April 9, 2003

Ms. Yvonne B. Burke
Chair
Los Angeles County Board of Supervisors
500 West Temple Street, Suite 866
Los Angeles, CA 90012

Re: Los Angeles County Juvenile Halls

Dear Ms. Burke:

We write to report the findings of our investigation of conditions at the Los Angeles County Juvenile Halls ("the juvenile halls"). On November 8, 2000, we notified you of our intent to investigate the juvenile halls pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and 42 U.S.C. § 14141.

Between February 12 and June 7, 2001, we conducted on-site inspections of the facilities with expert consultants in juvenile corrections, medical care, mental health care, sanitation, education and educational services for speakers of other languages. We visited Central Juvenile Hall February 12, 13 and 16, April 2-5, and May 21-24, 2001. We visited Barry J. Nidorf Juvenile Hall February 14-15, February 27 - March 1, and June 4-7, 2001. We visited Los Padrinos Juvenile Hall April 16-19 and May 7-10, 2001. While at the juvenile halls, we interviewed staff at all levels, resident youth, medical and mental health care providers, food service and sanitation personnel, teachers and school administrators. Before, during and after our visits we reviewed an extensive number of documents, including policies and procedures, incident reports, medical and mental health records, grievances from youth residents, suspected child abuse reports, unit logs, orientation materials and school documents. Consistent with the statutory requirements of CRIPA, we write to advise you of the results of this investigation.

We commend the staff of the facilities and County administrators for their helpful and professional conduct throughout the course of the investigation. Staff and administrators cooperated fully with our investigation, made

exceptional efforts to be hospitable during our visits, and have provided us with substantial assistance. In addition, subsequent to our visits and the County's further production of documents, the County provided us with updates of remedial efforts it has made since the time of our visits.

The County reports having gathered task forces and response teams to coordinate remedies for all items our expert consultants raised during their informal exit presentations at the end of their facility visits. We have not yet confirmed the effectiveness of those efforts through further on-site or document reviews, but will do so in the near future. We appreciate the County's responsiveness to our experts' on-site recommendations, and look forward to seeing the improvements the County reports it has made. We commend the County's effort to begin systemic change across the many departments responsible for the halls and hope that lasting improvement of conditions of confinement will be the long-term result of this reported collaboration. This letter will describe the conditions as we determined them to be through our facility visits and document review, and also acknowledge where the County reports it has undertaken remedial efforts in many of these areas.

As described more fully below, based on our documentary review and on-site investigations, we conclude that certain conditions at the juvenile halls violated the constitutional and federal statutory rights of the youth residents. We find that persons confined suffered harm or the risk of serious harm from deficiencies in the facilities' medical and mental health care, sanitation, use of chemical spray, and insufficient protection from harm. In addition, we conclude that failure to provide proper rehabilitation, education, opportunities to use the telephone and participate in religious programming, insufficient provision of translation services for Limited English Proficient (LEP) youth, and an ineffective grievance system also violated residents' rights under the 14th Amendment and other applicable laws.

I. BACKGROUND

A. FACILITY DESCRIPTIONS

All three facilities house both pre- and post-adjudicated youth, including those awaiting placement or transportation to a youth camp and some who have returned from unsuccessful placements or camp stays. Youth generally range in age from 11

to 19, though the facilities have housed youth as young as nine years old. While the average length of stay at the halls is 16 to 24 days, some youth are released in a matter of hours and some youth remain at the halls for months or even as long as a year. Youth who have been adjudicated or who have returned from an unsuccessful placement remain at the halls awaiting placement in an appropriate facility.

Youth are supervised by officers from the Los Angeles County Probation Department ("probation staff"). Mental health services are provided by employees of the County Department of Mental Health. Medical services at the halls are provided by contract with Los Angeles County - University of Southern California (LA-USC) Department of Pediatrics. All medical clinicians, medical support staff, and health administrative staff work for the contractor. Most maintenance at the halls is completed by a separate County agency, the Internal Services Department (ISD). Finally, the Los Angeles County Office of Education (LACOE), a subdivision of the California Department of Education, provides educational services. Coordination of these varied county and state agencies to provide safe, appropriate and integrated services at the halls is a significant challenge for managers of these facilities.

Central Juvenile Hall ("Central"), located in the Lincoln Heights section of the City of Los Angeles, is the oldest of the juvenile halls. Construction dates of various buildings at the facility range from 1924 to 1978, with some construction currently underway. The average daily population at the time of our visits was approximately 575[1/], although the rated capacity was 440.[2/] Central is the location for overnight stays for youth needing outside medical treatment, occasionally houses INS and U.S. Marshals Service youth detainees and has an average length of stay of 23 days.[3/] Some youth awaiting trial in adult court

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[1/]Populations at all the facilities fluctuate throughout the day as youth enter the facilities, attend their court hearings and are moved between the halls or to other facilities.

[2/]The Los Angeles County Probation Department ("Probation Department") reports that the population at the three halls since the time of our tours has declined from an average of 1970 to just over 1600 youth.

[3/]Average length of stay numbers cited in this letter are those provided by the County. In calculating those numbers, the County

were housed at this facility at the time of our visits.

Barry J. Nidorf Juvenile Hall ("Nidorf"), located in Sylmar, California, was constructed in 1978, with a significant expansion of housing space between 1994 and 1998. Average daily population was 712 during our visits, though rated capacity was 675. At the time of our tours, the movement control office and other structures had been closed following the Northridge earthquake in 1994, and were awaiting repair. Alternative temporary structures served in their stead. Youth who await transfer to one of the County's "camp" placements are housed at Nidorf, where they complete the first phase of the camp program. Average length of stay is 24 days.

Los Padrinos Juvenile Hall, located in Downey, California, dates from 1957, with buildings built through 1975. Average daily population was approximately 547 during our visits, though rated capacity was 421. In addition to pre-and post-adjudication youth, Los Padrinos also holds status offenders and some alien youth by contract with the United States Immigration and Naturalization Service (INS). Los Padrinos houses all hearing impaired youth confined at the juvenile halls. Average length of stay is 16 days.

Each facility has housing units, administrative areas, school buildings, a gymnasium, a pool, a medical observation building, a kitchen and a chapel. Juvenile courts are located on site at each of the juvenile halls. Youth residents in disciplinary confinement and those with challenging behavioral or mental health needs are housed in the Special Handling Units (SHU's). Youth are generally housed in either single or double rooms, though there are a few units with one or two larger rooms that sleep approximately three to seven youths. The INS detention units at Los Padrinos are dormitory-style, and the County had plans to refurbish two dormitory-style units for use at Central. At all three halls, some youth were assigned to a unit, even though there was no bed available for the youth in that unit. In those circumstances, youth either slept on cots in

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includes all youth who pass through the halls, including those who are only kept for a few hours while being processed. Thus the average length of stay for minors actually detained pending trial or placement is longer than the numbers reported here. The County does not compile separate statistics including only the youth held more than a few hours.

the day room or brought their belongings to another unit with bed space at night. Such youth are called "sleepers" at the halls.

B. LEGAL BACKGROUND

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional rights and the federal statutory rights of juveniles in juvenile facilities. 42 U.S.C. § 1997. Section 14141 of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, makes it unlawful for any governmental authority with responsibility for the incarceration of juveniles to engage in a pattern or practice of conduct that deprives incarcerated juveniles of constitutional or federal statutory rights. Section 14141 grants the Attorney General authority to file a civil action to eliminate the pattern or practice. The Religious Land Use and Institutionalized Persons Act (RLUIPA), 42 U.S.C. § 2000cc, prohibits governmental imposition of substantial burdens on institutionalized individuals' religious exercise, unless the government demonstrates that imposition of the burden is the least restrictive means of furthering a compelling governmental interest. RLUIPA applies to programs or activities receiving federal funding, or when the substantial burden affects interstate or international commerce, or commerce with Indian tribes.

The Due Process clause of the Fourteenth Amendment to the U.S. Constitution governs the standards for conditions of confinement of juvenile offenders and those awaiting juvenile justice hearings. Gary H. v. Hegstrom, 831 F.2d 1430 (9th Cir. 1987). Confinement of youth in conditions that amount to punishment, or in conditions that represent a substantial departure from accepted professional judgment violate the Due Process clause. Youngberg v. Romeo, 457 U.S. 307 (1982); Bell v. Wolfish, 441 U.S. 520 (1979); Alexander S. v. Boyd, 876 F. Supp. 773, 796-799 (D.S.C. 1995), aff'd in part and rev'd in part on other grounds, 113 F.3d 1373 (4th Cir. 1997), cert. denied, 118 S. Ct. 880 (1998). The Fourteenth Amendment prohibits imposing on incarcerated persons who have not been convicted of crimes conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. at 539-540.

The County has an obligation to assure the reasonable health, safety, and freedom from undue restraint of the youths in

its custody. See Youngberg v. Romeo, 457 U.S. 307 (1982); Gary H. v. Hegstrom, 831 F.2d 1430 (9th Cir. 1987); Alexander S. v. Boyd, 876 F. Supp. at 786-7; Santana v. Collazo, 793 F.2D 41 (1st Cir. 1984); D.B. v. Tewksbury, 545 F. Supp. 896 (D. Or. 1982). Youth must be provided adequate medical and mental health care. H.C. v. Jarrard, 786 F.2d 1080 (11th Cir. 1986); Morgan v. Sproat, 432 F. Supp. 1130 (S.D. Miss. 1977); Thomas v. Mears, 474 F. Supp. 908 (E.D. Ark. 1979); Ahrens v. Thomas, 434 F. Supp. 873 (W.D. Mo. 1977), aff'd in part, 570 F.2d 286 (8th Cir. 1978).

Because the purpose of the juvenile justice system is rehabilitative and not penal, incarcerated juveniles have a Due Process right to rehabilitative services including adequate education, counseling, vocational training, individual mental health treatment and programming reasonably geared towards helping juveniles correct their conduct. Gary H., 831 F.2d at 1433; A.J. v. Kierst, 56 F.3d 849, (8th Cir. 1995); Nelson v. Heyne, 491 F.2d 352, 358-60 (7th Cir. 1974); Reaves v. Peace, 1996 WL 679396 at *8 (E.D.Va. March 21, 1996); Alexander S. v. Boyd, 876 F. Supp. 773, 798 (D. S.C. 1995); Miletic v. Natalucci-Persichetti, 1992 WL 1258522 at *4 (S.D. Oh. February 6, 1992); Morgan v. Sproat, 432 F. Supp. 1130, 1140-41 (S.D. Miss. 1977).

