff with weapons or vile substances (referred to as gassings). The Nelles facility stands out as having the highest rates of violence, but the other institutions seem equally plagued by these events. These levels of ward-on-ward or ward-on-staff assaults are unprecedented in juvenile corrections across the nation. While there are no reliable data kept on disciplinary infractions in juvenile corrections across the states, many national corrections leaders were astounded by the apparent frequency of assaults in the YA.

As noted, each of the institutions uses different categories for reporting either violent incidents or the use of force, necessitating the review of these data for individual facilities. For example, in 2003, HGS had an average population of 872 for the first four months of that year. During this period, HGS reported 16 assaults on staff and 3 gassings. From January through April, 2003, there were 14 instances in which staff needed to use a pepper ball launcher to quell a group disturbance, and 1 alleged sexual assault. For the first four months of 2003. HGS had 2 ward injuries and 4 medical emergencies that were serious enough to report to the YA Central Office. In addition there were 10 ward fights that involved multiple wards. In December of 2002, HGS experienced 26 group fights. During the first four months of 2003, HGS used chemicals restraints a total of 535 times, physical restraints were used 109 times, and mechanical restraints were used 236 times. Pepper balls were used 10 times.

At Nelles there were 274 use of force reports that were submitted to the Central Office during the first 4 months of 2003, mostly involving chemical restraints. There were 1,413 wards "necessitating security dispatch." The vast majority of these incidents involved fights among

wards. In two cases, the wards used weapons. The average population of Nelles during this time frame was 439. These incidents included 52 wards who are identified as receiving intensive mental health services. According to the judgment of Nelles administrators, none of these situations involved "unnecessary or excessive" use of force, although these terms are only generally defined in YA policies.

Preston reported only 242 uses of restraint between January 1 and-April 30, 2003, and El Paso De Robles had 237 use of force reports in this same period. The El Paso De Robles report notes that the institution was "averaging 1.1 macings a day. With our population decreasing and things calming down, staff are reacting at the appropriate times." Chad reported 482 use of force incidents involving 812 wards. There were 284 incidents involving chemical restraints, 80 instances of physical restraints, and 19 incidents involving the use of mechanical restraints. There were also 19 cases in which less than lethal force (e.g., pepper ball launchers) were used.

Other Data Sources

The picture of frequent violence in the YA is further supported by letters that wards and their parents write to the Ombudspersons or the Director of the Youth Authority. I reviewed all the letters received by the Director for the first six months of 2003. Of the 136 letters written from wards or their parents at all YA institutions, 23 expressed concerns over physical safety, another 18 involved transfer requests, which often involved issues of ward safety, and 16 involved complaints about staff misconduct, especially verbal abuse. Letters about ward safety were most likely to come from Nelles, HGS, and Chad. Letters received by the Ombudspersons showed a concentration of safety issues at HGS and Nelles. Ward complaints over safety issues and excessive force also appeared in grievances filed by the wards, but were less frequent than

complaints of about everyday denials of requested services. As will become clearer later in this report, the Ward Grievance System (WGS), does not have very high confidence among the youths confined in YA institutions. The wards utilize the WGS to solve very basic issues and do not view the WGS as effective when the complaints are directed at staff actions. Consequently, the WGS is probably not giving the YA administration a complete picture of the issues faced by the wards.

My confidential interviews with almost 100 wards and with several staff were consistent with the statistical data presented above. Few youths felt that the YA was a safe place to be confined. Those who reported feeling safe explained to me that they managed their personal safety either by (1) keeping a very low profile, or (2) aligning themselves with others to band together for protection. Few wards felt that staff were responsible for the unsafe conditions. The typical response was that "this is a jail and it is filled with dangerous people." Many wards felt that the staff did what they could to provide safety, but that the YCCs and YCOs were generally unable to prevent the frequent violent attacks of wards on wards. In only a few cases did wards complain that individual staff knowingly placed wards in harm from other wards. Although there is no absolute way to check this impression, it appeared that the YA is well focused on investigating complaints that staff are exacerbating institutional violence. This YA Central Office focus is a result of revelations several years ago that some YA staff facilitated fights among rival gang members—the "Saturday Night Fights." It appears that YA staff are very concerned about trying to isolate wards who might attack each other, although these efforts seem not to substantially reduce the level of institutional violence.

The primary staff response to curtailing institutional violence is the use of gang intelligence information, the frequent resort to lockdowns of living units, expansive use of temporary detention, the DDMS system, and prosecuting wards in local juvenile and criminal

court systems. While there are treatment programs that cover anger management and avoiding gang involvement, there is little evidence that these programs are having any positive impact on institutional violence. The dominant YA response to ward violence is reactive and after-the-fact.

Preventive strategies are either nonexistent or very rudimentary. For example, I sat in on a number of meetings of the institutional use of force committees. These meetings typically went over statistical data on the number of incidents that happened in the preceding several months. The general sense of the meetings was for staff to convince each other that either "things were getting better," or that no specific actions were required. There seemed a consensus that more prosecutions and harsher DDMS sanctions could help make the institutions safer. Many staff were concerned that Central Office edicts that limited the use of the SMPs or required shorter stays in these units were not promoting safety. I never observed institutional managers planning proactive efforts to reduce the level of violence at their facilities. The focus on reactive and punitive approaches to ward violence has necessarily led to more formality in the investigative process (to meet due process and equal protection concerns), and was consuming ever larger amounts of manager's time at both the institutional and Central Office levels.

Both wards and staff suggested that the most vulnerable youths were those with mental health problems, those labeled as homosexuals or as sex offenders, or wards who were attempting to disengage from their prior gang affiliations. Open dorms were viewed as the most dangerous housing assignments, although attacks sometimes occurred in the lockup units. The classrooms, vocational areas, and recreation areas were also prime areas in which group fights or individual attacks were common. There were periodic group disturbances that broke out in the chapels.

Only Chad had a living unit devoted to wards who pledged to remain not involved in gang activities. Staff at Central Office and at almost all of the institutions talked about the possible

need for a protective custody classification and specialized housing arrangements. While some YA staff expressed concerns that PC units created a different set of ward management issues, I was repeatedly told by superintendents and security staff that many wards attempted to achieve some measure of personal safety by getting placed in mental health units (ITPs and SCPs) where there was somewhat enriched staffing and single rooms. YA staff also reported that some number of wards in the TD or SMP units tried to get into these programs as a means of self-protection. Some wards would build up a legacy of conflict with other wards, and saw transfer to other institutions as their only option. The absence of an effective YA custody classification system and the limited array of housing options makes the protection of especially vulnerable wards a challenging responsibility. Ironically, institutional staff and some wards reported that Central Office policies that are designed to better regulate entrance into mental health or SMP programs limited their ability to use these existing options to provide a measure of short-term safety.

A topic that came up in many of the ward interviews was the problem of individual wards being designated as "Green lighted," "Black lighted," or "Rainbow lighted." If a ward is under one of these "lights," this is a signal that other wards are encouraged to violently assault this ward. Green lights and Black lights refer to attacks by Latino or African American wards. A Rainbow light means that all the wards are encouraged to attack. It is wards who place other wards under the "lights" designation. The wards who believe that they are in these categories express tremendous fears for their safety. They are reluctant to attend school or be placed in living units with open dorms. Often these wards request transfers to SMP units or mental health programs for self protection. In some cases, the wards demand transfers to other YA institutions to avoid attack. "Lighting" feeds into the intense climate of fear among the wards, especially

those who fear that they will be placed in this category due to relatively minor slights against other wards, or to rumors.

Staff readily acknowledge the existence of the "lights" system. The staff explain that, while some of the wards in this category are viewed as "snitches" by fellow wards, the most typical reason for being in this endangered group is to engage in verbal disrespect of other wards. The offended party then rallies his friends and gang members to retaliate against the offender. For some gangs, attacking a "lighted" ward is a point of honor among peers. YA staff often describe these vulnerable wards as "window warriors," meaning that they yell insults at other wards from behind their locked doors, Apparently, this verbally hostile behavior is fairly common in the SMP and TD units. According to YA staff, the "window warriors" are not so much dangerous gang members as extremely immature wards who get themselves in trouble by provoking others.

The problem of "lights" existed at all of the facilities that I visited, but was the most prevalent at Nelles. The staff generally resolve the "lights" issue by informal conflict resolution approaches. YA staff, including the gang coordinators will talk to the offended parties and try to negotiate some diminution of tensions and violence. The staff may actually arrange meetings of wards in which the offender and offended are asked to work out a compromise solution that ends the threat of violence. If YA staff believe that they cannot help resolve these problems, they may support recommendations for transfers to other living units or other facilities. However, many of the attacks occur in common areas such as the schools, recreation areas, or the dorms, and the staff cannot prevent all of these assaults from occurring. The general attitude of the staff is to "work around" the problem of "lights," and they are often ambivalent towards the endangered ward who they believe contributed to this potentially violent situation. Each institution has a somewhat different policy of how they deal with "lights." While the Central Office management

supports a "zero tolerance" of the phenomenon of "lights," the YA has yet to adopt a coherent approach aimed at ending the practice.

Use of Excessive Force By YA Staff

Suspicions that YA staff were engaging in the use of excessive force were found to be well grounded in a number of audits and investigations that were conducted by the Office of Inspector General (OIG). These reports documented the dangerous and potentially fatal use of high-powered weapons that delivered chemical agents. These chemical restraints were designed by their manufacturers to be used by correctional staff to quell riots that broke out in prison yards, but YA staff were using these same powerful chemical agents during extractions of wards from their rooms and other secure areas. Since these powerful chemical agents absorbed the oxygen in the small ward rooms, there were real dangers that YA inmates could be asphyxiated. The OIG also found instances of wards who had received severe burns to their skin because they were not permitted timely access to showers after being sprayed. Numerous other problems in the use of force were identified by the OIG at Chad and HGS. But, the most dramatic physical abuses of wards were found at El Paso De Robles. The OIG found that wards at Paso were made to spend long periods of time on their knees with their hands bound behind them in mechanical restraints. In some cases the wards were made to kneel on sharp surfaces that increased their discomfort. This was called by staff "Gym TD." Other wards were made to strip down to their boxer shorts and were forced to sleep on cement slabs in very cold rooms. Some staff also struck the wards during these situations. Based on the OIG report and internal reporting, the YA launched a number of internal affairs investigations resulting in several early retirements and some transfers. Three cases were referred to the local District Attorney's Office. One case was successfully prosecuted. The seeming inability of top YA management to appropriately respond to the findings

of the OIG in 2000 and 2001 in areas of excessive force led to the recruitment of Jerry Harper, a former Under Sheriff from Los Angeles County. Harper had successfully reformed several illegal practices in the LA County Jail, and he possessed the reputation as a "no nonsense" law enforcement professional who could clean up bad correctional practices. Harper was an outsider to the YA bureaucracy who came in with a mandate for change. The OIG suggested that staff training needed to be significantly upgraded, and there needed to be far greater Central Office oversight as to the use of force at various institutions. Thus, it was not at all surprising, given the OIG reports and media accounts in the Los Angeles Times about abuses of force at Nelles and HGS, that the plaintiff's lawyers in *Stevens v. Harper* would raise the issue of excessive force in their pleadings before the court.

