

UNMET PROMISES

Continued Violence & Neglect in California's
Division of Juvenile Justice

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Center on Juvenile
and Criminal Justice

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“Reformers come and reformers go. State institutions carry on. Nothing in their history suggests they can sustain reform, no matter what money, what staff, and programs are pumped into them. The same crises that have plagued them for 150 years intrude today. Though the cast may change, the players go on producing failure.”

—Jerome G. Miller, founder of the Center on Juvenile and Criminal Justice

(Miller, 1991)

DJJ at a Glance

What is DJJ?

The Division of Juvenile Justice (DJJ) is California’s state youth correctional system. Throughout its history, DJJ, and the state systems that came before it, have grappled with periods of scandal stemming from the discovery of widespread abuse and neglect. DJJ is premised on a congregate approach to youth corrections, which places large numbers of youth from communities across the state in common facilities.

Who is confined at DJJ?

DJJ confines approximately 650 youth and young adults from across California, a 93 percent reduction from its peak in 1996 when it housed more than 10,000 young people. The average youth at DJJ is 19 years old and most of its population falls between the ages of 17 and 19 years old. Youth committed to DJJ must be placed there for a serious or violent offense.

Why study DJJ now?

In early 2016, DJJ was released from a years-long conditions lawsuit that brought heightened attention to the facilities. Now, after three years without court oversight, DJJ is overdue for a comprehensive review that examines the core elements of its mandate: youth rehabilitation and well-being.

How many facilities does DJJ operate?

FACILITY	N.A. Chaderjian Youth Correctional Facility (Chad)	O.H. Close Youth Correctional Facility (O.H. Close)	Ventura Youth Correctional Facility (Ventura)	Pine Grove Youth Conservation Camp (Pine Grove)
LOCATION	Stockton, San Joaquin County	Stockton, San Joaquin County	Camarillo, Ventura County	Pine Grove, Amador County
POPULATION (JUNE 2018)	200	174	185	68
CAPACITY	600	379	600	80
LIVING UNITS	<ul style="list-style-type: none"> • Core • Intake • MHRU • IBTP • SBTP • BTP 	<ul style="list-style-type: none"> • Core • SBTP • BTP 	<ul style="list-style-type: none"> • Core • Female • MHRU • BTP 	Common living area

Guide to Frequently Used Terms

BTP: Behavior Treatment Program; lockdown unit that places youth who exhibit violent or aggressive behavior in a highly-restrictive setting.

Core Unit(s): Refers to general population living units; male core units are divided into three types (low-core, moderate-core, and high-core units) based on characterizations of youths' behavior and risk.

Congregate: Refers to an institution, such as a prison, that is designed for the efficient management of large numbers of people through strict regimentation and harsh enforcement of rules.

IBTM: Integrated Behavior Treatment Model; a framework for service delivery, adopted during the Farrell lawsuit, that requires custody staff and mental health staff to collaborate to provide comprehensive treatment for youth.

IBTP: Intensive Behavior Treatment Program; a living unit intended for youth with the highest level of mental health needs that impair the youth's ability to function or receive services in a core unit, SBTP, BTP, or MHRU setting.

MHRU: Mental Health Residential Unit; a living unit for youth with mental health needs that impact their ability to participate in a core unit, SBTP, or BTP unit.

Northern facilities: Refers to Chad and O.H. Close, which are adjacent to one another and formally known as Northern California Youth Correctional Center.

SBTP: Sexual Behavior Treatment Program; a living unit intended for youth who have been placed at DJJ for a sexual offense and/or have a history of sexual offenses.

YCC: Youth Correctional Counselor; an entry-level peace officer with a higher pay grade than a YCO tasked with maintaining discipline and leading youth resource groups.

YCO: Youth Correctional Officer; an entry-level peace officer tasked with maintaining security and supervising youth.

EXECUTIVE SUMMARY

California's state youth correctional system, the Division of Juvenile Justice (DJJ), is violent, isolated, and lacks accountability. Fights and riots are a part of daily life and create a culture of fear. DJJ's violent conditions are concealed by an absence of state oversight and the facilities' long distances from youths' families and communities.

For decades, DJJ, and the agencies that preceded it, cycled through numerous controversies. Despite frequent attempts at reform, the state system has continued to subject generations of California youth to inhumane conditions and lasting trauma. In early 2016, DJJ was released from a 12-year lawsuit that had resulted from the discovery of abuse and grievous conditions in the facilities. Despite assurances that the state was entering a new era of rehabilitative treatment, in the three years since court monitoring ended, DJJ has returned to its historical state of poor conditions, a punitive staff culture, and inescapable violence.