Youth are entitled to seek redress with the government for their grievances, without fear of punishment for doing so. Bradley v. Hall, 911 F. Supp. 446 (D.Or. 1994); aff'd, 64 F.3d 1276 (9th Cir. 1995). Incarcerated youth have a right to access to telephones, subject to reasonable security limitations. Strandberg v. City of Helena, 791 F.2d 744, 747 (9th Cir. 1986).

In addition, as applicable to this investigation, juvenile detainees also possess federal statutory rights under the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq., Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("Section 504"), and the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. ("ADA".)

Recipients of federal financial assistance may not discriminate on the basis of national origin. Services must be provided in ways that allow Limited English Proficient ("LEP") individuals to have meaningful access to benefits and services, and to have the information they need for their health and safety while detained. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d; 28 CFR § 42.104.

II. FINDINGS

A. MENTAL HEALTH

At the time of our tours, both our investigative team and County staff agreed that the juvenile halls were failing to meet the serious mental health needs of detained youth. Los Angeles County had completed a study under which it determined that 50% of the youth entering the system needed mental health services, and staff estimated that perhaps one quarter of those in need actually received care. At the time of our tours, the County was making plans for reform and awaiting secured funds for additional staff and other improvements.

1. Screening and Initial Assessment

The screening and initial assessments conducted by staff as youth were admitted to the juvenile halls failed to meet accepted professional standards. The information collected by correctional and nursing staff was insufficient to identify serious emotional disturbance, substance abuse disorders and/or mental retardation, and make an appropriate disposition for these youth. If conducted, the brief screening form completed by probation staff did not appear in any of the charts we reviewed; thus the information was not available to treatment providers who might need it later. Although the County reported that it had instituted a new intake form and procedure during our visits to the halls, intake staff we observed and interviewed were unaware of a new system and continued to use the old form.

The initial medical histories completed by nursing staff were not sufficiently detailed to screen for problems the facilities need to identify immediately upon intake in order to keep youth safe. For instance, nurses identified daily drug use in a newly admitted youth, but did not determine whether he had any signs or symptoms of potential withdrawal. Some medical history information contradicted others in the file, suggesting that either nurses were not reviewing earlier forms or the charts were unavailable at the time the history forms were completed. Likewise, information collected during mental status exams was often insufficient. These problems contributed to an underidentification of youth with mental health needs at the facilities.

Furthermore, areas of the facilities where intake interviews and also nursing rounds in the housing units occurred lacked confidentiality. Staff questioned youth about sensitive medical

and mental health issues in areas where arresting officers or other youth could hear. Presence of police officers or other youth discourages youth from fully disclosing their medical and mental health histories and symptoms and prevents youth from receiving timely and adequate care.

The places where youth are held awaiting intake interviews presented safety and suicide risks. Some had blind spots that prevented staff from monitoring youth effectively. Others lacked a means for youth to communicate with staff while they were held in these waiting areas. These spaces presented various suicide risks, including live electrical outlets and hanging risks. This is especially problematic because the first 72 hours in which a youth is detained represent the greatest threat of suicide and withdrawal. The County remedied a number of these safety risks before we completed our visits.

At some point in the intake process, a staff member should exercise discretion in determining whether a youth whose serious psychiatric symptoms are not under control should be admitted to the juvenile halls at all, or be immediately hospitalized. If the halls are not equipped to handle a particular youth's present symptoms, then other arrangements should be made for care. One youth we encountered in the population at Nidorf was exhibiting psychotic behavior and hospitalized only after the intervention of a County psychiatrist who was accompanying us on our visits. This youth had been so unstable at the time of his admission that officers could not interview him or read him his rights. This youth should not have been at the halls, as the staff were not equipped to manage his mental illness. Someone in the intake process should be responsible for interceding in such cases.

Another example of a youth who did not belong at the halls was a young woman who had been there for over one year. In the course of her stay she was treated with at least 16 different medications for a variety of mental health diagnoses. Her head banging had occurred enough to result in "discoloration in the center of her forehead that may be permanent." She was on one to one observation most of her time. Despite this level of observation, staff frequently found the need to use physical and chemical restraint with her. The halls were not equipped to handle this young woman's mental health needs.

Numerous other youth whose mental health needs far exceeded the capacity of the juvenile halls to provide services remained at the halls. These youth never received appropriate forensic

evaluation, which could have determined an accurate diagnosis and placement recommendations based on the youths' needs, community safety considerations and available placement options.

The County reports that a new screening/assessment form has been in use since July of 2001, and that an interagency training committee is developing curricula under the direction of the Probation Department's staff training office, with a target date for completion of curriculum development in late 2002. The County reportedly has budgeted funds for additional space for mental health assessments. We plan to assess the implementation and adequacy of these reforms.

2. Specialized Mental Health Assessment and Referral

Some youth entering a detention system will need specialized assessments to diagnose mental illness, substance abuse disorders and mental retardation. The County's written descriptions and policies provide for adequate assessments, but none of the records we reviewed contained examples of adequate assessments.

We found that the County was not routinely providing psychological testing and gathering past treatment and school records. We found that no meaningful substance abuse assessments were conducted, and that staff did not complete most mental health assessment forms. In addition, staff failed to ask sufficient questions about symptoms such as hallucinations, suicidality, functioning and cognitive ability to make reliable decisions about diagnosis and care in many instances. In the small percentage of records where youth had received an estimate of functioning in their evaluations, most scored at a level indicating serious impairment, requiring highly structured mental health services. Nonetheless, there was no evidence that such structured services were provided to youth residents of the juvenile halls.

Our psychiatry consultant also found that many diagnoses in the files she reviewed did not match the information in the records of individual youth. For example, a youth experiencing auditory hallucinations including commands to commit suicide was diagnosed with depression and conduct disorder, which failed to reflect that the youth was actively psychotic and was being treated with medication for psychosis. Many of these diagnoses were determined without the review and approval of a medical doctor or Ph.D.-level practitioner, despite the County's policy requiring M.D. or Ph.D. review.

In other cases, the lack of availability of psychological testing limited the County's ability to identify mental retardation or other cognitive impairment in youth. Files we reviewed documented examples such as a 14-year-old who had not progressed beyond second grade level, and another teenager who could not read. No evaluations for cognitive impairment had been completed for such youth, even though such limitations may indicate existence of mental retardation.

Youth who commit self-harm may develop serious medical illnesses as a result of such behavior. Staff must assess and follow up with appropriate care for physical complaints from such youth. For example, one youth who engaged in self-injurious behavior frequently threw up blood, refused to eat and complained of abdominal pain was diagnosed as having bacteria that cause stomach ulcers, but was never treated for the infection.

In many instances, youth were referred for assessment but waited days or weeks for evaluations that referring staff thought should be done immediately. For example, youth experiencing suicidal thoughts or even making suicide attempts might wait three days or longer to be seen by a mental health provider. In another example, the medical director requested that a psychiatrist re-evaluate a youth's medication due to side effects including vomiting, dizziness, blurred vision and headache, noting that he should be seen that day. He waited nearly one month to see a psychiatrist.

Finally, an integral part of a complete assessment is acquiring records from other providers to develop a fuller understanding of a child's history. In most cases files we reviewed had no indication that the County ever requested such important records. Even when youth were hospitalized during the course of their juvenile hall detention, discharge summaries, pertinent laboratory results and results of specialized assessments were not in the records, nor was there any notation that the records had been requested.

New funding reportedly has allowed the County to hire several additional mental health care providers. Such staffing may improve some of the problems identified above. We will assess whether such additional staffing has remedied the identified problems.

3. Treatment Planning, Consent and Case Management

Individual treatment plans are necessary to ensure that treatment goals for youth with serious needs are identified and addressed, and that service among various systems is coordinated. Case management ensures that treatment plans are implemented. While the Probation Department's manual indicates that "an assessment and plan is prepared for each minor detained for a period of 30 days or more," none of the records we reviewed contained such an assessment and plan, despite lengthy stays of the youth. No staff asked were aware of any interdisciplinary treatment planning at the halls. In the two charts we received that did contain a service plan, the plans did not address some of the youths' most salient symptoms such as self-harming behavior or psychoses, and neither youth received the services promised in the plan.

The various agencies at the halls need to be able to work in a coordinated way from the same goals and information about a youth to meet needs effectively. For example, a minor was unable to attend school because of lengthy suspensions. Medications were insufficient to control her mood swings and she was not receiving counseling, but there was no notation in her records to suggest that further treatment or placement options were examined. In another case, mental health staff ordered that a youth be weighed by the medical staff every morning, since she had been hospitalized a week earlier for dehydration related to her "not eating or drinking due to psychosis." There is no indication in her records that she was ever weighed except at her initial physical. Proper case management would ensure that such interdepartmental collaborative needs were addressed.

Professional standard of care requires informed consent for treatment. At the halls there was no documented process for obtaining consent for treatment from youth or from a parent or guardian. Youth must understand the risks and benefits of treatment and the limits of confidentiality for a system to obtain informed consent.

In some cases, we found that mental health staff knew that a child had a mental retardation diagnosis, but the probation department staff responsible for his daily care did not know. We saw probation department notes wondering if youth were mentally retarded, or noting concern that youth did not appear to understand directions given to them. Mental health staff should provide guidance to probation staff as to what modifications of daily routine may be needed by someone who is cognitively impaired. Youth with mental retardation may not be able to read

and understand intake informational forms, unit orientation and rules forms, or complex commands. Without such guidance, youth may be disciplined and confined more than would otherwise be necessary.

For example, a 17-year-old youth with attention deficit/hyperactivity disorder, adjustment disorder, and mild mental retardation whose offense of record was "loitering on private property" accompanied by another youth with an air gun, was ordered into placement in September 2000, but remained at the halls "pending placement" until September 2001. During that time, she sometimes ended up on "modified program," an informal disciplinary status that requires youth to remain in their rooms except for school and physical training, due to her difficulty following directions. Probation staff were unaware of her mental retardation and lacked the knowledge to deal with her effectively.