As with other YA correctional issues, statistical data on the use of force are scant and not consistent across the facilities. Central Office staff review only a fraction of potential incidents involving force, and the primary responsibility for investigating these issues rests with the superintendents of each facilities. There are not very extensive reports that are available to assess the thoroughness and quality of these local investigations. Behavioral reports that are prepared by YA staff to accompany these serious incident reports (SIRs) are often very brief and not very helpful in understanding what transpired. At virtually all of the institutional use of force committee meetings there are concerns expressed about the thin content in the behavioral reports and the need to train YA staff to produce more in depth and detailed accounts of these incidents.

Ward Interviews on Use of Force

During confidential interviews with over 100 wards, I asked various questions about whether these youths had been physically or sexually abused by the staff. I asked about staff abuse in a variety of ways, and only after I had established a rapport with the ward and he or she was talking

freely to me about their experiences in YA. There were only one or two instances in which wards related stories about the alleged abuse by staff. These wards would show me injuries that they attributed to staff physical abuse such as twisting mechanical restraints too tightly or allegedly throwing a ward against a wall. In these cases I worked with the assigned YA staff Stephen Stenoski or Van Kambarian to further research these claims. They were unable to come up with any reports or records indicating whether excessive force was used. The attached behavioral reports that were forwarded to me about these youths were generally not very detailed, and it was unclear from the reports whether unusual force had, in fact, been used. In one case, the staff member had been investigated by Central Office, but no adverse staff actions were taken as of this date.

Most of the wards did not feel that they had been personally subjected to excessive force, nor did they report being witness to others being physically harmed by staff. The wards told me that staff used force to stop fights. While they did not relish being sprayed by chemicals as part of staff activities, the vast majority of the wards felt that the staff were not attempting to use excessive force. Their attitude was that some wards provoked staff reactions by their own behavior and that the staff use of force was appropriate. Several wards suggested that some staff who came to work were experiencing "bad days" and this might lead to short tempers and increase the likelihood that these staff would perceive ward behavior as threatening to the staff.

It should be noted that virtually all of the YA wards that I interviewed had spent time in county juvenile detention centers. It is fairly common that county staff use chemical and physical restraints in these institutions, so the YA wards may have perceived their treatment by YA staff as a continuation of the expected treatment of young inmates of California juvenile justice institutions. Further, many of these young people have endured long personal histories of violence directed at them by family members, gang peers, and other law enforcement personnel. It is quite possible that these young people find it difficult to gauge the level of physical abuse against them that actually

crosses the line of acceptable adult behavior. I could not unequivocally conclude that isolated incidents of staff use of excessive force did not happen. But, my ward interviews suggested that such behavior was not widespread or systemic in the YA.

The same positive report cannot be made about staff verbally abusing the wards. There was almost unanimous complaints among the wards that YA staff make demeaning and angry detrimental comments to the YA wards on a daily and routine basis. One of the YA Ombudspersons reported to me that she received many complaints from wards about verbal abuse of staff and that the youths were routinely disrespected by staff. This Ombudsperson observed that verbal abuse seemed to be "inherent in the staff culture," and she wondered why staff come to believe that their behavior was therapeutic.

A review of ward grievances that were filed between July 1, 2002, and June 30, 2003, revealed that there were 99 complaints about staff disrespectful behavior at Chad, 79 such grievances at HGS, 105 similar grievances filed by wards at Preston, and 112 grievances at Ventura. Staff disrespect was the basis of 36 and 19 ward grievances that were filed at El Paso DeRobles and Nelles, respectively.

The wards complained about demeaning comments by staff that communicated to them that the staff felt that the wards were worthless and had no chance for rehabilitation. Negative staff comments also extended to the wards' family members. Reported verbal abuse often involved expletives and coarse language. Wards told me that some staff routinely yelled in close proximately to their faces, attempting to elicit a physical response that could lead to disciplinary writeups, the use of temporary detention, or the escalation to the use of chemical restraints. While few of the YA wards complained about racially hostile statements by staff, there were several concerns about staff comments about the wards that suggested that they engaged in homosexual behavior with other wards. Some courts have held that this verbal harassment of inmates by staff constitutes a violation

of their rights. Few correctional experts would defend these practices as beneficial in terms of the treatment process. Indeed, adapting the military boot camp model in juvenile correctional programs has not been shown to be effective. There is even some speculation that harsh verbal behavior by staff makes facilities more dangerous for staff and wards.

YA staff did not deny that these verbal exchanges took place. Some managers felt that some staff believe this rough language can motivate the wards to improve themselves. The model that they had in mind was the stereotype of the military drill sergeant who constantly berated the new members of his unit. Other YA staff explained that the wards often used negative epithets in verbal interactions with them. YA were simply giving back the verbal hostility that they were getting from the YA wards.

Many YA institutional managers criticized the use of verbal abuse by staff. They argued that the staff should not try to "act like wards," and that there was a clear need to maintain a standard of professionalism. For example, such verbal abuse would not be tolerated by law enforcement officials during their interactions with citizens, including those that were being taken into custody. There was a range of opinions among YA managers as to whether they could do very much to stop the verbal abuse. There had been some inquiries and investigations about individual staff, particularly as a result of grievances filed by wards. However, staff action grievances often took a long time to complete. Union agreements and other state personnel rules made it quite difficult to enforce sanctions against offending staff members.

The reported extensive use of verbal abuse by staff, and the dubious theory that this behavior could be a positive motivational tool, is reflective of the very limited amount of training that YA staff have received on ward management issues. Staff are asked to perform a difficult job, managing many youths with severe behavioral and mental health problems. Training and ongoing

coaching on the most effective strategies of managing ward behavior by supervisors with their line staff appears to be quite limited.

Secure Area Extractions

Force is used by the YA primarily in connection with stopping ward-on-ward fights in curtailing group disturbances. However, another set of situations in which force is exercised is in connection with extraction or removal of wards from secure areas, principally their rooms. These events often entail significant risks of injury to both the staff and wards. A relatively new YA policy requires that all of these extractions be videotaped. As part of this review, I requested permission to view random samples of these videotapes. The YA complied with my request, and I was able to view 36 such videos from Chad, HGS, Nelles, and Preston. A smaller number of these extractions occurred at El Paso De Robles, but they also provided all of the tapes that they had completed in the last year. At this writing, I have not viewed the El Paso De Robles tapes. In some cases, I watched the tapes as part of a use of force committee meeting that was convened at the institution that I visited. Since the tapes are numbered differently at each facility, I would generate a random set of numbers and YA Central Office staff would acquire copies of the selected tapes from each facility. I watched the collected tapes at YA headquarters, usually with Stephen Stenoski and Van Kambarian in attendance. In two of these sessions, AG staff were also in attendance. In addition to the specific tapes, I had the benefit of reviewing all of the behavioral reports written by staff in the wake of these secure area extractions.

The first impression one gets in viewing these secure extractions is that YA staff are still learning the protocols for videotaping these events. The tapes often ended when the camera batteries or tape ran out. The tapes did not necessarily cover the entire duration of these incidents. It was clear

that the YCOs were not entirely clear on the purposes of the taping. For example, many of the tapes did not describe in sufficient detail the reasons for the room removals. The YA would use very generic language "for the good order of the institution," but there was little concrete information about the particular risks that were being responded to by the security staff. Further, the videos rarely contained a verbal description of the steps taken by the staff to resolve the problem without use of force. The videos seem to be focused on showing the sequence and extent of use of chemical or other restraints. The accompanying behavioral reports that were submitted by staff were equally thin on details as to the reasons force needed to be used or the alternative conflict resolution approaches that were attempted. The written reports were generally focused on the amounts and timing of the use of various methods of restraint that were employed in the secure area extractions. In one or two instances of the videos that I reviewed, the written files were empty.

It was often quite difficult, in viewing the secure extraction videos, to understand the necessity to escalate the use of force. A very typical scenario involved a ward who was refusing to come to the door of his room and submit to being handcuffed. In some instances the ward had barricaded himself under a mattress. Another apparent reason for a secure area extraction was a ward who had placed a towel or paper over the door window. Often, as the YA staff would open the door for the first use of chemicals, these window blockages would be pulled down, however the extraction would continue until the ward submitted to being placed in mechanical restraints. Sometimes the tapes or the written reports indicated that the ward was refusing to come out of the room, or that he had created a disturbance by banging on the door or making excessive amounts of noise. The video would generally show the staff giving a curt warning that chemical restraints would be used if the ward did not comply with staff requests. The balance of the video would document the sequence in which force was escalated, including the use of pepper ball launchers and physical entrance by YCOs. There was little evidence in the videos or in the accompanying files that the

YCCs had reviewed or were briefed by mental health or medical staff on any pertinent issues that might be useful in responding to the situation.

In every case, the ward would ultimately submit to staff instructions, although the process could take well over one hour to complete. Typically these events occurred during the Third Watch and tied up almost all of the security personnel at the institution during that time period. Once the ward was placed in mechanical restraints, they were moved to a shower and permitted to wash off the chemical agents. Other YA staff washed down the ward's room to remove chemicals from the environment. The ward was usually seen by a medical technician who washed out their eyes and examined the ward for any injuries. In most cases the ward was then returned back to the original room. This often appeared to me to be a great deal of investment of staff time and effort to slightly pacify the ward who was originally being disruptive. None of the videos showed the YCOs utilizing the advise or support of clinical staff or other non-security personnel. I was repeatedly told that once the security staff were called, the YCOs were supposed to back off. Ironically, the management of a very angry and upset ward is passed over to the staff that probably knew the least about that individual's psycho-social background. It was likewise unclear from the YA records, whether there was any subsequent mental health intervention for their wards by YA staff.

There is no doubt that YA staff must aggressively intervene in situations in which ward safety is a major consideration. However, it is not clear that the secure area extractions are always warranted, or if some lower level of force, including attempting a sustained conversation with the ward, might not produce a better result with less risks to staff and wards. Although there are no national data on this topic, my strong impression is that secure area extractions conducted by security staff alone is a very rare practice in juvenile corrections across the nation. It would be worth finding out if CDC has the same rate of cell extractions as the YA.

In my interviews with wards, especially those who were currently the SMP units, I was told that wards created disturbances in their rooms ("setting up shop" or "posting up") as a method of getting staff to respond to some concern or need that they had. For example, a ward told me that he needed a new toothbrush and made this request of the YCO on duty. Another ward was upset because his telephone time was shortened by a staff member. Others described having emotional crises after getting bad news from their families—e.g., expected visitors would not be coming, family members were ill, or close friends had been killed. This acting out behavior and subsequent room extractions was aimed at getting someone's attention and being taken seriously. This behavior does not necessarily reflect staff indifference to ward needs but may be a result of how many tasks must be completed during a shift by YA living unit staff. Further, many wards could benefit from help in communicating with others to achieve personal objectives. We know that many YA wards have serious difficulties with their interpersonal skills, especially with authority figures. Moreover, many YA staff acknowledged that the secure room extractions often involved wards with moderate or severe mental health issues, or those who were emotionally immature. Many of the wards told me that they would never "post up" and that this was the behavior of other youths who "have problems."