The state system has reached a crossroads. With more than 1,000 authorized staff and four aging facilities, all serving a youth population of just over 600, DJJ's cost per youth now exceeds \$300,000 per year (CDCR, 2018; DOF, 2018; DOF, 2018a). In total, California spends \$200 million each year to preserve an antiquated system that is operating at less than 40 percent of its capacity (CDCR, 2017; 2017a; 2017b; 2017c; 2018; DOF, 2018a). Californians must reckon with spending levels that are not supported by outcomes while considering DJJ's devastating effects on youth health and well-being. No amount of reform can reverse the failures of a correctional model predicated on prison-like facilities that are isolated from communities. Yet with a record-low youth population and claims by DJJ that they have corrected past harms, the public has turned its attention away from the troubled state institutions.

This report aims to examine life in DJJ, from staffing to safety to reentry. Too often, the story of youth confinement is told by those who operate institutions. We have highlighted the experiences of young people who know firsthand the challenges of navigating the system and are grappling with everyday life on the outside (See Methods section). Their insight forms the basis of our conclusions, namely that DJJ leaves youth traumatized, disconnected, and poorly prepared for life after release. Today, as it has for more than 100 years, the state system is failing youth, their families, and their communities, and is neglecting its most basic obligation: to rehabilitate young people and keep them safe.

Youth Voices

No one understands the experience of confinement at DJJ or its effects on families and communities better than those who have lived it. For that reason, we have placed youth voices at the heart of this report and we highlight, wherever possible, the insight and expertise of those with who have grappled with a disempowering youth justice system. Though they remain anonymous, we thank and acknowledge our youth partners who are working to uplift and protect those still behind the walls of these institutions.

Key Findings

- **Overcrowding living units exacerbates violence:** DJJ living units exceed national standards, substantially increasing the likelihood of violence in the institutions.
- **DJJ facilities are outdated and costly:** DJJ's three correctional facilities and one conservation camp were built according to an archaic congregate design that places large numbers of youth in a single institution. These institutions will saddle future state budgets with extensive maintenance and repair costs.
- **Hiring practices prioritize corrections experience:** In hiring its custody staff, including those who lead programming and treatment groups, DJJ emphasizes a corrections background over experience in youth development. Despite having more staff than youth, staffing ratios exceed recommended maximums during certain eight-hour shifts, placing youth and staff at risk.
- **Youth live in a climate of fear:** Violence and use-of-force rates have increased in nearly all of the DJJ facilities. A common response to violence is the isolation of youth or of entire living units. Staff exacerbate the climate of fear by reinforcing prevailing racial and ethnic conflicts, legitimizing institutional gangs, and abetting violence.
- **The reception unit is rife with violence:** When youth first arrive at DJJ, they are thrust into one of the most dangerous living areas in the facilities—the reception unit—where they are housed for more than a month. During intake, youth are subjected to a battery of assessments to identify treatment needs that staff are typically not equipped to address.
- **Youths' health suffers due to trauma and violence:** DJJ has seen a recent spike in attempted suicides and high rates of youth injuries. The facilities concentrate mental health resources in small, special-population living units, leaving few services for the remainder of youth in the general population.
- **Programs are rendered less effective by DJJ's violence and prison-like setting:** DJJ's rehabilitative programs are detached from the realities of life outside of the institution and are led by custody staff with correctional backgrounds. Youths' daily schedules include substantial time in locked cells, including during waking hours.
- **Remote facilities keep families apart:** It is not possible for youth to maintain close bonds with family and community members during their confinement at DJJ due to restrictions on phone calls and visitation as well as the remote location of the facilities, which are practically unreachable by public transportation.
- **Facility schools are failing to provide a basic education:** DJJ's schools do not offer a rigorous, high-quality education, evidenced by their low proficiency scores on standardized tests. After graduating from high school or earning a GED, youth have even fewer meaningful educational opportunities in the DJJ facilities.
- **DJJ fails to prepare youth for their release:** Youth released from DJJ struggle to adjust to life outside of a secure institution and find it difficult to navigate the transition from state custody to county supervision. The result is high rates of recidivism and low levels of employment or education after release.
- **The state system is not being held accountable:** In 2016, California saw an abrupt end to independent state monitoring of DJJ, which has allowed the facilities to operate for three years with limited scrutiny.