Disabled youth, including those with mental illness, should not be housed in especially restrictive settings within the halls unless safety and security needs require such restriction. We found that youth with mental illness were frequently placed in settings within the halls that were more restrictive than would have been necessary if their mental illnesses had been adequately treated. Many youth with mental illness were housed in the SHU's and/or received some form of close supervision which might have been avoided through adequate service delivery. Appropriate programming by probation staff and appropriate counseling and other mental health services should be available to assist such youth in developing skills to succeed in less restrictive settings within the institution.

Furthermore, discharge summaries were not evident in most charts we reviewed. Those that existed did not document the need for medication or mental health follow-up, or had incorrect information. Such summaries are needed for sufficient treatment planning and follow-up.

The County reports that it is developing a discharge/aftercare policy. It reportedly has implemented an interagency coordinating committee and on-site facility-based committees, which meet to resolve issues of mutual concern. We plan to assess the implementation and adequacy of these reported reforms.

4. Mental Health Counseling

We found that the halls were failing to comport with professional standards with regard to counseling. Staff did not create treatment plans or document progress toward stated goals. Much counseling was focused on crisis response, and many interventions for youth seriously in crisis were unacceptably delayed. Treatment often was too infrequent to meet the serious mental health needs of the youth at the halls.

For example, one youth had been transferred to the halls from a hospital, with a long history of psychotic thought disorder, bipolar disorder, poor impulse control and chronic suicidality. Despite a note by a social worker who assessed her that she should receive individual therapy twice a week, she primarily received mental health attention only after attempted self harm or disruptive behavior and received no regular therapeutic interventions during her two-month stay.

Another youth had an entry in his chart that indicated he refused to eat, was hallucinating and unable to ignore the voices in his head, and was self-injuring in response to internal stimuli. Rather than evaluate this youth on a daily basis and provide counseling, he was left under watch by probation staff for a week to await the next psychiatrist's visit with no other mental health support.

Another youth with a long history of self-injury was seen by mental health staff and found to be suicidal. The worker noted that the youth's primary therapist would follow up, but four days later, without receiving any further mental health attention, he swallowed a razor, engaged in other self-mutilation and reported auditory hallucinations telling him to harm himself. He still did not receive mental health attention until another day had passed.

Many youth engaged in self-harming behavior without appropriate interventions. Staff labeled much of this behavior as "manipulative," without mental health professionals talking with the youth to address their behavior and underlying emotional issues.

Doctors wrote orders for a number of youth who engaged in self-harming behaviors to receive behavior modification plans. In a number of files we determined that such plans were never written or carried out. The "Behavior Modification Contract of the Special Handling Unit" is not a behavior modification contract in any therapeutic sense. It is merely the list of

rules youth sign upon entering the SHU.

Youth often missed appointments to see mental health staff due to "population balancing," a daily occurrence at the halls in which youth are moved between the three halls in an attempt to ease overcrowding at a particular location. During the course of our tours we were told that mental health and medical staff could put a "hold" on a child to prevent his transport for population balancing, but we continued to hear stories of missed appointments due to sudden transport of a child to a different facility. This practice damaged any therapeutic relationships that might have been built with counselors, requiring that youth start over with a new worker at the next facility. While medical appointments and court appearances make some movement inevitable, administrators should find a way to minimize disruption of therapeutic relationships.

The County reports that it has enacted an effective system of therapeutic "holds" to prevent population balancing of youth in medical or mental health treatment or with special school or court needs, without Superintendent approval. The County also reports that various agencies have reviewed and augmented the behavioral management protocols, upgraded the delivery of mental health, health and educational services, screening and assessment, increased staffing levels, and trained staff in the behavior management system. Appropriate mental health staff reportedly have been provided with pagers and/or cell phones for 24-hour access. We plan to assess the implementation and efficacy of these reforms.

5. Management of Psychotropic Medication

We found that the juvenile halls were failing to manage psychotropic medications properly and safely. Nursing staff did not monitor the side effects of medications they administered. Sometimes staff failed to provide prescribed medications to youth. Psychiatrist availability was limited and interdisciplinary communication with medical staff was poor in most cases. Critical laboratory results were frequently unavailable.

Nurses did not have sufficient time or training to monitor properly the effects of psychotropic medications administered to youth. Abnormal movements such as tardive dyskinesia and dystonias both may become permanent disfiguring conditions and must be monitored regularly when youth are taking certain

psychotropic medications. Muscle weakness and lack of coordination must also be monitored. Many nurses responsible for administering medications were unaware of the potential side effects of these medications, and nurses and social workers were unfamiliar with standard tests for monitoring side effects.

Staff and youth widely reported medication errors and failures to maintain continuity in medications. We found files in which youth waited as long as weeks to be restarted on medications they reported taking before their detention. Illustrating the systemic nature of the delay in care, one youth was referred for mental health care after a mother called to express her concern that her son had not had Ritalin for months. A week later a note in the file said that mental health appointments were "backlogged for about two weeks...mother will call to expedite her son's referral...[she states] meds make all the difference in his behavior." This youth had experienced great difficulty complying with rules and was accordingly disciplined while off his medications.

We were told that a two to three day suspension of a child's medications was not uncommon when a child changed housing units. Such suspension of medication can cause harm to youths' physical and mental health. For instance, a psychiatrist's note in one patient's file indicates that the youth "switched to different units and missed two days of his medication with resultant withdrawal symptoms of depressed mood, headache, loss of appetite and disturbed sleep." Delays in medication administration were in some cases the results of clerical or administrative error (see Medical Care, Part 1, below), but the delays in restarting medications upon intake are attributable in large part to insufficient psychiatrist staffing.

Lack of psychiatric consultants and difficulty in communication between medical and mental health staff put the medical staff in the awkward position of having to respond to youth experiencing newly developed symptoms without knowing the full clinical picture of a patient. Also, because they had many days between visits to a facility, psychiatrists might order lab work, but not be able to review the results for a week or more after the work was completed, thus delaying potentially needed adjustments in medications.

When psychiatrists wished to review lab results, the results were frequently unavailable. Neither Nidorf nor Los Padrinos was equipped with computer terminals with access to laboratory

results. The failure to follow through on lab work and obtain results as ordered interrupts patient care and places youth at risk of life threatening side effects. For example, the chart of a youth prescribed mood stabilizing drugs lacked blood analysis for blood cell production and renal function. The medications he was on could cause immunosuppression and kidney damage if not at the proper levels. Another chart revealed that the psychiatrist had such a hard time getting the results of ordered lab work that he discontinued the patient from a medication because without lab results it would be unsafe to continue this medication.

In order for treatment records to provide sufficient guidance for future care, some documentation is essential. Medication administration must be recorded, and explanations (i.e. patient refusal, lack of availability, youth in court, etc.) must be written when medications are not administered as ordered. Psychiatrists should be informed when youth refuse medication so that the reasons for refusal can be addressed. Proper documentation and informing of psychiatrists were not occurring in the records we reviewed. Furthermore, reasons for changes of dosage or type of medication must be recorded so that treatment providers understand what medications have been tried and the reasons they were stopped. The files we reviewed lacked such explanations. They revealed youth who had been on twelve or sixteen different psychotropic medications, and as many as five at one time, without clear rationale for treatment. Medications were sometimes stopped before efficacy could be established.

The County reports that training regarding drug side effects and interactions is ongoing and will be included in yearly in-service training protocols, and reference materials in the medical units have been updated. The County reports that it hopes to research and develop a central medical records system, though the funding has not been allocated. In the meantime, short-term manual systems solutions reportedly have been implemented. Additional hiring reportedly has been occurring. We will assess the implementation and efficacy of these reforms.

6. Custodial interference with mental health

Probation staff sometimes impeded access to mental health services by failing to communicate youth needs for services to mental health staff. For example, one youth reported that he told staff he was hearing voices and wanted to see the nurse but his requests were not communicated to the nurse. Another youth explained that she told probation staff that she had been

experiencing dizziness for three months after starting her psychotropic medications. She reported that when she asked to be placed on the nurse sick call list, probation staff told her that the dizziness was normal. Youth should be able to make a confidential request for mental health care in writing with the expectation that the request will be triaged by a professional with mental health training.

We received reports from youth and staff that probation staff on many occasions made inappropriate comments about youths' medication status or told youth not to take their medications. One mental health worker reported that probation staff told a youth to stop taking his psychotropic medications, he did so and became psychotic. Mental health staff heard comments from probation staff such as, "What are you seeing psych for? They are going to make you crazy." One youth reported being told, "Come up so you can take your psych meds, you psycho," and others were told to "take your crazy meds."

Although management staff of the facilities had been attempting to address the problem of staff using abusive language with youth, we found that many line staff still engaged in dialogue with youth that would be harmful to their mental health. Many staff yelled at and cursed youth, and at times demeaned a youth's family or made fun of a youth's legal predicament, sexual orientation or mental illness. Others used inappropriate words with sexual connotations while talking with youth, including those who had histories of sexual abuse. Such conduct by staff is inappropriate, violates professional standards of behavior, and may exacerbate mental illness in youth.

The County reports that it continues to reinforce existing policy prohibiting such conduct and has identified and written to individual employees where appropriate. We plan to assess the effectiveness of these reforms.

7. Crisis Management

All facilities caring for youth must have a plan for emergency medical and mental health care and adequate support to implement that plan. The plan must address suicide prevention, the use of physical restraints and the use of chemical restraints. We found that the halls were not managing mental health crisis situations according to their own policies, and the response to youth with serious emotional disturbance who were experiencing crises did not meet professional standards of care.

(For discussion of use of chemical sprays at the facility, see Juvenile Justice and Detention Practices, Section 1, Use of Force.)

a. Suicide Prevention

The County does routinely conduct staff training to recognize youth at risk of suicidal behavior, an important component of suicide prevention. One notable absence in staff training, however, was the procedure for cutting down a youth who might be found hanging. Hanging is the most common method of suicide in detention facilities. The majority of staff we questioned did not know where they might find a cut-down tool in the event of a hanging.