Even more troubling, the secure area extractions are often perceived by staff and wards as contests of will. The wards witnessing the large contingent of staff that are required to subdue one ward are often cheering their peer and making disparaging comments about the staff. The entire living unit is disrupted, the security resources of the whole institution are being spent on this one incident, and the atmosphere of "staff against ward" tensions is exacerbated. Interestingly, there are significant differences among YA institutions in the frequency of secure area extractions. While some of these differences might be a simple function of the proportion of wards who are in single rooms, one suspects that distinct facility cultures effect how frequently the YCOs are called in to perform these tasks. The YA needs to take a comprehensive look at the occurrence of secure area

extractions, including the policies and procedures that govern these events. Greater use of counseling resources or assistance from medical staff or chaplains might obviate the need for many of these situations in which large amounts of force or chemical restraints are employed against wards.

Monitoring the Use of Force

Since Jerry Harper assumed the role of the Director of the YA, he has taken several steps to build more review and accountability about the use of force. Some of these changes were instituted in response to reports by the OIG, and other policy changes were based on Harper's experience managing the LA County Jail. The YA seems to take a very long time to actually institute new policies. Extensive consultation with CCPOA representatives is often cited by management staff as a major hurdle to finalizing new policies or revising older ones. Further, the traditional organizational style of the YA was to delegate most of the details on implementation to the facility superintendents. This practice was justified due to the different types of wards that each institution was managing, but this highly decentralized model led to widely disparate practices. In the past, there was almost no Central Office oversight or monitoring on how each facility was interpreting basic YA policies. This traditional relationship between the Central Office and the facilities is starting to change, engendering a substantial amount of complaining at the facility about unnecessary Central Office paperwork requirements and general meddling into daily operational issues. As a result of this history, the Central Office has tried to solicit input and ideas of facility-level staff, adopting a consensus-building model as part of the development of new policies. This consultative process makes the creation of new policies a fairly lengthy process. As a result, Director Harper and his staff have moved on a number issues via the mechanism of Temporary Department Orders (TDO) to address important concerns in a number of operational areas.

Until fairly recently most reviews of force were conducted at the institutional level without Central Office review and oversight. In December, 2002, TDO 02-06 mandated that all inquiries as to the use of excessive force needed to be forwarded to the Central Office. About this same time, each facility was required to organize a use of force committee that was to meet monthly, forwarding a summary of their data and their deliberations to the I&C Branch. Facility superintendents continue to exercise a fair amount of discretion as to the level and intensity of these inquires. However, all of the superintendents that I talked with were keenly aware that the PLO lawsuit, audits by the OIG, and a more pro-active management style in the Central Office, were putting them in the spotlight, and these investigations consumed a very large portion of their work time and attention.

If an event at a facility requires a Serious Incident Report (SIR), a ward files a staff action grievance about excessive force, or another staff members makes a report about excessive force, then the superintendent will lead an inquiry into the matter. The superintendent will typically include his COS and Assistant Superintendent in this matter. The involved staff, the Seniors (their supervisors), and the Treatment Team Supervisors may be called upon to assist in their inquiries. In the last year, the Central Office required that all of these investigations must be reviewed and signed off by the Deputy Director of the I&C Branch. Copies of these investigation reports also go to the Internal Affairs Division and are reviewed for the quality of the investigation and the completeness of the report. The IA Unit determines if all the right questions have been answered, if further investigation is required, or if Internal Affairs needs to start its own investigation. According to the head of the YA Internal Affairs Unit, Mark Gantt, "In the past there was never a review by anyone outside the institution. We never saw them. The new process assures that there is an objective review and final approval."

Information provided to me by Stephen Stenoski reported that, in 2002,the I&C Branch had received 20 inquires that pertained to ward safety issues from El Paso De Robles, 12 each from HGS

and Chad, 10 from Nelles, 7 from Preston, and 6 from Ventura. These were usually inquiries that followed ward grievances about their lack of safety. Ten of these inquiries were referred by Stenoski's Unit to Internal Affairs. Interestingly, 40% of the inquiries from Nelles were sent to Internal Affairs.

Mark Gantt found 197 cases from Fiscal 2002 that were investigated by the Internal Affairs Unit. Of these, 52 were for excessive force cases, of which 16 were sustained. There were an additional 4 investigations for excessive force involving chemical agents, of which 2 were sustained. There were 8 IA investigations for "discourteous treatment of wards," with 3 of these sustained. The balance of the IA cases involved staff charged with domestic violence or failure to appear at work. The IA Unit spends a average of 150-160 hours on these investigations, which are conducted by trained criminal investigators. The report from IA goes back to the superintendent of the facility (or the parole office supervisor). These latter staff decide if the charges have been sustained and what if any sanctions are required. The Deputy Director of I&C must review these superintendent decisions and can agree or disagree. Assuming that an adverse staff action is recommended, there is a further examination by the Adverse Action Review Committee that includes the Director of YA, the Chief Deputy Director, the Deputy Director of the I&C Branch, the Chief Counsel, and the head of the Internal Affairs Unit. The legal department of YA puts forward the presentation of the case to this committee. The final outcome of an adverse action against staff requires the approval of the first four members of this group. According to Mark Gantt, approximately 35% of these cases are sustained at this level. There are also follow-up appeals that can be brought up to the State Personnel Board.

The YA takes these cases very seriously, but that they follow a process which is very deliberate and cumbersome and takes a substantial time to complete. Given the very frequent incidents involving the use force, especially chemical agents, it is obvious that current investigatory resources are stretched very thin. The small number of sustained adverse staff actions does not

appear to provide very much accountability, except in the most severe cases. The YA must rely on the aggressive pursuit of its policies by the institutional superintendents to reduce the use of excessive force. These superintendents, in turn, must depend on their middle managers to convey the YA mission and culture, providing continuous reinforcement to line staff to do the right thing.

Summary and Recommendations

The YA suffers from a serious problem of violence in its institutions. This plays out in terms of large numbers of assaults of wards on wards, as well as a significant number of ward assaults on staff. Of equal importance, the climate of violence has engendered high levels of fear among wards and staff that affect virtually all aspects of daily operations. These tensions produce an extensive use of force, especially chemical agents. Further, the YA staff are mostly relying on a reactive response to the violence, involving the use of the DDMS and the resort to extensive use of restrictive programs and temporary lockdowns. YA policies in these areas are relatively new and are still being field-tested at the individual institutions. Training resources for line staff are limited, especially in the areas in which TDOs and other interim rules are being enacted. The absence of new training academies means that most front line staff are receiving limited training under the 7K program, and supervisors and other middle managers are not being trained under these efforts. Training costs come out of the institutional budgets, requiring the superintendents to juggle expenditures to find budgetary resources for training. While greater Central Office oversight on critical incidents and the use of force is a very positive step forward, the levels of resources being devoted to this oversight by the Compliance Review Unit or through Internal Affairs are not yet sufficient to fully implement the goals of the Central Office.

Staff in the Central Office and at the various institutions claimed that levels of violence had gone down as the ward population was lowered. Living units hold fewer wards, especially when

compared with the chronic crowding of just a few years ago. The YA has generally responded to the declining ward population by closing housing units, or proposing to close whole facilities. These plans are clearly driven by budgetary pressures, especially from the legislature.

There is some convincing evidence that lowering the size of living units and enriching staff resources can reduce violence in the YA and promote better rehabilitative outcomes. Impressive research that was conducted by the YA Research Division from the 1960s and 1970s showed that lowering the size of living units to no more than 50 wards substantially improved correctional management and advanced treatment goals. This research has been influential for the design of juvenile correctional facilities across the nation, and was important to establishing professional standards (e.g., ACA standards) on the appropriate size of living units. Ironically, California policy makers chose to ignore the findings of their own research and attempted to operate living units that were too big.

Saving money was the rationale for the larger units, but this justification may have fueled the problems that now plague the YA. Staff overtaxed by the number of wards that they must manage have resorted to seemingly time-saving approaches that employ greater use of restraints and force. Many staff complained that they lacked enough time to even talk to the wards on each shift, and were consequently not aware of the emotional state of the wards under their supervision. The staff freely admitted that daily interactions with wards was very important to creating safer environments. The YA needs to consider implementation of cost-effective methods to reduce the size of living units and to increase the level of positive interactions among the YCCs and the wards.

One very promising step in this proposed direction that was initiated by Jerry Harper was the deployment of the Enhanced Casework Pilot Program. This program was implemented in September, 2002, at one living unit at Chad, Nelles, O.H. Close, and El Paso De Robles. The Program sought to reduce the size of the Pilot Project living unit to below 60 wards. The Pilot

Program also incorporated the YCOs into many of the daily operation posting assignments of the living units, so that YCCs could be freed up to conduct more small and large group therapy sessions, provide more hours of individual contact with wards, and so devote more time to developing and monitoring individual case plans.

The early results of the Pilot Program have been quite encouraging. The wards are involved in 4 times as many hours of treatment than previously. The wards are more involved in small groups, and they are getting more hours of individual counseling. Of equal importance, there are many more time credits for good behavior being awarded to the wards in these special units, and they are receiving fewer time adds for serious disciplinary infractions. Fewer wards in the Pilot Program units are placed on TD.

Although not all of the Pilot Program sites have fully implemented the model, due to shifting staff or ward populations that have reduced the full effect of the program, the most stable and consistent Pilot Program sites have witnessed reductions in Level B infractions and other troublesome ward behavior. These units have seen a reduction in serious incidents and in the need for the use of force when compared with the situation in these same living units before the implementation of the Pilot Program. For example, at the Pajaro Unit at Chad, there has been a noticeable reduction of wards transferred to the SMP or TD units. Further, Pajaro has witnessed a growing number of its inhabitants who are moved to less secure YA institutions including the camps and pre-parole units. Whereas Chad had been traditionally viewed a "the end of the line" for YA wards who would stay there until they reached their maximum confinement time, Pajaro is showing significant progress in moving wards to settings that actually increase their chances of succeeding upon release. The Pajaro unit has been traditionally referred to by staff and wards as "The Thunder Dome," a place of extreme tension and violence. Now staff, both YCCs and YCOs, are requesting assignment to the unit.

Staff in all the Pilot sites report that ward behavior has improved and that the milieu has improved. Levels of treatment services have increased, and they report that the wards seem to incorporate the treatment curriculum at a higher level. The YCCs have more time to complete their casework responsibilities because there are freed, by the presence of the YCOs, of some of their posting responsibilities. The staff report that they are getting to know the wards better, their files are better organized, and YA supervisors suggest that case work preparation has improved.

The use of YCOs to perform some of the living units duties was employed by the YA administration as a cost savings strategy for the Pilot Programs, rather than increasing the number of the YCC staff. At present it appears that the Pilot Program is not substantially more expensive to implement than the conventional model.

The YCOs who work in the living units are given the option of wearing their street clothes when they are working in the living units (similar to the YCCs), and most of the YCOs have opted for this choice. Staff morale in the living units is reported to be higher than in previous times. Staff of the Pilot Programs feel that the program would be improved with even greater levels of staffing. They express concerns about the well-documented problems of the physical plants that inhibit effective casework and treatment services. The staff note that some wards do not embrace the more intense interactions with staff. To date, YA has not tried to select those wards who would be best suited for this program (another example of how an effective classification system would help the YA), but this makes the early results impressive because the selected living units have not be filled with the wards that are the most easy to manage.