HISTORY

Since the establishment of the San Francisco Industrial School in 1859, California's experience with youth correctional institutions has been characterized by repeated cycles of neglect, violence, and abuse. Although California established a juvenile court in 1903 and introduced greater legal protections for minors in the 1960s, California's youth correctional system has remained relatively unchanged for over a century and a half (Macallair, 2015; Shelden, 2012). Many of the key issues raised in this report have been persistent themes in evaluations of California's youth correctional system throughout its history. For example, in the 1980s, the Commonwealth Research Institute published a series of in-depth reports that found a widespread culture of fear in the institutions and poor conditions that undermined the effectiveness of programming (DeMuro et al., 1988; Lerner, 1982; 1986).

Since the Gold Rush, California has relied on large, congregate institutions to house youth in need of care. Yet these facilities are inherently violent and highly vulnerable to scandal. From the severe floggings and isolation practiced on youth at the San Francisco Industrial School, to the "underfed, poorly clothed, and overworked" youth discovered in facilities during the California Reform School era, to widespread abuse reported at the California Youth Authority, California has seen that, time and again, scandal launches a predictable cycle: public outcry followed by failed attempts at reform (DeMuro et al., 1988; Gladstone, 1999; Lerner, 1982; 1986; Macallair, 2015; Sullivan, 1988).

In the early 2000s, a rash of youth suicides and reports of horrific staff abuse, including staged fights and sexual abuse of female youth, prompted legal action by the Prison Law Office, termed the Farrell lawsuit (CJCJ, 2013). In response, the court initiated a consent decree, requiring the state to develop remedial plans in several key areas, including mental health, medical care, and education (Farrell v. Allen, 2004). In February 2016, after more than a decade of court oversight, the Farrell lawsuit ended, halting the routine inspections and reporting that had allowed the plaintiff, court, and public to monitor and assess the state's reform efforts. While DJJ leaders heralded the end of the lawsuit as a sign of progress and an endorsement of the new rehabilitative ethos, CJCJ investigations have identified continued deficiencies with indications that the system has drifted back to its old and dangerous patterns (CDCR, 2016; CJCJ, 2016).

California's history has shown that a state-run correctional system for youth premised on a congregate model placing large numbers of youth in prison-like facilities is, by nature, impervious to reform. Rather, best practices indicate that youth served in smaller settings closer to their families and communities experience better outcomes (CCLP, 2018; CSG, 2015). Yet California continues to commit nearly 300 additional youth each year to its antiquated state facilities with little accountability (CDCR, 2018a).

YOUTH POPULATION

Key Takeaways

- DJJ's population has declined by 93 percent since 1996, yet the population of many of DJJ's living units exceeds nationally-recognized maximums designed to keep youth and staff safe.
- African American youth are confined at 1.5 times the rate of white youth after accounting for differences in violent felony arrests. Latino youth are confined at 1.7 times the rate of white youth.
- Youth face vastly different odds of being placed at DJJ, depending on their geography. Approximately half of the DJJ population is committed by just five of California's 58 counties.

DJJ's population is primarily composed of 17- to 19-year-olds, youth of color, and youth from a small number of counties with an outsized reliance on the state system. Most are committed through a juvenile court for an assault or robbery offense.

Research shows that youth in the juvenile justice system, and particularly those placed in a locked facility, are more likely to have been exposed to adverse childhood experiences (ACEs) at a young age. A 2013 study found that nearly 90 percent of youth involved in the justice system nationwide have had prior traumatic experiences and 24 percent of youth meet the criteria for post-traumatic stress disorder (PTSD) (Abram et al., 2004; Carrion & Steiner, 2000; Dierkhising et al., 2013; Falk et al., 2014; Pasko, 2006). For these youth, the experience of being confined in a prison-like setting can deepen trauma and derail their healing (Burrell, 2013).