We also encountered delay in the assessment of youth identified as at risk for suicidal behaviors. In several files we reviewed, youth who had made statements of intent to commit suicide waited one to three days to be seen by a mental health practitioner. In one egregious case, a youth "talked about killing himself all night." He was not seen right away, and did cut his wrist the following day. Despite a staff request for mental health attention for this youth on the day of his initial statements, followed by a serious suicide attempt, no one in mental health came to see this youth until six days later, at which point he required hospitalization.

Once youth were finally evaluated, their suicide assessments were frequently incomplete. Assessments we reviewed did not contain documentation of past suicide attempts nor exploration of the youth's risk and protective factors.

Once youth were placed on suicide watch, they did not receive the care that they needed. Mental health staff did not follow up on a daily basis to counsel youth or assess their needs, even for very high risk youth. For example, one mental health assessment found that the youth was anxious, depressed, self injurious (deep scratches to both arms), and unable to agree not to hurt himself. Although mental health staff indicated that follow-up the following day was necessary, the youth was not seen for five days.

At times, because of staff shortages in the SHU's, contrary to the agency's own policies, one staff member would supervise more than one youth placed on one-to-one supervision due to self-harming behavior or suicidal ideation. Sometimes youth were

watched directly, and at other times by camera. In these situations, suicidal youth who staff determined to be in need of constant supervision for their safety might not receive it. We found that at Nidorf in the Boys' SHU, rooms where youth were placed to be viewed by camera did not allow staff to view parts of the room, so that a boy could remain outside view while he should have been on camera observation. Staff shortages might also mean that staff not qualified for some tasks were assigned to them anyway. A superintendent's report from January 2001 read, "Heavy 1:1 and hospital coverage created an artificial staff shortage. Staff were not trained to handle minors with severe mental and/or emotional problems."

In addition, allegedly constant supervision by staff were not always effective. Youth placed on constant watch by staff succeeded in numerous acts of self-harm, including taking 27 pills, ingesting hair relaxer and Windex, swallowing staples and inserting staples in wounds.

Staff of various disciplines should work together to ensure that suicidal youth receive appropriate supervision and care. Some probation staff appeared to lack the information and skills necessary for such a role. We received reports that probation staff sometimes tried to talk mental health staff out of putting a youth on close watch. Probation staff sometimes ridiculed youth for being on suicide watch, which may increase self-harming behaviors and suicide risk. Records reveal no effort to assist probation staff in understanding the psychiatric diagnoses of individual youth, recognizing target symptoms or implementing interventions designed to address the root causes of self-harming behaviors and promote healthy development. Finally, documentation of suicide attempts and communication with administrators, outside officials and family members after a suicide attempt was insufficient.

The County reports that it has established "need to know" protocols, casework conferences in the units, and a system for sharing assessment and screening data. It has reportedly increased mental health providers' presence in the living units, including the SHU, and increased other types of interdisciplinary communication. New suicide prevention policies and staff training reportedly are in effect, and the mental health department reportedly was designing behavior and treatment planning policies. We plan to assess the implementation and adequacy of these reforms.

b. Physical restraint

Mentally ill youth experiencing crisis may be restrained for the time necessary to prevent them from harming themselves or others, when other less restrictive responses would be insufficient. Uses of restraint must be promptly followed by evaluation to ensure that restraints have been applied safely and last only as long as necessary. Los Angeles County policy requires referral to mental health staff within 15 minutes of initial application of restraints, and an assessment completed within eight hours of the time of the restraint. Records indicate that mental health staff did not evaluate most restrained youth within eight hours. Documentation of restraints was also inadequate.

We were especially concerned about a restraint we observed while visiting Los Padrinos. Probation staff placed restraints on a boy's ankles and wrists with his wrists behind his back and the boy lying on his stomach. Restraint in this position increases the risk of asphyxiation, and has contributed to deaths of youth and adults in institutions around the country. The probation staff member was asked to put the youth on his side and refused until a psychiatrist explained the reasons for not restraining people on their stomachs. The nurse who came to check restraints found them to be too tight, and the probation staff member was unable to loosen the restraint because it was too small. The restraint was then removed at the psychiatrist's request. The psychiatrist had to ask security staff to monitor the youth in restraints, because there was confusion as to who was responsible for the boy. During this episode youth locked in other rooms in the medical unit were not monitored by staff. The probation staff member who conducted the restraint stated that he had not received training on the use of physical restraints for two years. We learned that other youth have been restrained in the same position at the halls.

The County reports that crisis related issues are discussed in on-site weekly meetings, and training protocols on crisis response are pending. We plan to assess the implementation and adequacy of these reforms.

B. JUVENILE CONFINEMENT PRACTICES

1. Use of Force

We found that staff at the facilities were using Oleoresin

Capsicum (OC) spray excessively and without sufficient warning. Staff sprayed youth in situations in which such uses of force were not necessary, including situations that did not present serious threats of bodily harm, circumstances in which youth had already complied with staff's directives, and circumstances in which staff already had control of the youth.

For example, staff wrote in one incident report that they had placed a minor in handcuffs and she began sobbing and screaming over and over that she would kill herself. When the minor did not stop sobbing and threatening self-harm after being instructed by staff to calm down, they warned her she would be sprayed. Staff tried to spray the youth and she attempted to push the staff member, after which two staff members held the girl while the other staff member sprayed her. Because staff were able to hold her, the use of pepper spray in this case was unwarranted. In addition, the minor's behavior, which did not pose an imminent danger to herself or others (as long as she was not permitted to act on her stated desires of self-harm) was not a circumstance that warranted use of pepper spray. We found in other cases that staff sprayed youth for talking back or "disrespecting" staff, standing up when ordered to be seated, yelling or banging on doors, circumstances that do not warrant this high level use of force.

In other incidents, relatively minor conflicts, such as a resident possessing a piece of paper he should not have, ended in staff spraying youth once the youth became hostile or aggressive. While in the end the spray might have been necessary in some of these cases once the situations had escalated, staff lacked the skills to de-escalate incidents in which youth failed to comply with orders, causing minor problems to become major confrontations that otherwise would not have required spray.

Staff also inappropriately used OC spray on youth who should not be sprayed for health or mental health reasons, including pregnant girls, suicidal youth, youth on psychotropic medications and youth who physicians had ordered exempted from chemical spray use due to respiratory problems. In one example that is representative of several in which staff relied on pepper spray to intervene in head-banging incidents, staff sprayed a young man who was banging his head against a wall and threatening to kill himself after he failed to comply with an order to stop banging his head. The youth was cognitively impaired, psychotic and receiving psychotropic medications. In other cases, staff sprayed a young woman who had begun to cut herself with a plastic

fork, and a young man who was trying to tie a shirt around his neck. In these examples it is likely that lower levels of force, coupled with mental health intervention, would have been more appropriate to intervene in the residents' harm to themselves.

Several files we reviewed showed examples of youth who were asthmatic and/or on psychotropic medications, who were subjected to OC spray in violation of both Probation Department policy and doctors' instructions. In one case of a youth who was asthmatic and had a heart murmur, the youth was OC sprayed only one week after probation staff had noted in his file that he could not be sprayed.

Staff also failed to provide proper warning and opportunity to comply with an order before spray was used on them. For example, some staff gave a "blanket" warning intended to be in place for an entire shift or activity, warning all youth that if they acted out in any way they could be sprayed. Other staff would give the warning immediately before use without waiting for youth to respond. Such warning methods do not allow youth the opportunity to comply with staff members' requests.

In addition, we learned that staff were using hot or warm water to wash faces and bodies of youth after spraying. This practice increases the pain and suffering from OC spray use, intensifying the burning sensation the spray causes. After our consultants brought this problem to their attention, officials promptly issued a new policy providing clearer guidance to staff for OC spray decontamination and appropriate use. However, this lack of knowledge by staff reflects the inadequacy of their previous training in use of OC spray.

Furthermore, management failed to keep proper control of OC spray use, by allowing all staff to carry OC spray and simply request more when a canister ran out, rather than weighing canisters after each use. In a detention setting in which use of spray inside locked units may cause pain to other residents who are not involved with harmful behavior, due care should be taken to restrict its use and the quantity of use to those situations in which it is necessary.

The county reports having instituted a new use of force data collection system and a more thorough investigation process for uses of OC spray. In addition, there are reportedly new policies with regard to uses of force and specifically OC spray. Non-criminal INS and status offender detainees may not be sprayed

under this policy. The County informs us that it has updated staff training to reflect new policies it issues, and that newly hired probation staff currently receive four hours of OC spray training. We plan to assess the implementation and adequacy of these reforms.

2. Protection from Harm

At Central, youth-on-youth fights occur routinely, some resulting in significant injury. This problem appears to be attributable, in part, to the lack of sufficient staffing at the facility. Low staffing levels left staff with too many responsibilities, limiting their ability to detect problems and attempt to resolve them before violence erupted. At Los Padrinos, staff members' logs included comments such as, "Very, very, very, very, extremely, totally unsafe again," describing a staff member's frustration at what he believed to be insufficient staff numbers to supervise safely the youth on his unit. Staff from all three halls expressed their concern regarding insufficient staff to youth ratios on the units.

Units operated with more youth than bedspace, requiring some youth to be "sleepers," on cots in the dayrooms or in other less crowded units. Such practice, paired with understaffing, prevents staff from being able to develop understanding of individual youths' needs and relate to them in meaningful ways that can help reduce tensions and control behavior.

The system we encountered of reporting and investigating allegations of child abuse failed to protect the youth held in the halls. There was no independent, consistent, objective and thorough system in place to report, investigate and follow up allegations of child abuse. Reports often lacked specific information, leaving out accurate detailed descriptions of the events or injuries, or failing to mention by name the staff alleged to be involved in the incidents. The facilities were inconsistent in their attempts to interview staff or youth who might have witnessed the incidents. Although staff of the Department's Ombudsman's office attempted to respond to the specific complaints they received from youth who called the toll free number, the office had insufficient staff to respond adequately to complaints coming from the three detention facilities and the County's probation camps.