The early results of the Pilot Program, as well as past research conducted by the YA and other jurisdictions, suggests that the Pilot Program be expanded throughout the YA. A special task force should be immediately created to develop plans for an expansion of the Pilot Program concept. This planning group would estimate the needed startup costs and training requirements, draft a

detailed program manual, and resolve other operational issues such as potential union concerns. Projected savings in terms of reducing the lengths of stay in YA facilities for those assigned to the Enhanced Casework program, as well as savings due to reduced need for DDMS and other investigatory functions, would appear to make this effort very marketable to the legislature and the Governor's budget staff. Further, the Pilot Program represents a proactive strategy that could de-escalate the levels of violence experienced by both wards and staff. The expanded Pilot Program should be evaluated by an independent research group that is very knowledgeable about juvenile corrections.

Also important to reducing violence in the YA is to upgrade and expand the training of staff at all levels. Current curriculum on the use of force is good, but is not delivered with the frequency and intensity that is required. The current curriculum is primarily aimed at getting greater staff compliance with the newest Central Office Use of Force policies and monitoring requirements. There is still a great need to equip staff, especially those assigned to the living units, with interpersonal skills to allow them anticipate violent situations and to prevent them. Staff are given remarkably little guidance in working with very emotionally troubled, and often mentally ill, wards. Some YA institutions are experimenting with new models of dealing with aggressive and violence-prone wards. For example, staff at the SMP unit at El Paso De Robles have instituted the "Limit and Lead" program as a guide to staff assigned to the SMP unit. There has been some training on "Limit and Lead" for middle managers at institutions. There presently does not exist more than anecdotal evidence that this new approach is effective. The YA has encouraged a fair amount of staff creativity in building solutions to institutional challenges. I heard about many new ideas that might be implemented at different sites. While this practice is desirable, it also means that there is a tremendous amount of flux in terms of suggested approaches, few with solid research support. It

almost appears that institutional practices are being molded by whatever consultants capture the interest and limited budget resources of the local superintendents.

The YA should commit to implementing a limited number of approaches to managing disruptive wards that are based on rigorous research and testing. These strategies need to be formalized in training materials, and integrated into the daily operations of each of the institutions. Ideally, approaches to preventing violent behavior by wards should involve teams of security staff, counselors, and health and mental health clinical personnel. Other YA staff including the teachers and the chaplains can be valuable resources in heading off violent confrontations in the institutions, providing support and guidance to the front line staff. There are juvenile correctional agencies that have been very successful in enlisting the support and assistance of their youthful inmates to increase the safety of facilities. One national leader in this "Normative Model" is the North American Family Institute in Danvers, MA, which runs juvenile correctional programs in several states.

Monitoring of serious incidents must also improve. The current use of force committees are meeting regularly, but the mandate and responsibilities of these groups are ambiguous. For example, it may be advisable for the Central Office to set very tangible goals for the reduction of ward violence and the use of force. The institutional committees could be charged with developing specific plans to meet these goals. They would become responsible for achieving sustained measurable declines in institutional violence, rather than conducting after-the-fact assessments of institutional statistics. The YA should explore ways of providing incentives to line staff, supervisors, and managers who can de-escalate the violence in their living units and facilities.

The YA needs to substantially increase its budgetary commitment to ensuring compliance with new policies on the use of force, and other key policies. The current investigatory process is too

limited and takes too long to complete to be the primary tool that the Central Office employs to implement its crucial policies.

At root, the Central Office needs to infuse a "new organizational culture" that does not accept the current levels of ward violence or staff use of force. A clear example of this need was revealed during my site visit at El Paso De Robles. Few YA institutions have witnessed the same level of breakdown of basic rules of how wards should be lawfully treated as this facility. The abuses that were uncovered by the OIG and the YA Internal Affairs Unit were abhorrent. While current leadership at El Paso De Robles has moved firmly to change practices, it was stunning to me to hear the prior investigations referred to as "The Witch Hunt." Many current middle managers felt that it was the staff who were victims of over zealous investigators, not the wards who had been brutally treated by some staff. An objective view of the older situation at El Paso De Robles was that there were "real witches" and the culture that continues to view the investigators or "whistle-blowers" must be changed.

Organizational culture change is aided by a new clarity of policy and procedure, but this must be strongly reinforced by ongoing training, as well as daily reaffirmation of the values of the new culture. It is admittedly very difficult for Central Office staff to effectively control the behavior of staff who work in institutions that are hundreds of miles from Sacramento. It is hard enough for superintendents to control the behavior of staff in their own institutions, especially in the evenings and hours of lower staffing. There is no substitute for continuous and regular communications of organizational values and expectations. There must also be opportunities for staff to learn and participate in the new culture.

More frequent visits by Central Office staff to each of the facilities is a must. These visits should last over several days and be focused on monitoring compliance with important policies. These sites visits should also provide institutional staff a chance to offer their suggestions on how

best to achieve organizational goals. Regular site visits should include confidential interviews with random samples of wards (similar to the interviews that I was able to conduct). Giving wards a clear way to raise issues of concern to them with Central Office staff sends a very important message to the wards and the staff. The Compliance Review Unit staff making these visits ought to be selected for their proven track records to be completely objective and professional. Instituting a very intensive schedule of routine facility visits could be a crucial step to building and strengthening the hold of a new YA organizational culture throughout the entire system.

III. RESTRICTIVE PROGRAMS

- ***Does the CYA have appropriate policies and procedure for restrictive housing?***
- ***Does the CYA use appropriate criteria for placing wards in restricted programs?***
- ***On a system-wide level are wards housed in a restrictive program for inappropriately long periods of time (i.e., too many hours a day or too many days at a time?***
- ***In its restricted programs, are the cages appropriate for exercise and learning, and if so, does the CYA use cages to provide exercise and education in an appropriate matter?***
- ***Are the CYA's restrictions on ward's access to visitors, newspapers, radio, television while in restricted programs appropriate?***
- ***On a system-wide level, do wards in restrictive housing receive adequate food?***
- ***On a system-wide level, do wards in restrictive housing receive adequate exercise?***
- ***Do wards have appropriate opportunities to contest CYA's decisions to place them or retain them in restrictive housing?***
- ***Are wards given adequate notice of why they are being disciplined or segregated?***

- ***Has the CYA implemented ward grievance procedures that are appropriate or functional? Are they understandable and expeditious?***
- ***Are the wards inappropriately placed in restrictive housing due to transfers between*** CYA ***institutions?***
- ***On a system-wide level, do CYA staff receive adequate training regarding restrictive housing procedures, and does the CYA appropriately monitor restrictive housing?***

In response to a number of concerns expressed by wards, their families, and other complaints, the OIG conducted a series of reviews of YA lockup programs in 2002, including the SMP programs and Temporary Detention Facilities. There were very specific reports of abuses at the O and R living units at HGS that brought urgency to this OIG investigation. This initial review, which covered lockup units at Chad, El Paso De Robles, Preston and Nelles, found "a system of disciplinary detention fraught with identified and potential constitutional rights violations; and a mental health delivery system in complete disarray" (OIG, *Statewide Review of California Youth Authority Lockup Units,* June 28, 2000). The OIG review team concluded that many of the abuses stemmed from systemic problems and inadequate department policies and procedures.

These earlier review of lockup programs uncovered many examples of the use of chemical agents as punishment for wards that were physically restrained or otherwise under control. The OIG further found that in 2000-2001 that the YA policies, procedures, and training failed to give sufficient consideration to the harmful effects of OC and CN chemicals. Ward injuries resulted from improper use of chemicals, or failure to provide first aid treatment in a timely manner. The OIG also concluded in this older review that the use of restraints at each of the investigated institutions were out of compliance with Central Office policies, and that these reports were poorly written and failed to adequately document the detailed staff actions involved in restraining the wards. Further, the OIG

reported that YA management review of the use of force was inadequate and that the quality of investigations was poor. Also covered in earlier OIG reports were problems in the ward grievance system which minimized the value of this system to highlight ongoing problems. In 2002 OIG investigators talked to 80 wards who complained about informal punishments such as failure to provide hygiene items, room stripping, and extensive periods of providing only sack lunches to wards in lockup. The wards in lockup complained of formal disciplinary actions against them that involved little regard for their rights to due process. The OIG also found that a significant number of mentally ill wards were held in the lockup units due to the lack of more appropriate treatment and housing alternatives.

This OIG review involved a team of outside experts in the field of juvenile corrections in addition to OIG staff. These consultants noted that YA practices relative to lockup units were generally at odds with practices across the nation. It was also noted that federal courts in cases involving the states of Arizona and Georgia had criticized practices that were ongoing in YA, or that were even more egregious than in those two states.

As a follow-up to this initial OIG review, there was a subsequent investigation covering Temporary Detention programs at Chad, Preston, Nelles, El Paso De Robles, Stark, and the Southern Reception Center that was completed in November of 2002. This review found that on any given day, between 10-12 percent of wards were housed in units in which they were confined to their rooms for 23 hours a day, with one hour permitted outside their rooms under close supervision. During this one hour that they are out of their rooms, the wards may be in wrist and leg shackles, or they are moved to small cage-like confinement areas known euphemistically as Special Program Areas (SPAs). The wards in TD and the SMPs receive their educational services and counseling in these cages.

The OIG reported that roughly 16 percent of all wards at the six facilities that were visited were residing in an SMP unit and another three percent were in TD units. At HGS as many as 28 percent of the wards were in restricted housing units; 16 percent of wards at Nelles and 14 percent of wards at Chad were in lockup units. It was very difficult to determine from YA data the precise reasons why wards were placed in these lockup units. There were no systematic data on how long wards were confined in these units. The OIG found that institutional ICCs exercised broad discretion on when and why some wards would be placed in the 23 and 1 programs. There was similar localized discretion on when and how they would be released. There was little Central Office oversight into this process, and no clear data flowing into the Central Office on these restricted programs. Towards the end of 2000, the YA Director was trying to pilot test a very rudimentary data system for determining how the lockup programs were being utilized. There was optimism expressed that the new Ward Information Network (WIN) would eventually provide a method of increasing oversight over the lockup programs, but the WIN system's full implementation was expected to take well into the future.

Several of the 80 wards in lockup units that were interviewed by the OIG complained that they were not receiving legally required services. Thirty-six of these wards said that they did not always receive the one hour out of their rooms, especially on weekends or other times in which the staff were short handed. Almost 90 percent of the wards claimed that they did not get religious counseling. Some wards said that they never saw a Chaplain in the detention unit. One-third of interviewed wards alleged that they had not been allowed to make required phone calls; 40 percent said that they had not received regular visits from their treatment team after being placed in TD. At the time of this OIG review, the YA record keeping on the mandated services to wards in SMPs and TD units was insufficient to either refute or validate the claims by the wards.

The OIG review also found that many of the restricted housing units were in disrepair, with walls filled with graffiti, poor lighting, and inadequate temperature controls. Wards in these units were only allowed to be dressed in underwear and socks. Some wards, attempting to increase the temperature in their cells, had plugged up air vents, causing many of the rooms to possess extremely noxious odors. A third of the rooms had dirty floors and walls, with a variety of unsanitary substances covering air vents. OIG staff found that 54 percent of wards were missing basic hygiene items such as toothpaste and soap; 40 percent lacked writing materials; and 26 percent of the rooms had inadequate lighting.