A. Increased spending amid a shrinking system

DJJ's population has fallen dramatically in recent years from more than 10,000 youth at its peak in 1996 to approximately 650 in September 2018—a decline of approximately 93 percent (Figure 1)(CDCR, 1996; 2018). This population reduction is largely attributable to steep declines in California's youth arrests as well as changes in the law that have limited the number of youth who are eligible for commitment to the institutions. From 1996 to 2017, juvenile felony arrests fell by 77 percent statewide, a decline that included steep reductions in violent offense arrests (DOJ, 2018). Due to promising trends in arrests of young children under 12 years old, future violent offense arrests of youth and young adults are predicted to continue declining through at least 2020 (CJCJ, 2016a). In the midst of declining youth involvement in the justice system, California enacted reforms to restrict DJJ commitments. One such reform was Senate Bill 81 (2007), termed juvenile realignment, which prohibited counties from committing youth to DJJ for any offense not included in a defined list of serious or violent crimes

“

“I didn’t have a voice in there so, being out, I often still feel like that. That place made me feel like I didn’t have a voice so when I got out, people would have to tell me, ‘You can speak up and you can say something. You can complain about it.’ I was so used to me complaining and nothing happening. I was so used to speaking to say something and it just going unnoticed or brushed off at [DJJ].”

(Youth Interview, 2018)

(SB 81, 2007; WIC § 707(b)).¹ As a result, counties, rather than the state, assumed increasing responsibility for justice-involved youth and, by 2017, DJJ oversaw less than 1 percent of all youth declared wards of the juvenile court in California (CDCR, 2018b; DOJ, 2018a). This reform was essential to curbing dangerous overcrowding in the DJJ facilities.

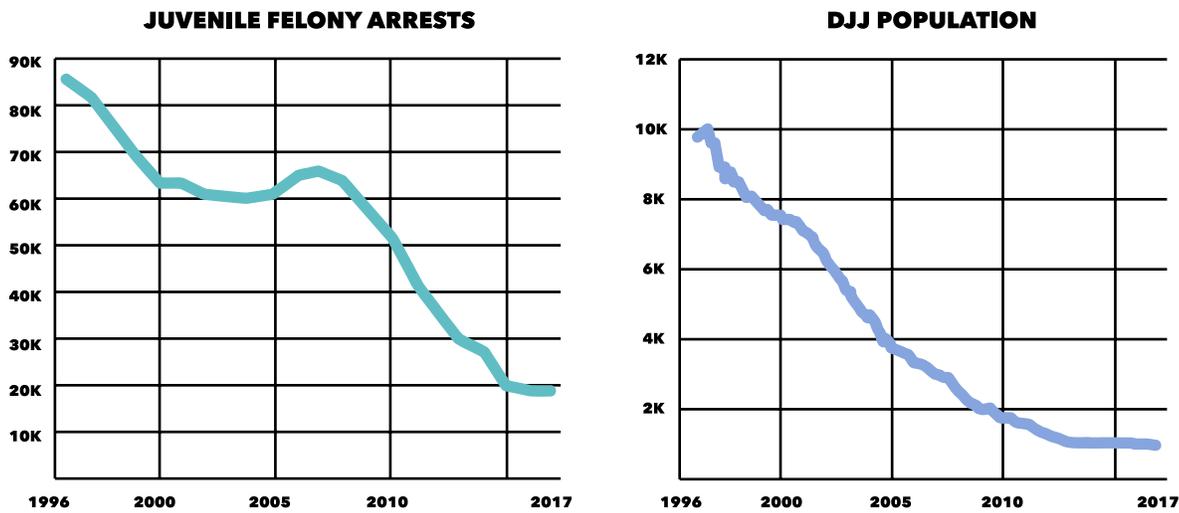


Figure 1. Trends in California's juvenile felony arrests and DJJ population, 1996-2017

Sources: CDCR, 1996-2004; 2005-2011; 2012-2017; DOJ, 2018.

Despite these steep population declines, California has not seen an equivalent reduction in spending on its DJJ facilities. The DJJ budget increased by 13 percent between Fiscal Year 2012-13 and Fiscal Year 2017-18, growing by more than \$20 million. A rising budget in the face of declining populations has produced sharp increases in the cost per youth housed at DJJ. In Fiscal Year 2012-13, the state spent an average of \$208,000 per year for each youth in the facilities, but by Fiscal Year 2017-18, that cost had increased to \$315,000 per youth (DOF, 2014; 2018a). By contrast, counties compensate the state for less than 10 percent of this cost, paying a flat fee of just \$24,000 per year for each youth committed to DJJ through a juvenile court (WIC § 912).

B. Transitional age population

By law, DJJ may confine youth ages 11-25 (WIC § 733; AB 1812, 2018). However, most youth in the DJJ population fall between the ages of 17 and 19 years old. As of December 31, 2017, the average age of youth in the facilities was 19 years old, with just 8 percent of its population under the age of 17 (Figure 2)(CDCR, 2018b). In 2018, Assembly Bill 1812 revised the maximum age of confinement at DJJ from age 23, making it possible for youth with more serious offenses to remain at the facilities until age 25 (AB 1812, 2018). The bill also ensures that youth who were prosecuted in adult court may be placed at DJJ if they can complete their sentences by age 25. This reform is likely to increase the population at DJJ as well as the average age of youth in the facilities.