On July 31, 2002, an unfortunate incident occurred at Central Juvenile Hall, reflecting security lapses. Late at

night, a youth being held in the Special Handling Unit was allowed out of his cell to get water, and pulled out a handgun. He and two other youths handcuffed the three officers on duty, locked them in a utility closet, stole their keys and escaped, aided in part by a ladder left accessible by workers doing repairs. During our visits we also noted that building and maintenance contractors were leaving supplies and debris such as pieces of metal that breached security. County officials are investigating how a handgun made its way into the facility, and developing new protocols to prevent further such incidents.

The County reports that it has made progress toward reducing the average daily population in the halls, including increased use of electronic monitoring, daytime school and work programs that allow youth to live at home, and expedited release of youth to their post-disposition placements. Plans are reportedly underway to develop additional institutional and non-institutional options for youth placements. The use of such options should allow the County to improve its staff to youth ratio and reduce the need to have youth sleep in dayrooms or away from their units. We plan to assess the implementation and adequacy of these reforms.

3. Opportunity to attend religious programs

We learned that the halls were not accommodating many youth's desires to participate in worship services due to staff and space limitations. RLUIPA requires that actions by officials which impose a substantial burden on an institutionalized person's religious exercise must be justified by a compelling governmental interest and must be the least restrictive means available to achieve that interest.

The County reports that minors are now assured access to religious services of their choice if they wish to attend. We plan to assess the implementation and adequacy of this reform.

4. Programming

In order for the juvenile halls staff to meet the needs of at least the adjudicated youth in their care they must have in place a meaningful structured program, including an effective behavior management program. The juvenile halls attempt to provide life skills and personal responsibility education through their EXCEL program. The EXCEL manual describes a "high intensity" approach to education of youth regarding social issues

that may have contributed to delinquent behavior, such as substance abuse, self esteem, personal hygiene, negative social influences and other topics. The program is supposed to incorporate pressure from a therapeutic community of peers and staff, and infuse all aspects of the youth's detention, from one-on-one counseling from the time a youth enters a housing unit, through "a busy daily schedule, punctuated with formal education sessions, informal educational opportunities, community meetings, physical training, and situations allowing minors to practice newly acquired skills...." While in policy and written manuals the halls professed to provide therapeutic structure based on the EXCEL program, the reality for the general population at the time of our visits was far from that goal. Staff reported to us and we observed that the EXCEL program was not consistently in operation. Even staff who made an effort to conduct discussions about behavior, self-esteem, personal hygiene or other relevant topics varied widely in their abilities to conduct these activities in a productive manner. Medical and mental health staff reported that they had attempted to inform management that the lack of activities and programming for youth contributed to mental health problems experienced by youth, but that this communication had not resulted in improved programming.

Programming for girls was not meeting their rehabilitative needs. Their programming gave inadequate attention to issues that disproportionately affect girls, such as health issues, mental health needs as a result of histories of abuse, parenting and other gender-specific needs. While staff had begun planning for more gender-specific programming, no plans had been completed nor programs implemented as of the time of our visits. Planned opportunities for youth who were parents to have visits from their children were sometimes cancelled due to insufficient staffing.

Some staff engaged in inappropriate group punishment. For example, if one youth persisted in talking when she was not allowed, the entire unit would lose the evening activity, or might not be allowed to make telephone calls for some number of days. The practice of group punishment that does not address exigent security concerns violates professional standards and gives residents a sense that following rules will not result in fair treatment.

Due in part to thin staffing on the weekends, youth spent large blocks of time in their cells on the weekends, with little opportunity for stimulation while in their cells. While some

youth were allowed to keep books among their personal belongings, in many units they were not allowed to have books in their rooms during various times of day when youth were locked down. Although some units had an extra supply of reading materials, they often did not make them available to youth during times when youth were confined to their rooms. When asked, many staff were unaware whether they had any books to lend to youth in the unit at all.

The County reports that it has revised its EXCEL program, drafted a new behavioral management model and is working on training staff. Girls' program content was being evaluated for improvement. The County reports that it already had procedures in place for minors' visits with their children but is reinforcing them. Additional reading materials reportedly have been procured and distributed. The County further reports that it has created additional policies and training with regard to rules for youth conduct, in an effort to standardize expectations throughout the halls. We plan to assess the implementation and adequacy of these reforms.

5. Language

The juvenile halls detain a number of youth who do not speak or understand English well. With the exception of the detainees housed by contract with the INS, almost all youth at the halls with limited English skills speak Spanish. Detention facilities must provide sufficient opportunity for Limited English Proficient (LEP) individuals to have meaningful access to programs and services, especially those that affect health and safety, length of stay or discipline. Facilities should not rely solely on written translations if the youth cannot read and understand them. Using other residents to translate is generally not appropriate unless the topic of communication is not sensitive, confidential, important or technical and the other resident is competent in the skill of interpreting. At the juvenile halls, opportunities for youth who could not read or understand English well to communicate with staff about important matters in reliable ways were not provided sufficiently.

We found that youth with limited English proficiency generally had not received sufficient orientation to understand how to access essential services such as medical or mental health care if they needed them. Some Spanish-speaking youth had been

provided a written handbook in Spanish and others had not.[4/] Youth who could not communicate in English reported that they learned rules from asking other detained youth, and if they needed things they asked other youth to translate or waited for another shift when there might be a staff member who spoke their language. Grievance forms were not available in Spanish.

Although administration officials told us that telephone translation services were available as staff needed them to deal with speakers of other languages, none of the staff members we interviewed who supervised youth had any idea that youth and staff would be permitted to use telephone translation services if they needed them. The medical department did seem to use telephone translation services as needed, and facility administrators made an effort to educate staff about the availability of this resource following our visits.

One example of the communication problems staff have involves a Chinese youth who was being disciplined and moved to the SHU. He was instructed to remove his pants and shoes but did not do so, so staff removed them. He kicked a staff member, was given an OC spray warning, but began banging on his cell door once in the SHU. He was subsequently pepper sprayed and remained agitated. The nurse involved in his decontamination and examination found it necessary to contact an interpreter in order to explain the effects of OC spray, but the rest of the discipline process to that point had been carried out without translation. It is quite possible that his agitation was attributable to not understanding all of what was happening to him. Furthermore, he may not have understood all the orders staff gave him.

A Spanish-speaking youth who could not communicate in English was notably upset at the time we met with him. He told us that he had been moved from one hall to another several days before and had been unable to ask staff for the opportunity to use the telephone to tell his family where he was. Another Spanish-speaking youth reported he felt hopeless and in despair,

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[4/]We encountered youth detained by the INS from a number of other countries, including China, Sri Lanka and others. No written materials were available in languages other than English or Spanish, and these youth varied in their English proficiency from little to no comprehension to functional understanding and communication abilities.

but did not know how to get mental health help.

Youth who did not speak English had a harder time receiving necessary evaluations and care. While Nidorf did have a Spanish-speaking social worker, Central's bilingual counselor left, and no Spanish-speaking replacement had been identified during the time of our tours. We reviewed records of non-English-speaking youth who had not received needed mental health assessments or counseling.

The County reports that it has surveyed staff to determine non-English language capabilities, is working to deploy bilingual staff more effectively, and has identified community volunteers to translate less frequently encountered languages. The County reports that it has revised the orientation procedure and booklet, providing language interpretation where needed, and that youth with special needs reportedly now receive individual orientation. The County also reports that it issued a policy in February 2001 regarding the availability of telephone translation services for non-English speakers. We question the effectiveness of this policy, since staff we interviewed after February did not know of its existence. We plan to assess the implementation and adequacy of the reform efforts above.

6. Grievance system

We found that the facilities lacked an effective grievance system. The orientation process at the halls was insufficient to provide youth with the information they needed in order to understand the grievance system and how to access it. While a form was in existence and administrators were able to show us some forms that had been completed by youth, the system was not operating in a meaningful way at the time of our visits. In order for youth to file a grievance, they first had to ask staff for a form and for a pencil (for security reasons, writing implements are strictly controlled at the halls). Once youth completed grievances they had to turn them in to staff. Interviews with staff and youth confirmed that staff did not always maintain confidentiality of these forms and in some cases did not process them or tore them up. Furthermore, youth feared retaliation by staff for filing grievances. One mental health staff member reported, "I hear [from youth that staff say]'We can lie because they will believe us before they believe you' enough for it to be disturbing," suggesting that staff threatened youth that they should not file grievances because they would not be believed anyway.

Furthermore, there was no system for ensuring that a grievance that had been "granted" was ever remedied. The results were not consistently documented or reported to youth, further undermining confidence in the system, as youth could not tell what had been done about their complaints. The halls need to ensure that a working, confidential system is in place for youth to seek timely redress of their grievances.

The County reports that the grievance process has been revised, including new forms and a new logging procedure. Management reportedly will monitor to ensure that grievances against staff are answered in a timely fashion. We plan to assess the implementation and adequacy of these reforms.

7. Telephone access

Detained youth are entitled to reasonable access to telephones. In the halls, some youth were able to use telephones as many as four times in a week, while others went a week or more without any access. Staff denied access to telephones as a means of group punishment when one youth acted out. Such punishment is not reasonable, and is contrary to accepted professional standards.

Some youth reported having trouble gaining permission to telephone their attorneys. They have no opportunity to make such calls in a private location. We witnessed one youth attempting to talk on the phone with his attorney crouched under a table in a busy staff area with youth and staff walking in and out. Another youth was forced to discuss her concerns with her lawyer while three staff members sat within two feet of her, watching and listening. While some staff would occasionally allow youth to use the facility's telephones to call their families free of charge, there were no consistent provisions for youth whose families could not accept collect calls to have telephone contact with their families.

C. ACCESS TO MEDICAL CARE

For the most part, Los Angeles County is meeting its obligation to address the serious medical needs of its incarcerated youth. However, our investigation uncovered the following deficiencies:

At all three facilities, youth were, at times, denied timely services for both specialized and routine medical needs.