These alarming findings by the OIG have led to major restructuring of YA policies and procedures about restricted housing programs. Top YA leadership has placed a major emphasis on greater Central Office control over who enters these units and how long they are confined. Data on the wards in lockup are somewhat better. Serious attempts are being made to shorten lengths of stay in restricted housing units. There are increased efforts to train institutional staff on the importance of ensuring that the wards in SMPs and TD receive the legally mandated services and care to which they are entitled. The YA Director has been very clear in his communications that restrictive programs are not intended as punishment. In Jerry Harper's view "the courts send wards to the Youth Authority *as* punishment not *for* punishment." Harper also began the process of removing all wards with mental health issues out of the lockup units, and is attempting to close down the lockup units that are in the worst physical condition. All these efforts have met with opposition from some CCPOA members who accuse the Director of coddling offenders and somehow endangering their membership. In the next section, I will review my own impressions on how much these attempted reforms have achieved.

The Current Status of YA Restricted Programs

As part of the current review, I toured the TD and SMP units at each of the facilities that I visited. Several of the wards with whom I conducted confidential interviews were current residents of lockup units. I also asked wards from other living units if they had spent time in TD or in an SMP and asked them questions about that experience.

YA has assigned Mark Blaser to head up reviews of the restricted programs. He compiles ongoing data on these programs, and visits all of them on a regular basis. The YA has instituted a new policy in which all wards assigned to restricted living units must be considered for transfer within 60 days of their assignment of units. A team consisting of Central Office staff and a multi-disciplinary team from the facility reviews each ward and either approves a three-day extension of the time in lockup, or develops a plan to move the youth to another program setting.

Data for a four-week period in August and September of 2003 showed that the number of youths in restricted programs throughout the YA ranged from a low of 427 to a high of 468. The average daily population of restricted programs was 445. This represented approximately 10 percent of all wards confined in the YA. For this four-week period, there was an average of 155 youths housed in TD units and 244 in SMPs; another 46 wards were housed in other restricted programs. According to the YA data, more than 10 percent of the wards in restricted programs were designated as mental health cases, and 8 percent were identified as special education cases.

The vast majority of wards living in restricted programs were at Chad and HGS. As of September 5, 2003, there were 100 wards in lockup units at Chad and 143 at HGS. On the same day, there were 81 wards in restricted programs at Preston, 66 at El Paso De Robles, 47 at Nelles, and 7 at Ventura.

Other YA information suggests that the average number of days in TD was 4 during the first six months of 2003, with the longest detention stays at Chad and HGS. These average lengths of

stay (ALOS) do not include those wards that are on court holds, awaiting potential criminal prosecutions. These wards spend substantial amounts of time in this court hold status, with some remaining in lockup for nearly one year.

Wards on court holds are typically held in the SMPs and were 54 percent of all wards in SMPs who were reviewed by the YA Restricted Program Committee from April, 2002-June, 2003. The average length of stay in lockup for these court holds at the time of their reviews was 114 days. Court holds in HGS had been locked up for an average of 86 days compared to 135 days for Chad. Preston court holds had been in 23-hour-a-day lockup for an average of 110 days; similar wards from Nelles had been confined for an average of 121 days and Paso wards for an average of 118 days. Court hold wards who spend very long times in SMPs must pose a serious management problem for staff that are trying to operate a much shorter term restricted program.

As for the overall SMP population, the average length of stay in these living units ranged from a high of 70 days at HGS to a low of 52 days at Chad, based on data from the first quarter of 2003. During this same period, average lengths of stay in SMPs were 54 days at Nelles, 67 days at El Paso De Robles, and 59 days at Preston. There is some fluctuation in these average stays from quarter to quarter. For example, the average SMP stay at HGS went up from 50 days to 70 between the third quarter of 2002 and the first quarter of 2003, whereas the ALOS in SMPs went from 54 days to 52 days at Chad in this period. Preston, El Paso De Robles, and Nelles witnessed slight increases in the ALOS in their SMP units.

In the aftermath of the OIG reports, the YA developed a very detailed set of policies governing the operation of restricted housing programs. There is far more Central Office oversight on lockup programs than in the recent past. YA manager Mark Blaser has worked very intensively with institutional staff to develop more uniformity in admissions criteria for TD and SMPs, and to reduce lengths of stay. The regularly scheduled visits of Blaser and other Central Office staff to each

facility to conduct reviews of the status of every ward in a restricted housing program has introduced an important set of "checks and balances" into this process.

The data available to YA on the restricted housing programs is still less than ideal. For example, there are weekly snapshots of this population, but no efficient way to determine how many wards go through these programs in a given year, or how many wards are multiple admissions to these programs. Further, it is not easy to calculate the actual time that wards spend in lockup if they are first sent to TD and then placed in SMPs. YA can track current cases that are in lockup on court holds, but lacks accurate data on how long these youths stay in restricted programs until their court cases are finally resolved. Still it is clear that lengths of stay in TD and the SMPs have declined. At the time of the OIG investigation, the expected stay in SMPs was over nine months. This extraordinarily long time in 23-hour-a-day lockup began to drop as the YA Central Office starting monitoring these cases more closely. Today, wards are generally housed in SMPs for 60 to 90 days. After 60 days, the institution must justify holding the ward for additional time. This added time in the SMPs must be subsequently reviewed every 30 days by teams that include institutional parole officers, treatment team supervisors, education staff, mental health personnel, and gang coordinators. The deliberations of this group are monitored and approved by Blaser and other assigned Central Office staff. The SMPs are now viewed as short-term interventions requiring the team to formulate strategies to return the ward to more suitable housing units.

YA staff are also more focused on assessing the potential for suicide and other mental health issues of wards placed in TD and SMPs. The YA has developed increased awareness that lockup units are unacceptable places to house wards with mental health problems. Director Jerry Harper has already ordered that all wards with mental health designations should be removed from the Tamarack SMP at Preston. The review teams led by Mark Blaser have moved aggressively to facilitate the timely transfer of wards with mental health issues out of lockup and into ITPs and

SCPs. At Preston, the YA has opened a special program designed to manage mentally ill wards whose behavior is violent or extremely confrontational. The YA Central Office has clearly communicated its policy that lockups are not designed for mentally ill wards.

I attended several reviews of the current status of the residents of restricted programs. These reviews were quite comprehensive and allowed many YA staff to provide their suggestions. The process seemed to work best for youths who were identified as mental health cases. In these instances the mental health staff seemed to work effectively with the Central Office and other institutional staff to plan for transitions out of lockup into ITPs or SCPs. This was more of a problem for facilities that lacked sufficient onsite mental health programs.

More difficult were the cases in which the ward's assaultive behavior seemed unlikely to change. Wards who had already hit their maximum confinement time and who were set to be released posed the most serious challenges for the review committee. Another issue was the reduced number of general population living units. As the YA has witnessed a greatly reduced ward population, the response has been to close down living units and to consolidate the remaining wards in fewer housing units. Although this might make sense from a budgetary standpoint, it means that institutions must balance the problems of violence and gang conflicts in fewer places. For example, if a ward in an SMP was regularly involved in fights with rivals in their previous dormitory, sending that ward back to the same living unit might simply create a replay of the original confrontations. Further, grudges and perceived insults that evolved during ward stays in lockup could easily spill over to the regular living units.

The restricted program review committee struggled with these problems on an ad hoc basis. One sensed that the group felt that there were few real options and that the original behavior that got the ward into lockup might well continue. The major criteria that seemed to govern the review decisions (except in those cases in which mental health issues were clearly involved) were the

degree to which the wards followed staff instructions and did not receive additional DDMS charges while in the restricted program. There was little discussion about whether the ward's participation in the SMP program had accomplished a reduction in the underlying problem behavior. YA staff often told me that the really dangerous gang youths were very adept at "staying low profile" while in lockup so that they could quickly return to regular housing units to pursue their gang activities or to retaliate with other wards. It was as likely that the emotionally troubled wards or the more immature ones would continue to defy staff instructions, provoking secure area extractions, and piling up more disciplinary problems. Some staff suggested that some wards were using the lockup units as self-protection from other wards, and they would violate rules and "act-out" to try to remain in the restricted programs, or to convince YA staff to transfer them to other units.

Despite vastly improved YA processes to regulate how youths enter restricted programs, and to expedite their return to more appropriate housing units, the restricted programs are still very problematic. First and foremost, the lengths of stay in the SMPs are still much longer than those encountered in virtually any other juvenile correctional system in the nation. For most juvenile correctional systems, restricted programs rarely last more than a week. While 60-90 day programs are better than the 270-360 day stays in the past, the duration of lockup programs in YA poses a serious problem. YA has worked to reduce stays in the TD units, however, wards facing criminal prosecutions routinely spend many months in lockup units.

It is hard to imagine that 23-hour confinement over several months has any therapeutic value. Most psychologists and mental health professionals would argue that this severe isolation is antithetical to sound treatment practices. Since the invention of solitary confinement by the Philadelphia Quakers in the 18th century, we have learned that this approach produces hostility and illness, not health. The enforced isolation of troubled wards and minimal meaningful social interactions with YA staff can only plausibly lead to their psychological deterioration. The YA has

no data suggesting that the use of SMPs produces more than a very short-term response to various forms of prohibited behavior by wards. The ongoing levels of violence in the YA suggest that SMPs are not effective to reduce this problem.

It is worth noting that the physical conditions of many of the SMPs and other lockup units remains deplorable. The programs that are housed in the "270" living units are a bit cleaner, but still lack needed program or counseling space. One positive sign was the closure of an SMP unit at Nelles that was filthy, vermin-infected, and subject to flooding in the rainy season. When I visited this unit, it was filled with litter and trash on the floors. Staff and management seemed unable or unwilling to maintain even basic conditions of sanitation. In response to the closing of this unit, CCPOA objected and some of its members alleged that action was coddling the wards. Another SMP unit at Preston has been repeatedly labeled as a "dungeon" by YA Director Jerry Harper. Other units are poorly lighted and have terrible ventilation. The cells are not well designed to monitor potentially suicidal wards, and the video equipment in the rooms is in disrepair. YA staff have often made room conditions worse by blocking off doors or openings in their attempts to stop gassings. It is worth noting that gassings of staff primarily occur in the lockup units. It is difficult as one tours the lockup units to reach any other conclusion than that these conditions of confinement are designed to punish their inhabitants.

I did not find deliberate efforts on the part of staff to deny access of wards in the restricted programs to religious services, visiting, or phone contacts. However, the operation of these units makes normal forms of contact with other staff and family members quite difficult. For example, Chaplains or treatment staff are often required to communicate with wards through the doors to their cells. Time outside of the cells almost always involved full mechanical restraints or time in the cages. Wards told me that they spent most of their day in lockup units sleeping or reading. They would often sleep through most of the daytime hours and be up all night. The noise levels and

chaotic environment of the lockup units led to conditions of insomnia and other forms of sleep deprivation. Some of the wards told me that they began hearing voices and experiencing symptoms of other mental health problems. Most wards reported symptoms of severe depression, including suicidal ideation. The staff felt that some wards feigned suicidal potential as a way of getting transferred out of restricted programs to the mental health programs.

It also appears that YA is paying more attention to seeing that wards in restricted programs receive mandated services. The responsibility for monitoring the mandated services still is handled by the facility administrators. The WIN system does include entries that allow for Central Office staff to see if mandated services are provided. However, in my own attempts to sample these data, I found that the WIN system did not offer a foolproof way of measuring compliance. For example, data entry delays at one facility made it appear that wards had not received meals for several days. Typically this information is available from written logs kept in the individual units. The Central Office needs to establish other methods to reliably audit the delivery of services in the restricted units in addition to the WIN system.