Specifically, youth with special health care needs such as diabetes, epilepsy, unstable asthma, pregnancy, and HIV/AIDS ("medically fragile youth") often missed appointments for outside medical consultations due to a lack of transportation. In addition, at Central Juvenile Hall, the facility failed to track and monitor adequately the medical needs of its medically fragile youth. As a result, medically fragile youth missed important follow-up appointments with physicians and treatment plans were not developed in a timely fashion. Finally, Los Angeles County did not have a system for transferring medical records from one facility to another at the same time the youth was transferred. Laboratory reports were hard to track down and often absent from patients' charts. The inability of staff to review prior health records in a timely fashion delays medical treatment and places medically fragile youth at risk of harm.

With regard to routine medical care, we found that barriers existed which had the effect of discouraging and/or denying access to timely medical care. For example, at all three facilities, the medical request log the youth use to request medical services was referred to as the "complainer's list," a term which discourages the use of sick call because it suggests that youth seeking medical care are inappropriately complaining. In addition, youth were, at times, required to explain their need for care to probation staff in order to get on the list. The screening of medical care by probation staff may deter youth from seeking needed medical and mental health treatment. Finally, some youth did not even know how to access the medical care system, a deficiency that appears attributable to the orientation process.

The County reports that it will create additional patient examination space at all three halls and may have funding to computerize its recordkeeping system in 2003-2004. There are reported plans for nurses to receive additional training in communication with patients, and new policies have been drafted to govern youth requests for medical care. A treatment plan monitoring system is now reportedly in place, and a new policy requires that doctors write treatment plans at the time of initial evaluation of patients if such plans are needed. The County also reports that additional staff were added to the budget beginning fiscal year 2001-02. The County reports that it has revised the orientation procedure and booklet, providing language interpretation where needed. Youth with special needs reportedly now receive individual orientation. We will assess the implementation and adequacy of these reforms.

D. EDUCATION

1. Special Education

a. Screening and initial identification

School systems have a responsibility to locate, identify and evaluate all eligible students with learning disabilities to determine their need for special education and related services. The screening systems used by the Halls to identify youth in need of special education were insufficient to meet these requirements. The schools identified youth needing special education services in three ways: (1) through self-reporting; (2) through records of prior detention at the Halls when a special education need was verified; and (3) through teacher identification and then follow-up testing. The schools did not identify a significant portion of students who appeared to need special education through these three systems and thus were not consistently providing the special education services to which youth are entitled under the Individuals with Disabilities Education Act (IDEA).

The school system did not conduct intake interviews in a manner that could produce reliable information. Staff completed the intake interviews we observed in less than one minute. When a youth is interviewed, probing and follow-up questions are often necessary to obtain an accurate special education history from a youth. Concern over current legal difficulties, misunderstanding of the services youth had received previously, fear of their new environments at the Halls or simple inability to comprehend the screening questions are factors that prevent recently detained youth from accurately reporting their education histories. The one-minute or shorter interviews we observed at the Halls could not overcome these barriers. Assessment personnel reported to us that they were unable to conduct longer interviews due to staffing shortages.

The school system maintains a database to record students' receipt of special education services at the Halls. However, youth who previously self-identified as having received special education services in the community, but whose special education needs had never been verified through record retrieval, did not appear in this database. Thus, unless a youth self-reported again at a later admission to the Halls and staff retrieved the student's records from the school where he or she received the

special education services, the youth was not likely to receive the needed services while at the Halls.

The school system took insufficient steps to gather youth education records needed to determine special education eligibility and guide services. Cut-backs in staff slowed record retrieval from students' community schools to a trickle. Until the Halls received verification that a student did need special education, either through prior school records identifying that need or through testing at the Halls, the student received no special education services.

In addition, medical and mental health staff sometimes failed to convey to education staff necessary information that might assist in developing appropriate education programs for individual youth. For example, although vision and hearing screenings are required for youth referred for special education eligibility determination, the medical staff performed only about half of the vision and hearing screenings the schools requested.

The practice of population balancing between the three Halls also impeded completion of special education assessments as well as other education goals such as planning for high school equivalency examinations. Staff moved youth between the Halls to even out the number of youth detained at each Hall, disrupting testing and examination preparation.

Finally, staff at Central Juvenile Hall provide no education services to youth aged 19 to 21, despite youth entitlement to special education through age 21.

The County Office of Education reports that it has improved both its screening system and its referral process to identify students in need of special education, resulting in an increase in referrals for assessment. The County reportedly has made efforts to avoid moving youth between Halls when it would disrupt ongoing testing or high school equivalency examination preparation. The County Office of Education also reports that it has worked with juvenile court judges, school principals and other juvenile court leadership to enhance the retrieval of prior education records, and has enhanced its database as well as increased computer storage of documents. We plan to assess the implementation and adequacy of these reforms.

b. Delivery of special education services

The Halls were providing students identified as needing special education services with inadequate services in insufficient quantities. General education teachers were expected to provide special education services for the students in their classrooms identified as special education students. Often, the general education teachers had no idea which of their students had been identified as needing special education. At the time of our tours, special codes on the classroom rosters identified special education students, but none of the teachers we interviewed knew what the codes meant. Additionally, even if a teacher knew that a particular student was in need of special education, the teacher often did not know what the identified student's disability was or what special education was needed to address that disability.

Many general education teachers did not participate in meetings regarding the student's Individualized Education Program (IEP), despite the IDEA's requirement that they participate in such conferences. The teachers reported that either staff did not invite them to attend the meetings or they could not locate coverage for their classes in order to attend. Most general education teachers we interviewed had not read the IEPs for their students. The schools also made inadequate efforts to ensure meaningful parent participation in IEP conferences through use of alternative methods such as speakerphones and scheduling of IEP conferences to coincide with facility visitation schedules.

Delivery of special education services outside the classroom by resource specialists also failed to meet the IDEA's requirements. While these services should be provided by certified special education providers, unqualified paraeducators attempted to provide services. The halls lacked proper spaces for youth to work one on one in a private setting. Instead they had to carry on individual services in noisy, shared offices that interfered with youths' concentration. Furthermore, due to staffing shortages, the Halls did not provide youth the amount of services required in the youths' IEPs.

Counseling and speech services were limited at the Halls due to lack of staff. Space to conduct exams and provide counseling also lacked appropriate privacy.

The County Office of Education reports that it has hired additional special education staff, provided extensive training to teachers, involved special education service providers more in classrooms and engaged in monitoring of outcomes and training

needs. New management reportedly focus on instructional leadership and strategies, and schools have developed procedures for obtaining appropriate representation and input at IEP team meetings. We will assess the implementation and adequacy of these reforms.

c. Behavior Management

The IEP teams for learning disabled youth who have behavioral problems that interfere with their learning or that of others must consider and implement appropriate strategies that can address the behavioral concerns. Such strategies may include positive behavioral interventions and supports, with correlating behavior intervention plans. At the Halls, many youth are confined in the special handling units (SHUs) or returned to their units from school as a result of "refusal to attend school" or "behavior referrals" from school. A substantial portion of these youth have identified special education needs. The schools did not review these youths' IEPs to consider their need for more intensive supports and interventions, or include positive behavior intervention plans in their IEPs.

While behavior management assistants (BMAs) saw some youth with emotional disturbances, these paraeducators had little specific training in special education or in positive behavior management strategies.

The County Office of Education reports that it has increased training on behavior intervention, and that vice principals are routinely involved in disciplinary procedures to ensure consistency. We plan to assess the implementation and adequacy of these reported reforms.

d. Transition services

The IDEA requires education programs to provide transition services to teenage special education students to help them move from school to employment, higher education or other goals. The Halls showed little evidence of providing individualized transition services to special education students.

The County Office of Education reports that it has enhanced transition training for the staff and increased youth opportunities for transition skills development. We will assess the implementation and adequacy of these reforms.

2. Exclusion from Classroom Instruction

At the time of our tours, the Halls did not have enough teacher positions to provide the entire student population with consistent, daily instruction. Teachers' contracts limit the classroom size to no more than 17 students. Students who arrived to a classroom once that maximum capacity had been reached were sent to overflow classrooms. Substitute teachers ran the overflow classrooms. From our observations, very little educational instruction took place in the overflow classrooms. Staff did not assign youth to overflow classes based on educational criteria such as reading or grade level; teachers were often unaware of youths' instructional and special education needs; overflow classes did not have appropriate instructional materials or equipment; and the classes were held in dayrooms or gymnasiums which provided inappropriate environments for teaching and learning.

Furthermore, we observed many days when the overflow classrooms also reached capacity. Students who encountered this situation were sent back to their units and received no educational instruction for the morning (or the afternoon unless the situation had resolved itself). Likewise, in the residential units where students stayed for their daily classroom education, those classrooms often exceeded their 17 student capacity as well, in some cases preventing youths from attending those assigned classes.

The County Office of Education reports that students are now consistently receiving 300 minutes a day of education at all three halls. We look forward to assessing the implementation and adequacy of these reported reforms.

3. Classroom Placement

Staff assess students' math and reading skills as they arrive at the Halls. The schools use the results of these assessments to determine appropriate classroom placement. However, at the time of our review, rational classroom placement decisions were compromised. First, the schools gave assessment tests in English only. Students whose primary language was Spanish were not assessed adequately. Second, due to the lack of teachers, the schools often shuffled students between classes to keep the classroom numbers balanced, ignoring the students' assessed levels.

The County Office of Education reports that it allows parents, students and teachers to request changes of placement for youth throughout their enrollment, and that changes in instructional strategies allow all students' skill improvement. We will assess the implementation and adequacy of these reforms.

4. Guidance Counselors

Guidance counselors serve important functions in juvenile incarceration facilities, including planning and tracking of students' academic goals and progress toward high school graduation or receipt of equivalency certificates. They help students determine courses they need to graduate, and help prepare youth for equivalency examinations. In recent years, all guidance counselor positions were eliminated from the juvenile halls. This cancellation of previously provided services resulted in fewer students at the Halls receiving high school diplomas and equivalency certificates.

The County Office of Education reports that it has placed guidance counselors back at the schools within the Halls, numbers of graduates and high school equivalency recipients increased in the past school year, and more funds were available to provide college scholarships to graduates. We will assess the implementation and adequacy of these reported reforms.