A major challenge for the restricted programs is the apparent lack of a clear and coherent treatment program that would transition wards back to regular housing units. It was difficult to determine if wards in these units received any additional treatment services compared to wards in general population units. Treatment in the YA often amounts to giving the wards "canned" workbooks that cover topics such anger management, gang avoidance, or substance abuse. Wards in 23-hour-a-day lockup often used these workbooks to pass the time, but it is unclear how much real interaction that they get from the counseling or treatment staff. Further, it is difficult to determine if there are specialized and individual treatment plans that are implemented for youths in lockup programs. As noted above, at least one SMP unit at El Paso De Robles has instituted a particular ward education and management curriculum, but other restricted units appear to lack well-defined

treatment objectives. Although behavior modification approaches were once very popular in the YA, these approaches seem to be mostly operationalized in terms of the Phase System. The Phase System is differentially applied at each institution, and mostly involve the giving or taking of daily privileges based on whether the wards get sustained DDMS charges. The Phase System does not seem to focus on promoting the positive interpersonal skills and abilities that could help wards avoid future behavioral problems. Further, many of the wards in restricted units have ongoing DDMS investigations that may well result in time adds. This means that successful stays in lockup may still result in subsequent punishments that are above and beyond the time spent in lockup. The wards that I interviewed often complained that time in restricted programs was "dead time" during which educational advancements or completion of YOPB ordered treatment plans was very difficult. Thus, a stay in lockup frequently meant a longer stay in YA.

Court Cases

The YA has worked to reduce the amount of time that wards spend in TD and to quickly return them to regular living units. This process often involves expedited investigations of the incidents leading to placement in a TD unit, or the timely development of alternative treatment plans and living unit assignments for these wards. One big exception to this process has been for wards facing potential criminal prosecutions. The CCPOA has lobbied the YA administration to increase the number of cases of institutional misconduct that are handled through referral for further prosecution rather than via the DDMS system.

I found that there is a great deal of variation in how aggressively individual superintendents pursue these criminal prosecutions. It seems to matter whether local prosecutors are interested in pushing these cases in local criminal courts. Further, some YA staff complained that cases that were

sent back to juvenile courts rarely received additional time from judges. On the other hand, adult court prosecutions could result in prison sentences. Some institutions really push these prosecutions. For instance, Preston and El Paso De Robles are more focused on these prosecutions than is Nelles. At El Paso De Robles, they have funded through the institution's annual operating budget, a mini-police department with impressive crime lab capacities that can investigate and bring these cases forward. The head of this unit, who is also responsible for managing the ward's rights, is very proud of his relationships with local prosecutors that produce a nearly perfect conviction rate. Other superintendents devote less of their budgets to this activity. Thus, it appears that the same ward misconduct could result in a criminal prosecution at one facility, whereas it might be handled through the DDMS system at another. Criminal prosecutions are more common at HGS and Chad, because the wards at these facilities are almost always over 18. Further, wards at HGS and Chad have often received many time adds while at other facilities and have already been given their maximum confinement time. Thus, staff at these two deep-end YA facilities feel as though the DDMS system provides no practical deterrent effect for the wards.

Wards awaiting court trials are subject to very long stays in TD units. All the problems of lengthy stays in lockup are multiplied for these wards. First, one wonders if there is any evidence that the pursuit of criminal prosecutions is, in fact, an effective behavioral management tool for the YA. Some wards who receive prison terms actually return to HGS or Chad if they have remaining time left on their YA commitments. YA superintendents and other staff have expressed concerns that wards returning CDC institutions can create even larger problems for the youth institutions to which they return. Some believe that these wards worsen the gang problems at HGS and Chad. Wards that are sent to CDC have the option to request that they serve their remaining YA terms in CDC facilities. Second, the variability in institutional practices to pursue criminal prosecution raises issues of equal protection of law. To my knowledge, there is no Central Office review or oversight of these

decisions to pursue criminal prosecutions. It is unclear why some of these wards could be screened for their further potential for violence and returned to regular housing units, or mental health units as appropriate, while awaiting the resolution of their criminal charges. Finally, there is the question of where these wards facing prosecutions should be housed in YA SMP units as opposed to the local county jails. In some instances, the conditions of confinement in local jails would not be as restrictive as in YA SMP units. At best, this policy should receive a top-level management review.

The Cages

Wards in restricted programs usually receive their educational, counseling, and recreational services in cages that are referred to as Secure Program Areas (SPAs). A number of outsiders have raised grave concerns about the SPAs, including the Board of Corrections that requested that the YA conduct a thorough review of the cages. In 2002, the YA formed a task force to look at the practice of utilizing the cages. Besides YA staff, Sue Burrell of the Youth Law Center was invited to attend these meetings.

The task force found that the cages were introduced in 1998 as a method of providing legally mandated educational services to wards in restricted programs (*Secure Program Areas: Report of Committee,* May 15, 2002). Before the cages, these wards received their educational materials and communicated with teachers through a food slot in their room doors. YA has approximately 70 cages that are operated in 4 facilities (Chad, HGS, Nelles, and Preston). There are seven other YA facilities with no cages. The YA task force found that only a small percentage of the wards who were in TD or SMP units that used the cages were there due to assaults on staff (8.5 percent in SMPs and 6.8 percent in Temporary Detention units. For one-third of the wards in these units, the reason for being in SMP or TD did not involve assaults on staff or other wards Other profile data suggested that these wards were similar in their criminal histories to other YA wards and

that they were somewhat younger than other YA residents. Youths who were managed in the cages were disproportionately African American, Asian or Latino compared to the general YA male population.

Staff that were surveyed expressed the need to use the cages for at least some of these wards. They pointed out that the residents of the restricted programs had been removed from other general population units and did pose a danger to others. The staff liked the cages because it made them feel safer. However, other staff recognized that the use of the cages could be dehumanizing, and the cages did afford the wards the opportunity to interact peacefully with others. These staff feel that the SPAs made the institutions less safe because they did not allow for resolution of the underlying conflicts that would flair up again as the wards were released. Concern was expressed by staff that the cages actually cut down on the healthy communication that should be taking place among staff and wards.

The YA task force found that no other states were using the cages. The YA basically designed their own prototypes, since these units were not being manufactured for the corrections market. Some other states provided education for youths in lockup by increasing staff supervision, others did not offer education for youths in lockup units despite clear legal requirements. The Youth Law Center has suggested that the cages pose several important constitutional problems, and that providing educational services in the cages did not meet federal or state statutory requirements. For example, wards in the cages received far fewer hours of schooling or special education services than are mandated by law.

There was general agreement that not all wards who experienced the cages needed this level of security. There was a sense among the YA working group that the use of the cages should be reduced. A minority of the committee called for their complete elimination. In any event, it was agreed that the YA lacked an effective screening mechanism to decide which wards should be

managed in the cages. Further, it was agreed that wards should be moved out of the cages after a brief period of time. The cages needed to be part of a continuum of responses to the potential dangers posed by youths in the lockup units. The SPA committee recommended that more specific policies and procedures be developed about the use of the cages. It was acknowledged that the cages were symptomatic of larger issues confronting the YA. I have already alluded to some of these issues such as of the prevalence of institutional violence, the control of gang behavior, the lack of effective classification, and limited training of staff in offender management strategies.

When I conducted my site visits, some of the institutions were already attempting to reduce their reliance on cages. At HGS the superintendent was encouraging staff to reduce the use of the cages after 30 days; at Preston, some wards were receiving educational services in classrooms or in teachers' offices. Institutions are attempting to allow some joint programming among wards in the lockup units.

To the visitor, the cages seem to be in stark opposition to the mission and philosophy of the YA. Without minimizing the amount of violence that plagues the YA, it is difficult to see how the cages provide more than the illusion of safety. As one of the Chaplains explained to me about the use of the cages: "The YA has a serious problem with gangs, but their solution is demonic." It also seems clear that the YA could upgrade staff and ward safety through other less degrading methods.

Summary and Recommendations

While the courts have recognized the need for juvenile corrections agencies to operate very short-term lock up programs, none of these cases has approved 23-hour-a-day lockups for as long as they are used by the YA. There is a general professional consensus that solitary confinement is not a desirable correctional strategy for either adults or juveniles, except under emergency situations. I

know of no other juvenile correctional systems that operate SMP programs that are in any way similar to those of the YA. Programs for very violent juvenile offenders are often designed to provide enriched counseling and treatment resources. Youths in these other locales are not locked in their rooms for all but one hour per day. No one else uses cages for education and treatment purposes.

Other sections of this report have suggested a number of methods by which the YA could attempt to stem the violence in its facilities. I have indicated that I consider that this climate of fear and violence is very real and very disturbing. However, there is no credible evidence that the SMPs programs, as presently operated, contribute very much to a de-escalation of these problems. Indeed, there is reason to believe that the extensive use of lockup makes the violence worse.

YA has made significant strides in better Central Office oversight of the restricted programs. There is greater accountability in terms of who is placed in these programs and when youths can be returned to other housing units. Progress has been achieved, but many of the concerns expressed by the OIG are still present.

I would urge the YA to continue to phase out the SMP program as currently operated. Many of these decrepit living units need to be closed immediately. YA should convene a task force, including top juvenile corrections professionals from other states, to redesign programs for violent wards. It is entirely possible that YA could institute programs for their most dangerous wards that are more consistent with the best research in "what works" and with its own mission of providing treatment and education. This new program model must be rooted in the fact that all of these wards will be released to the community in a relatively short period of time, and that effective institutional programs must be integrated with preparation for returning home.

Part of this review of restricted programs should be an examination of ways to further reduce ALOS in the TD units, and to reexamine the current policies and practices relating to wards being prosecuted for alleged offenses while they are in the YA.

The cages should be eliminated as quickly as possible. They are degrading and antithetical to the mission and goals of the YA. Staff need to be convinced that other more humane approaches can be equally safe, and more effective, in stemming future assaults on wards and staff. A key area for examination is the value of much smaller living units, with greatly enriched treatment and security staffing patterns. Staff training, especially in the management of disruptive wards, must be expanded and intensified. YA staff at all levels should be enlisted in efforts to reform and replace the current lockup programs.

The YA's progress in limiting the use of the restricted programs can also be used to demonstrate that further moves in this direction are possible and beneficial. YA leadership needs to continue its strong message that the courts "send youths to YA *as* punishment, not *for* punishment." If this statement is true, then current SMP programs should be ended and replaced by more suitable correctional interventions as soon as this is practical.

IV. ACCESS TO COURTS AND WARDS RIGHTS

- ***Are the CYA's policies and practices appropriate to protect confidential communications between wards and their attorneys?***
- ***Are the CYA's policies and practices appropriate to protect the wards' ability to file grievances without fear of retaliation?***
- ***On a system-wide level, are wards threatened or harassed for communicating with their attorneys?***

- ***Is the ward grievance procedure fair, simple, and accurate?***

My review of the YA policies and practices relative to ward communications with their attorneys did not reveal any systemic problems. The nearly 100 wards that I interviewed on a confidential basis did not complain about being denied access to attorneys or to legal libraries at their institutions. This question was asked of virtually every ward with whom I spoke. Only one youth complained that he was denied access to the law library, and he did write a letter to the Ombudsperson about this issue. I have requested that the YA Office of Legal Counsel look into this complaint and report back to me on the circumstances of this incident and the resolution of the dispute.. The YA reponse suggested that the ward's concerns about access to legal materials did seem valid. This particular ward was housed in an SMP unit. . Staff were instructed by the Central Office to assist the ward in locating the materials that were requested. The ward has since received the requested law books in his room.