5. Homework and Classwork

Teachers wished to assign homework to students in their classes, but were unable to do so due to security policies. Though the rules varied between units, many staff did not permit students to bring paper from school back to their residential units, and did not provide access to writing implements in the units. Some students reported that teachers assigned them letters to write as classroom exercises, but they would not be permitted to mail them.

In addition, we noted that students did not receive feedback on many classroom assignments. In reviewing work folders, we noted work that had inappropriate language as well as coded notes between students, evidencing the lack of instructor review of the material in the folders. Assignments several weeks old had no correction or other teacher's markings, and many youth complained that they did work on which they never received feedback.

The County and Office of Education report that they have

coordinated to resolve homework impediments, and that teachers now assign homework on a standardized schedule, with time and pencils available in the living units for homework completion. In addition, the County Office of Education reports newly restructured approaches to the curriculum to maximize instruction in shorter modules, greater instructional guidance and more after-school extended learning opportunities. Principals and vice principals reportedly observe classrooms regularly, and there are plans to more appropriately assess the merits of the instructional program. Through grants and other efforts, the County reportedly has acquired more books and computers for instructional purposes. We plan to assess the implementation and adequacy of these reported reforms.

6. Instruction to Speakers of Other Languages

School districts must provide educational services in a manner that allows language minority youth to participate meaningfully in the educational program. While there are a variety of acceptable ways in which schools can provide meaningful access to the educational program for speakers of other languages, we found that the Halls were failing to provide such access.

Youth who could not understand English did not receive information on school rules or how to access special educational services while at the Halls. They were asked to sign papers written in English, which they did not understand.

Staff assigned many limited English proficient youth to classrooms in which the teachers did not engage techniques in reading, writing or discussion assignments that could aid those youth in understanding the lessons. In many classrooms teachers overrelied on bilingual youth translating for limited English proficient youth. Many youth with only limited English proficiency reported that they did not know what was going on in their classes and that they had to depend on another student in the class to know what to do. We observed classrooms in which teachers were not even aware of students' limited English proficient designations.

Furthermore, classes had insufficient reading materials at appropriate instructional levels for youth, and lacked other instructional materials needed to adapt the program effectively for speakers of other languages.

The County Office of Education reports that it has adopted and is implementing a new policy for education of English language learners, that it has held numerous trainings and has acquired additional recreational and instructional materials in Spanish. In addition, the school system reports that translation services are available where appropriate. We plan to assess the implementation and adequacy of these reforms.

E. SAFETY AND SANITATION

1. Fire and Life Safety

Our investigation found inadequate fire safety measures that compromised residents' safety at all three halls. These deficiencies included: absent, inaccessible and improperly maintained fire suppression equipment; excessive and improperly stored combustible materials; inadequate smoke and fire alarm detection equipment; substandard evacuation routes and procedures; and an overloaded and substandard electrical system.

a. Fire extinguishers and sprinkler system

Fire extinguishers were present throughout the three halls but the extinguishers were not always accessible or properly maintained at Los Padrinos and at Nidorf. These deficiencies were most apparent in the schools, housing units, and maintenance areas. Some fire extinguishers were outdated or were not being properly inspected. Others were not accessible to staff in the event of a fire. Some staff did not know where to find the closest extinguisher.

There were few automatic sprinkler systems in any of the three halls. The few areas that were sprinklered were not properly maintained. Leaking or dusty or misused sprinkler heads were found at both Central and Los Padrinos.

The County reports having inspected, replaced or recharged, and marked all of the fire extinguishers at all three halls, and repaired fire hoses. We will assess the effectiveness of these reported reforms.

b. Combustibles and electrical hazards

Many of the maintenance/mechanical areas at Central and Los Padrinos contained combustible materials that were not properly stored, such as gasoline and oily rags. This problem was

especially severe at Los Padrinos. Many of these same areas contained flammable debris or were otherwise cluttered. These maintenance/mechanical areas did not appear to be routinely inspected for fire safety.

Overloaded electrical outlets and unsafe electrical appliances were a problem throughout the halls. Staff have brought to the facility electrical appliances that are not grounded or polarized. We found such appliances plugged into extension cords not suitable for high amperage appliances. These fire hazards were especially severe in the classrooms, and most notably at the Los Padrinos school where the electrical system was outdated and unsafe. Other electrical hazards included unsecured electrical cabinets and substandard or damaged electrical outlets.

The County reports having inspected all electrical systems, boxes, and sockets for safety compliance in all three halls, and instituted a maintenance housekeeping policy. We will assess the effectiveness and adequacy of these reported reforms.

c. Fire and evacuation preparedness

Exit signs and other emergency lighting were missing or not working along evacuation routes throughout the halls. It was unclear whether emergency generators would supply power to essential functions at the halls in the event of a power outage because maintenance and supervisory staff at the halls did not know and had no documents to show which items at the facility were covered by the generators. Emergency exits were blocked in some locations due to furniture arrangements. Some of the housing units at Los Padrinos had blocked exits or faulty door locks to the residents' rooms, which could make evacuation difficult in the event of an emergency.

There were no smoke detection systems in some areas at Los Padrinos. Non-working smoke detectors were found in at least one housing unit at Nidorf. The halls' fire alarm systems were not connected directly to the local fire stations.

The County reports having posted fire evacuation plans in all areas, and inspected and repaired or replaced all faulty doors, locks, and keys. We will assess the effectiveness and adequacy of these reported reforms.

2. Food service

The food service operations at the three halls did not meet sanitation requirements and put residents at risk of developing food borne illness. In addition, there was inadequate control of medical/special diets at two of the three halls.

We found numerous examples where foods were kept at unsafe temperatures, which could allow for growth of food borne bacteria. At all three halls, some of the freezers were not working properly. At Central, frozen food deliveries were not handled safely to maintain freezing.

The food temperature and safety were further compromised because the closed carts that were used to transport meals from the kitchen to individual units did not maintain safe temperatures until the food was served.

Food service staff were also storing, preparing, and serving food in unsanitary conditions at the three halls. At Central, food was sometimes stored unlabeled and undated risking unsafe food rotation. Our investigation identified food stored in soiled containers and prepared and/or served with soiled utensils/equipment. Food and food utensils were stored with cleaning supplies. At Los Padrinos, food contact surfaces, utensils and equipment were not kept in sanitary conditions. Staff in the kitchens were seen using bare hands on food contact surfaces. Some food was stored in a bathroom. At Nidorf, some food was stored unlabeled and undated risking unsafe food rotation. Equipment and utensils were being stored in an unsanitary manner.

Other unsanitary conditions in the kitchens compromised safe food preparation at all three halls. These included: water, plumbing and sewage problems at Central; water, sewage, plumbing, bathroom, garbage, rodent, and insect problems at Los Padrinos; and garbage problems at Nidorf.

A percentage of residents at all three halls are on special diets (medical or religious). At Central and Nidorf, we saw evidence that residents who were supposed to be on special diets did not always receive those meals. In addition, many of the housing units' pantries contained no or minimal snacks necessary for special needs children (i.e. pregnant youth, diabetic youth, etc.) for occasions when medically ordered snacks were not delivered.

The County reports having put weekly kitchen inspection protocols in place to determine if food in freezers is properly labeled, decreased meal service delivery time by 15 minutes, and repaired many kitchen appliances in need of repair. The County also reports the development and implementation of several more kitchen inspection protocols. We plan to assess the implementation and adequacy of these reforms.

3. Plumbing, ventilation, and lighting

All three halls had deficient plumbing, ventilation, and lighting. We found broken or uncleanable toilets, urinals, showers, and sinks at all three halls. Some sinks had on/off valves too hard to operate, or that would not allow for proper hand washing.

All three halls lacked proper ventilation in some locations. There was no evidence that the ventilation systems had been cleaned or rebalanced. Uncomfortable temperatures, mold-encouraging humidity, disease transmission potential, and foul odors existed in some areas at all three halls due to the failure of any adequate inspection, maintenance, and repair programs for the ventilation systems. Temperature control on the housing units and in the classrooms varied greatly. Some ventilation grills were plugged or blocked in each of the halls. Many individual classrooms and residents' rooms had no intake air circulating or no working exhaust and, in some cases, both were not working.

Adequate lighting must be provided for reading, to ensure security, and allow for good sanitation and proper personal hygiene. All three halls had numerous instances of inadequate or unsafe lighting. Unprotected lights, which can lead to food contamination, were found in the food service areas at Central and Los Padrinos. Many housing units at all three halls had broken, blocked or inadequate lighting for reading and personal hygiene. Emergency lighting and security lighting were not working or inadequate at some locations in all three halls. Some of the classrooms at Central and Los Padrinos were not adequately lit. In addition, medical facilities at all three facilities lacked adequate lighting.

The County reports having developed and implemented a physical plant maintenance inspection system and made all necessary repairs. In addition, the County reports having inspected and repaired all plumbing in the bathroom/shower

areas and kitchens and lighting in selected areas. An overhaul of the three halls' HVAC systems was expected to be completed in August 2002. We plan to assess the implementation and adequacy of these reforms.

4. Medical areas

There were several environmental health deficiencies in the medical areas at the three halls, in addition to the plumbing, lighting and fire safety problems outlined above. At Central, the dental clinic had no means to dispose of bio-hazardous materials, was experiencing an ant infestation, and had a dirty, unorganized pharmacy. After hearing our grave concerns regarding environmental health and safety conditions in the pharmacy (risk of contamination of both medical and non-medical products), staff quickly cleaned and reorganized the pharmacy.

At Los Padrinos, the pharmacy was poorly lit and non-medical items were stored in the room. Uncovered waste containers and soiled rooms and furniture were evident.

The medical areas at Nidorf were especially problematic. Lighting in the storage area and admission exam room was poor. Medications were stored on dirty floors and in dirty containers. Sterile supplies were stored with non-sterile supplies. Plumbing fixtures were broken and dirty. Patient rooms were soiled. Staff invited us back during our later visits to see improvements they made after our initial feedback, and many of the problems, but not all, had been addressed. Inadequate lighting in the medical storage area and admission examination room had not been corrected. Broken and poorly maintained plumbing fixtures had not been repaired.

The County reports having installed a temperature alarm on the medical refrigerator at Central, repaired a drainage problem in the medical area at Central, and added biohazard and sharps buckets in each medical services room at all three halls. The County also reports having been allocated money for additional space, and having instituted additional training for nurses. All three halls have implemented pharmacy inspection plans and staff training, according to the County. We plan to assess the implementation and adequacy of these reforms.

5. Personal hygiene and laundry

Facility practices interfered with residents' personal hygiene in several respects. At all three halls, security

practices did not allow for necessary handwashing at appropriate times. Stains were not always removed from clothing by the laundry service. Female residents especially complained of "freshly laundered" yet stained undergarments. We saw mattresses with splits in their coverings, which prevent them from being sanitized properly. In many units there were not enough clean sets of clothing and towels to supply all residents.

Some housing units had an insufficient number of working toilets and/or showers. Residents' access to toilets, especially at night, was sometimes limited. Although management had been attempting to improve the toileting problem, we received reports of youth having to relieve themselves in their towels, pillowcases, or corners of their rooms when they were not allowed out of their rooms to use the lavatories. Some pregnant girls reported not being allowed out to use the bathroom as frequently as they needed to.

The County reports having increased allotments of clothing and towels and having tried new stain eliminating products, as well as having instituted laundry inventory, inspection and sorting procedures. We plan to assess the implementation and adequacy of these reported reforms.

III. REMEDIAL MEASURES

In order to rectify the deficiencies we identified and to protect the constitutional and statutory rights of the facilities' juvenile residents, the County should implement, at a minimum, the following measures:

A. MENTAL HEALTH CARE

1) Provide sufficient mental health, probation and medical professional staff to meet the serious mental health needs of the juvenile halls population. Ensure that professionals' time is used efficiently and that there are adequate means of communication to provide for appropriate response to crises.

2) Develop and implement policies, procedures and practices for initial mental health screening to allow the identification of previously diagnosed and potentially existing mental or substance abuse disorders, including potential suicidality.

3) Develop and implement policies, procedures and practices for specialized mental health assessments to timely and

accurately diagnose mental illness, substance abuse disorders and mental retardation, including potential suicidality.

4) Develop and implement policies, procedures and practices for interdisciplinary treatment planning for youth with serious mental health needs, which would allow for the ongoing identification, goal setting and monitoring of youths' target symptoms in a detailed and organized fashion.

5) Develop and implement policies, procedures and practices for case management which would allow for the implementation of the treatment plan and ensure that treatment planning follows each youth from facility to facility and into the community.

6) Develop and implement policies, procedures and practices to ensure the availability of sufficient and adequate counseling services that meet the goal of ameliorating target symptoms of identified mental illness.

7) Institute an adequate information management system to allow adequate tracking of laboratory results and response to medication including side effects, adequate documentation of mental health services and compilation of complete records. This should include documentation of the goals of mental health counseling and progress toward those goals.

8) Develop and implement special individualized behavior modification programs for individual youth where needed.

9) Develop and implement policies, procedures and practices to ensure that mental health counseling services address substance use disorders appropriately.

10) Develop and implement policies, procedures and practices to ensure that psychotropic medications are prescribed, distributed and monitored properly and safely. Provide in-service training to nursing staff regarding the side effects of psychotropic medication and require nursing staff to document the side effects that youth are experiencing.

11) Revise policies, procedures and practices to limit uses of restraints for mental health crises to circumstances necessary to protect the youth and other individuals, for only as long as is necessary, and to accomplish restraint in a safe manner.

12) Provide annual suicide prevention training to all staff, which includes practical matters such as how to access and use a cut down tool for youth who attempt to hang themselves.

13) Develop and implement policies, procedures and practices to ensure that arresting officers, probation, medical and mental health staff share appropriate information regarding potentially suicidal or self-harming youth.

14) Ensure that mental health staff provide timely assessment and daily reassessment of youth deemed at risk for suicidal behaviors, as well as appropriate follow-up assessment once youth are discharged from suicide precautions.

15) Develop and implement policies, procedures and practices to ensure that mental health staff are sufficiently involved with probation staff in the management of youth exhibiting suicidal behaviors, including creation of individual behavior modification programs and decisions about appropriate clothing, bedding and housing.

16) Develop a continuum of services and responses to meet the needs of self-harming youth, including revised supervision practices to minimize incidents of self-harm, and increased access to hospital services, specialized residential facilities and intensive community services.

17) Notify appropriate outside officials and family members following a suicide attempt.

18) Develop and implement policies, procedures and practices that allow youth to access mental health services without interference from custody staff, except as dictated by institutional safety needs and due process rights of youth.

19) Train custody staff in appropriate interactions with and needs of mentally ill youth.

20) Develop and implement policies, procedures and practices to ensure that youth with disabilities at the halls are not housed in more restrictive settings than safety and security require.

B. JUVENILE CONFINEMENT PRACTICES

21) Provide sufficient staff supervision to keep residents safe from harm and allow rehabilitative activities to occur successfully.

22) Provide sufficient sleeping spaces in individual units for the number of youth assigned to each unit.

23) Develop and implement policies, procedures and practices to restrict use of OC spray to appropriate circumstances, enable supervisors to maintain tighter controls over spray use and storage, restrict the carrying of OC spray to only those individuals who need to carry and use it, prevent wherever possible the use of OC spray on populations for whom its use is contraindicated or contrary to doctors' instructions, and ensure that decontamination occurs properly.

24) Improve training to all staff in de-escalation techniques, crisis counseling, youth development, supervision, building positive relationships with youth, using appropriate language when communicating with youth, and specific writing skills aimed at improving the clarity and specificity of incident reports written after uses of force.

25) Develop and implement a system for timely, thorough and independent investigation of alleged child abuse.

26) Develop and implement a system for review of uses of force and alleged child abuse by senior management so that they may use the information gathered to improve training and supervision of staff, guide staff discipline and/or make policy or programmatic changes as needed.

27) Ensure adequate rehabilitative programming, access to reading materials, especially during non-programmed time, a reasonable behavioral management system, and gender-specific programming, where appropriate.

28) Ensure that youth have the opportunity to attend religious programming in the faith of their choice if they so desire.

29) Ensure that group punishment is not used unless there are exigent security concerns.

30) Develop and implement a strategy for reducing youth on youth violence that includes training staff in appropriate behavior management and violence reduction techniques.

31) Minimize the movement of youth from facility to facility and unit to unit.

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

33) Assess the needs of the facilities' LEP residents and develop and implement a method for providing meaningful access to programs and services for that population, as well as provide for their health and safety.

34) Develop and implement policies, procedures and practices to ensure reasonable telephone access.

35) Develop an effective grievance system to which youth have access when they have a complaint, ensure that grievances may be filed confidentially and ensure that they receive appropriate follow-up, including informing the author of the grievance about its outcome and tracking implementation of resolutions.

C. MEDICAL CARE

36) Develop and implement a system to monitor the medical needs of medically fragile youth to ensure that these youth receive timely and adequate medical care.

37) Ensure that medically fragile youth are transported to community medical appointments in a timely fashion and that they are seen by a physician on a scheduled basis.

38) Develop and implement an effective system for transferring medical records from one facility to another so that youth receive timely and consistent medical services.

39) Develop and implement policy, procedures and appropriate training of medical and correctional staff to ensure privacy and confidentiality in all medical encounters, except as dictated by institutional safety needs and due process rights of youth.

40) Develop and implement policy, procedures and practices to ensure that probation staff do not deter youth from requesting medical care.

D. EDUCATION

41) Develop and implement a systematic, comprehensive process to locate, screen, identify and provide appropriate services to all youth through age 21 with disabilities who require special education services.

42) Staff schools to support adequate education and special education services, including guidance counselors.

43) Provide adequate counseling and other related services to special education students with those needs.

44) Utilize alternative methods to facilitate parent participation in IEP meetings.

45) Provide adequate transition planning and services for all eligible youth with disabilities.

46) Eliminate the use of overflow classes and the associated exclusions of youth from educational programs.

47) Provide sufficient and appropriate instructional materials, space and equipment for all classes.

48) Implement a positive behavior management and support system for the education programs.

49) Implement a professional development program for teachers, emphasizing research-based instructional strategies that are effective for detained youth with disabilities in the general education classroom.

50) Consider education needs in determining whether to transfer youth among the halls. Consider whether youth are in the middle of special education assessment or preparation for high school equivalency examination.

51) Develop and implement means for including limited English proficient youth meaningfully in educational programming, including acquiring adequate educational materials.

E. SAFETY AND SANITATION

52) Complete necessary repairs to kitchen appliances, plumbing, ventilation, fixtures, temperature controls and lighting.

53) Complete cleanup of food service and medical areas.

54) Institute a maintenance system that ensures prompt response to needed repair work and incorporates preventive maintenance.

55) Ensure that staff and contractors do not leave debris or tools that may be used as weapons or escape devices.

56) Ensure adequate smoke and fire alarm coverage, which communicates with appropriate entities.

57) Eliminate electrical hazards.

58) Institute a plan for food preparation, storage and service that eliminates risk of food borne illness.

59) Provide medical and therapeutic diets as required.

60) Develop and implement policies, procedures and practices to provide youth with adequate hygiene opportunities, and needed personal hygiene products, linens, bedding and clothing that are sanitary and in good repair.

61) Provide adequate ventilation and appropriate temperature in all areas where youth are present.

62) Provide adequate lighting to perform needed tasks.

63) Minimize fire-loading in all areas, especially the school buildings.

64) Establish a comprehensive Infection Control and Surveillance Program in the medical facilities.

65) Inventory all equipment that should be powered by emergency generators and ensure that the generators function and power necessary equipment.

E. QUALITY ASSURANCE

66) Institute quality assurance and improvement systems that cover all areas outlined above.

* * *

In light of the County's cooperation in this matter, under

separate cover we will send you our experts' reports. Although the experts' reports and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analyses and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

Pursuant to CRIPA, the Attorney General may institute a lawsuit to correct deficiencies of the kind identified in this letter forty-nine days after appropriate officials have been notified of them. 42 U.S.C. Section 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you, and we have every confidence that we will be able to do so.

Sincerely,

/s/ Ralph F. Boyd, Jr.

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Assistant Attorney General

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