The wards rarely, if ever, file grievances about being denied access to lawyers or legal reading materials. My review of six months of letters written to Director Harper included no communications on this topic. I found no evidence that wards are threatened by staff if they request access to lawyers. It appears that attorneys from the Youth Law Center had open access to wards as part of their monitoring of the Nick O consent degree.

Attorney visits to wards are relatively rare. For example, Ventura logged in 20 such visits over a 12-month period. For other institutions, the number of visits was smaller. Institutions replied back to the YA Legal Counsel that they had not denied access of any ward to their lawyers. Departmental policies are clear on the right of wards to have legitimate access to their lawyers in appropriate settings. In most cases, these meetings occur in rooms designed for YOPB hearings, counseling offices, or some rooms that are specifically set aside for these visits. All wards are

escorted to these meetings by YCOs who remain outside of closed meeting rooms. Wards in restricted housing units are escorted in mechanical restraints. I did not observe any of these attorney meetings, but the YCOs always permitted me to interview all wards behind closed doors.

My discussions with wards suggested that many of them could think of few reasons why they needed to talk to lawyers, except in instances in which they were appealing their original YA commitments. Wards do not have the right to have legal counsel present at their board hearings, or during most DDMS proceedings, and these are the circumstances in which they are most likely to want to consult with attorneys. Typically, requests for access to attorneys are initiated with the YCCs, but are often arranged by the institutional parole agents. Most wards are unaware of other reasons, for example civil and family court matters, that might lead them to seek legal representation. Many wards told me that they had no idea that the YA had legal libraries that were available to them. Nor were they aware of the steps they needed to take to request access to these facilities. As will be discussed later, the YA faces more serious needs in the provision of wards' rights through the Ward Grievance System (WGS). It is suggested that, as YA improves its educational process on the rights of wards, issues of access to attorneys and to legal materials should be part of these informational efforts.

One area in which the access to legal representation by wards should be further explored is in the instance of court cases. Wards charged with new felony charges while they are incarcerated are entitled to full constitutional guarantees of legal protection. The YA wards must depend on the energetic commitment of the local public defender's office to provide legal advice and to protect their legal rights. The YA staff are focused on informing wards of their Miranda rights, but it is the local district attorney and public defender who decide how vigorously to purse these cases. It is worth examining in the future if the quality and timeliness of legal representation of YA wards in potential criminal investigation meets the same standards as in the community at large.

Traditionally young people in juvenile correctional facilities do not avail themselves of the access to legal libraries and attorneys that one sees among adult prisoners and jail inmates. The YA has developed an elaborate dispute resolution process via the WGS to attempt to cure reasonable complaints by wards. There are far fewer "jailhouse lawyers" in the YA. The very limited amount of prior legal complaints on conditions of confinement and civil rights violations by YA wards, compared to the extensive history of similar issues raised in CDC, may argue for increasing the access of wards to appropriate legal consultation. Prior lawsuits against the CDC have ushered in a range of policy changes and procedural reforms that have improved the overall operation of that system. While litigation should never be the first recourse to bring about needed reforms, conditions in the YA might improve at a quicker pace if the potential for judicial scrutiny were more realistic.

The Ward Grievance System

In the 1970s, under the leadership of Allen Breed, the YA implemented an innovative system of giving wards a method to bring forward their concerns in a safe and effective manner. The Ward Grievance System (WGS) was intended as an application of alternative dispute resolution techniques such as mediation and arbitration to resolve institutional problems. Every YA institution has a ward's rights coordinator who is responsible for logging in the grievances and tracking their resolution. The system is operated by YA wards who are trained by the wards rights coordinator. Every living unit, including the restricted housing units, has a WGS clerk and access to the system. Once grievances are logged, there is the assumption that these will be resolved at the level of the living unit. If this fails, the dispute will be reviewed by the top facility management. In about a dozen cases a year, the YA brings in an outside arbitrator who is under contract to be the final voice in resolving problems.

Over the course of a year, the YA processes several thousand of these ward grievances. From July 1, 2002, to June 30, 2003, there were 7,356 grievances at the nine major YA institutions. There were 2,119 filed at Chad and 1,413 filed at HGS, the institutions with the older wards who generally have had the longer correctional stays in YA. Interestingly, there were 1,695 grievances logged at Ventura that has a smaller ward population than at these other facilities. According to YA staff, most of the ward complaints at Ventura came from the young women housed there. During this same time frame there were 482 grievances at Preston, 344 at El Paso De Robles, and 385 at Nelles. The vast majority of these complaints were for a broad range of personal issues raised by the wards; the next most frequent category involved "disrespect."

Grievances are categorized into three groups. Emergency grievances that need to be resolved with that work shift or the problem becomes moot, such as failure to provide meals. Regular grievances can take a bit longer to work through and generally involve ongoing issues. Finally, there are "staff action" grievances in which there is an allegation that a staff member has acted inappropriately. This last category has proven to be very difficult to handle within the WGS. Increased concern over the years by the CCPOA has meant that staff action grievances must be handled via more formalized investigatory processes. The older tradition of alternative dispute resolution that was the origin of the WGS has given way to a very different organizational method for handling staff action grievances.

My interviews with wards suggested that the WGS system was not functioning as intended. Most of the wards told me that they never filed grievances, because that the WGS did not work. Many wards laughed at the question "Does the WGS help you resolve problems?" Several of the wards that I interviewed were WGS clerks, and they offered a similarly negative view of the process. Wards complained that they were more likely to try to work out issues via conversations with sympathetic staff members, or by discussing problems with living unit supervisors. About half the

wards felt that the WGS had helped them resolve fairly minor personal issues, but that the system was useless for handling bigger problems including the use of force, denial of treatment or educational services, or gaining better access to medical and dental care. Wards reported that they were often told that their complaints did not fit under the jurisdiction of the WGS, but they remained aware of other formal channels that they could utilize to solve these concerns. For example, many wards wanted to complain about their treatment by the YOPB, such as for extending their terms, but the YA staff told them that the WGS was not designed to hear complaints against the YOPB. Several of the WGS clerks claimed that some wards used the system to provoke the staff, or that they grieved fairly minor issues that could be resolved through more dialogue between wards and staff.

It is in the area of staff action grievances that wards were most negative about the WGS. Many wards told me that staff and the WGS clerks often discouraged them from filing staff action grievances. The wards were told that these matters would "go nowhere" and that filing grievances might lead to harsher treatment by the staff. Some wards suspected that their grievances were "lost" by the WGS clerks and never forwarded to institutional managers. Further, the wards complained to me that they never heard back on the resolution of their grievances. They were either told that an inquiry was ongoing, or that the matter had been dismissed. The wards claimed that they were never given an explanation of what had determined the outcome of the grievance. The wards reported that staff action grievances took a very long time to resolve.

These findings were reinforced by a review of the WGS conducted by the YA Compliance Review Unit (*Report to The Director on Staff Action Grievances, July 2003)*. This review was intended to determine if the various institutions were complying with policies and procedures governing the timeliness of responses to staff action grievances. To complete this study, the CRU interviewed 44 Sergeants or Senior YCCs. In addition, interviews were conducted with 237 wards,

of which only 66 reported that they had ever filed a grievance. The Compliance Review Unit also interviewed 44 WGS clerks.

This review confirmed and enhanced many of my own interviews and observations with YA staff and wards. The CRU concluded that YA employees from line staff to superintendents were not following the proper policies and procedures relative to the WGS as delineated in the I&C Manual and more recent Temporary Policy and Procedure notices. It was found that virtually every institution had its own interpretation of the WGS policies and procedures, and staff at these facilities had their own interpretations of how the WGS was supposed to operate. The CRU acknowledged that each facility has special issues and differing types of wards, but they found almost no consistency across the YA in dealing with staff action grievances. Even very basic processes on how to file a grievance varied from place to place.

The CRU found that wards were not receiving education as to how the WGS should function. Wards are typically given a very basic introduction to their rights as part of the orientation process at the Reception Centers, but this training is not followed up once they are assigned to other YA institutions. Many of the wards that I interviewed asked for a copy of the Ward's Rights Manual. Although wards were usually given a copy of this document at the Reception Centers, these manuals were often lost as the wards moved to new institutions or to other living units. Several of the living units did not have copies of the manuals at the living units for wards and staff to consult on a regular basis.

The CRU found that many WGS clerks and YA staff had an inadequate understanding about how to properly complete the WGS forms. Processes by which staff action grievances were distributed and collected to insure that the complaints were not misplaced or destroyed varied across all of the institutions examined by the CRU. The review also revealed that these methods of distribution and collection were different among various living units at the same institutions. Wards

who were transferred between YA facilities, rarely, if ever, heard back on the resolution of staff action grievances that they filed at their initial placement.

Denial of staff action grievances can be made by the superintendent, assistant superintendent, or a designated staff person. But, the CRU found that a wide range of staff including the Duty Lieutenants, Program Administrators, Treatment Team Supervisors or Sergeants may answer the grievances and determine if the complaint meets the appropriate criteria. Current Policy does not clearly define who can be designated to act on behalf of the superintendent, or what specific training in the WGS that these staff should receive.

The CRU also reported that wards were not given very much information about why staff action grievances were being denied. The wards were usually told that the complaint did not meet the criteria, or they were encouraged to re-file their grievance as a regular grievance. Similar to my findings, many of the wards that were interviewed by the CRU said that line staff at 9 of the 11 YA institutions has denied them the right to file a staff action grievance. The CRU reported that wards at HGS were told to put off their complaints or that the wards were told by the WGS clerks that "its not going anywhere, you're going to get bad luck form it." YA policies require that staff action grievances be answered after hours or on weekends by the Duty Lieutenant, but the CRU found that this was not occurring at half of the YA institutions.

The YA internal review found that timeliness of responses to staff action grievances was a problem. The CRU found that the response due dates were lacking in about half of the grievances that they reviewed. They also found that only half of the staff action grievances had the dates noted by the superintendents. Many responses were delivered after the time frames set forth in YA policy. During my interviews at six YA facilities, each of the ward's rights coordinators told me that the existing time frames to process the staff action grievances were too short. They reported that deadlines were often missed and these inquiries took a good deal of staff time and effort.

Summary and Recommendations

My own analysis and the work of the CRU strongly suggest that there are major deficiencies in the WGS. Many wards seem unwilling to file grievances, especially those that involve complaints against staff. This means that YA managers may not learn about all of the potential problems that should catch their attention. Often wards would complain to me about specific staff abuses, inadequate medical care, or about fears for their safety. Often the response to my inquiries about these matters to the institutional management was that "the ward did file a grievance on this matter." This is a classic "Catch 22" situation. To the extent that wards do not trust the WGS, they are less likely to file complaints. Middle level and top level managers assume that the absence of formal grievances implies the absence of problems. By letting the WGS fall apart, the YA is losing a crucial indicator of potential management issues that could be addressed via preventive or early interventions.

The WGS seems to work for some wards that like to use the process to solve some of their basic issues or needs. For wards who have difficulty communicating verbally or in writing, the WGS provides obstacles to resolving issues. I found that the WGS clerks worked hard to assist other wards who needed some help in negotiating the process. These clerks were often frustrated if the staff response to the grievances did not appear to follow policy, or if the ward was not properly informed about the status of his complaints or the reasons why his grievance was denied.

The WGS needs a major overhaul in the handling of staff action grievances. In a sense, it appears that serious complaints against staff require a very different process. The traditional approach in handling ward grievances was mediation and, ultimately, arbitration. But, if the complaint is defined by YA as a staff action grievance, an entirely different set of actors and actions

come into play. The response to staff action is more akin to a conventional investigation and personnel review process. Mixing the two models insures long time frames, limited communication back to wards, and a good deal of frustration on the part of wards, staff, and superintendents.

The YA needs to reexamine the areas in which the WGS system, with its preference toward mediation and mutually agreeable conflict resolution, is the better approach. There are clearly some areas in which allegations of staff misconduct must be fairly and fully investigated with appropriate respect given to the rights of the staff member and the ward. Perhaps, there is method of early intervention and mediation that might be appropriate for certain kinds of ward complaints against staff. At present the complain system is muddled and is not working effectively.

Wards need a better foundation in the rights to which they are entitled, and the methods open to them to exercise these rights. The other side of rights is, of course, the responsibilities that wards must accept to meet the expectations of the YA. The current orientation in wards rights that occurs at the Reception Centers is insufficient. Educational curriculum on wards' rights should be part of the orientation as they arrive at a new facility, and as they are assigned to living units. The YA should make sure, on a regular basis, that each ward has an up-to-date copy of the Ward's Rights Manual. Moreover, copies of the Ward's Rights Manual should be readily available on each living unit and in the classrooms and library. Discussions about rights and responsibilities should be integrated into the individual and group therapy sessions that most wards receive.

Current policies and procedures on the WGS are very well written and very clear. These are some of the best formulated of the YA policies. The issue here is about implementation. The YA cannot allow each institution to make up its own rules; facilities should not allow individual employees to impose their interpretations about how the WGS should operate. If the WGS is to be rescued from obsolescence, there must be a very high priority placed on training or retraining all levels of staff on the goals of the WGS and the proscribed methods of meeting those department-

wide objectives. Most important, the YA must communicate to all staff that the WGS system is not a nuisance to be tolerated, but rather is crucial to the safe and efficient management of the institution.

As with other areas of this review, the rebuilding of the WGS requires continuous and close monitoring by the Compliance Review Unit through ongoing and periodic audits of the functioning of the WGS at each YA institution. It is also recommended that the YA management demonstrate the importance of the WGS by requiring that each institution convene top managers to review monthly grievance data, similar to the use of force committees. Routine examinations of WGS data could highlight areas for improved training and better operations. More serious problems could identified at earlier stages when remedial actions can be taken. Moreover, these regular reviews would communicate to staff and wards that the WGS has the capacity to help resolve both individual concerns and institutional problems.

V. ACCESS TO RELIGIOUS SERVICES

- ***Are wards housed in restricted housing units given adequate access to religious materials and services:***
- ***Are Are wards housed in general population given adequate access to religious materials and services?***
- ***Are the CYA's procedures for documenting ward access to religious services adequate?***
- ***Are the CYA's written policies and procedures adequate to protect its ward's religious rights?***

Initial concerns about YA policies and practices about access to religious services and programs were raised by a number of faith-based groups such as the Catholic Archdiocese of Los

Angeles. Issues pertaining to the exercise of religious beliefs are often brought to the attention of the YA through letters to the Director, correspondence with the Ombudspersons, and the WGS.

My interviews with both YA Ombudspersons revealed that occasional complaints about access to religious services did come to their attention. Looking at the first 6 months of 2003, ward correspondence to the Director was the main topic of 17 or 13 percent of these letters. Only ward safety issues and concerns about transfers generated more letters. There were 10 letters concerning denial of religious practices at HGS, 4 at Chad, and one each at Nelles, Holton, and the Northern California Reception Center. Complaints about access to religious programs and services accounted for 31% of all the letters from wards at HGS and were the most frequent area of concern from wards at that facility. Similarly, an examination of ward grievances filed in Fiscal Year 2002-2003 showed a significant number of complaints about access to religious programs and services. There were 66 grievances about religious issues filed at Chad, 13 at Ventura, 12 at HGS, 3 at Preston, and two each at El Paso De Robles, and Nelles.

Recognizing traditional problems with respect to the religious observances of wards, the YA leadership has convened a special staff working group that will produce a comprehensive restatement of departmental policies and procedures in this area. The new policies were finalized on April 16, 2003 and went into effect on Sept, 1, 2003. The YA is now moving forward to make this policy the foundation of departmental policies on religious observance. The new policy is more than three times as long as the one it replaces, giving excellent levels of detail on questions about access to religious practices, attendance at religious services, limitations of religious practice, and the role of Chaplains.

During my site visits to six institutions, I interviewed at least one, and sometimes all, of the Chaplains at these facilities. They were asked to provide documentation on the nature and extent of religious services being provided. I also asked them to outline any major concerns or issues that they

had as the primary YA staff responsible for seeing that all wards had access to appropriate religious education and expression. My interviews with wards at these facilities also covered their experiences with accessing religious services and programs.

Despite general agreement on the part of the Chaplains that the new YA policies would improve matters, there were still concerns over the implementation of those policies at each of the institutions. Staff were still unclear about reasons why some wards could be denied temporary attendance at religious services. For example, some staff in the living units continued to impose their own definitions about the "sincerity" of the ward's religious beliefs—some staff believe that wards manipulate these activities to pursue gang activities or to attack other wards. Further, some staff were not responsive to ward requests to change their religious designation so that they could attend additional or different religious services or programs. Staff were more likely to deny wards access to religious programs, even though YA policies give these programs equivalent weight as religious services. There was also continuing confusion on the part of some staff that wards in the lowest phase levels could be denied access to religious programs or services as part of other limitations of privileges for these wards. The YA Central Office is working to resolve these issues. For example, the wards who wish to sign up for religious programming now are entered into the computer system on a weekly basis, and any denials of these requests must be noted. This new system seems to be working at most facilities, although some Chaplains have expressed concern that the new approach requires that wards sign up every week, rather than assuming that they are automatically enrolled in scheduled religious services and programs.

Other related issues that were raised in the past concern the delivery of religious programming to wards in restricted living units. While these wards cannot generally attend regular religious services, the Chaplains have regular weekly visits to the lockup units and see whichever wards want to avail themselves of these contacts.

My interviews with wards surfaced a number of concerns about access to religious services. For example, several wards who have work assignments told me that their work supervisors would not give them time off for religious activities. This is clearly contrary to YA policies and must be clarified with all staff who run the work details. Two wards complained that the Protestant Chaplain denied them access to religious education (but not religious services) because of their avowed homosexual orientations. I raised this issue with the facility superintendent who has already clarified to this Chaplain that all wards who wish to attend religious services and programs can do so unless there is demonstrable threat to safety and security.

A more serious issues has to do with the limited religious personnel who are available for wards who are either Native American practitioners or Muslims. While there are full-time Protestant and Catholic Chaplains at all YA institutions, it is the case that Native American and Muslim Chaplains generally work part-time. Only Paso has a full-time Muslim chaplain. For example, the Native American and Muslim religious leaders at Chad both work part-time and have to service all 4 facilities at the Stockton complex. Religious leaders for wards who are interested in groups such as Latter Day Saints, Buddhists, Jehovah's Witnesses, and others are provided religious services through volunteers that are recruited from the community by the current YA Chaplains. The allocation of paid time for Chaplains is decided at the individual institutional level and comes out of facility budgets. The YA periodically takes a inventory of the religious preferences of wards, but these data are not used to establish staffing patterns for those staff responsible for religious programming. Moreover, many superintendents expressed difficulties in recruiting Native American practitioners or Muslim Imam from their neighboring communities. Consequently, these positions may be vacant for long periods of time. There is little question that wards interested in pursuing Native American and Muslim faiths are not getting a fair share of YA resources that are devoted to

religious programming. There remain serious questions as to whether some of these youths are de facto being denied access to religious observance due to YA organizational and budgetary practices.

Some ward expressed complaints about YA requirements with respect to the amount of facial hair that they are permitted, or the overall length of their hair. Staff have raised security issues in some cases, and the wards may view staff restrictions as violations of their core religious beliefs. The YA's new policies go far in the direction of clarifying the appropriate responses to these conflicts. Other wards expressed complaints about being denied access to certain religious groups that YA officials believe can ferment racial hatred in YA facilities. The YA Legal Office spends a fair amount of time screening materials for content that appears to advocate violent activities. The current policy allows wards wide latitude in selecting religious groups with whom they might want to communicate, but it seems entirely reasonable that materials or persons urging racial warfare not be permitted in YA institutions.

Summary and Recommendations

The YA recognizes that access to religious services and programs is a central constitutional and statutory requirement for wards. The new policies move the Department forward in these areas. Further, the Chaplains and the volunteers that they recruit provide an important contribution to the YA mission of education and treatment. The major unresolved issues have to do with implementing the new YA policies.

As with other topics covered in this report, the provision of religion is variable across individual facilities and living units. Staff have yet to receive sufficient training in the new policies, and monitoring of compliance at either level of superintendents or the Central Office is extremely uneven or non-existent. For example, the Chaplains at one facility reported that no wards had signed

up for any religious programming at several living units for several weeks, but this odd result did not trigger an administrative review. The Chaplains visited these units and found a range of reasons why staff were not complying with new YA policies. Training of line staff, middle managers, and superintendents in the importance of providing all wards access to religious services and programs must take on a higher priority in YA training activities.

YA should reorganize the provision of religious programming under the leadership of Central Office staff. There needs to be a rational basis that allocates staff resources to religious programming, and this policy should be consistent across all facilities. The YA should be very focused on providing appropriate religious staffing to all wards, especially to Native Americans and Muslims. Provision of these religious personnel should not be the sole responsibility of facility superintendents. Also, the provision of services to some wards that depends entirely on the availability of community volunteers, should be replaced with a system of providing fair stipends for these individuals. The YA should develop an operational manual for its Chaplains and offer regular training to them. The Chaplains need an organized way to raise their concerns and suggestions to top YA leadership about how to upgrade the delivery of religious programs and services. This would be particularly important in areas in which custody and security concerns often interrupt or halt the provision of religious services and programs.

At the institutional level there is no consistency in how the Chaplains are integrated into facility management teams. All the of the Chaplains that I talked with suggested that they could help institutional staff by offering insights to areas like ward safety, suicide prevention, improved educational services, and the use of force. Chaplains can be very effective in engaging wards, especially those who are emotionally distraught. The Chaplains shoulder the major responsibility of informing wards and staff about deaths and serious illnesses in their families. The Chaplains already put in large amounts of time, with minimal compensation. They most often work on weekends and in

the evenings so as not to interfere with the school schedule; but, they all volunteered to do more to advance the mission of the YA. Creating a formal department-wide recognition of the great value of these contributions, and making the Chaplains full participants in institutional leadership teams, would be an important step. The Central Office could model this behavior, by increasing the role of Chaplaincy, in all of its major management deliberations.