Although DJJ is primarily composed of young adults, some DJJ facilities report wide age gaps that place younger children and youth in direct contact with an emerging adult population. Wide age ranges in youth facilities can

¹ The California Legislature passed another important reform in 1996. SB 681 established a sliding scale fee, providing an incentive for counties to retain youth with less serious offenses in local facilities (SB 681, 1996).

pose serious safety challenges, as older youth tend to be more sophisticated than younger populations and may negatively influence or victimize them (Stevenson, 2014). In June 2018, male youth in the Ventura facility ranged in age from 16 to “24 years or more” and Chad youth ranged from 15 to 22 years old. O.H. Close, which has an open dormitory layout, reported the broadest age span, a ten-year gap, with youth as young as 14 and as old as “24 years or more” in the same facility (CDCR, 2018c).

Beginning in the summer of 2018, DJJ undertook a major reorganization of its northern facilities, with O.H. Close—a facility that has traditionally held DJJ’s youngest youth—transitioning to an older population (Tour, 2018). Staff in the northern facilities (Chad and O.H. Close) have expressed concerns about the impact of this population shift on youth in their facilities: at O.H. Close, an older population is seen as potentially increasing violence in already dangerous open dormitory settings, while at Chad, staff are concerned that placing younger and more vulnerable populations into single cells could be isolating and psychologically distressing (Staff Interview, 2018).

“

“A person goes into an institution at that age, those kids have been through so much in their life, and they don’t have no support system.”

(Youth Interview, 2018)

C. Disparate confinement of youth of color

African American and Latino youth make up 87 percent of DJJ’s population and are committed to the facilities at far higher rates than white youth (CDCR, 2018b). In 2017, the African American youth population at DJJ constituted 8.6 percent of all violent offense arrests of African American youth, while the Latino population made up 9.8 percent of all violent offense arrests of Latino youth. These rates are 1.5 and 1.7 times higher, respectively, than the rate of confinement for white youth for whom DJJ placements constitute 5.8 percent of violent offense arrests (Figure 3)(CDCR, 2018b; DOJ, 2018). As a result, the harms of DJJ confinement are borne, disparately, by youth of color.

D. Geographic disparities

Counties vary considerably in their reliance on DJJ and, as a result, the institutional population is heavily skewed toward a small number of counties, particularly those that have failed to invest in local alternatives. For example, in December 2017, Contra Costa, Fresno, Los Angeles, Riverside, and Sacramento counties constituted 41 percent of the state’s 10- to 17-year-old population and 37 percent of its 2017 juvenile felony arrests, but nearly 50 percent of the population of the DJJ facilities (Figure 4)(CDCR, 2018b; DOF, 2018b; DOJ, 2018). By contrast, 19 California counties with a cumulative youth population of more than 100,000 and just under 400 juvenile felony arrests had no youth at DJJ, and 16 counties, including Butte, Orange, and San Mateo, with a population of more than 600,000 youth and approximately 2,400 felony arrests each held five or fewer youth in the facilities (CDCR, 2018b; DOF, 2018b; DOJ, 2018).

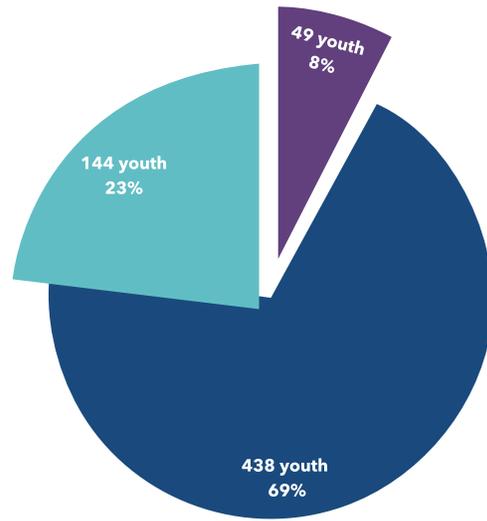
E. Youth offenses vary

Youth may be committed to the DJJ facilities if they are adjudicated delinquent for a specified sexual offense or for one of the serious or violent offenses defined under Welfare and Institutions Code section 707(b) (WIC § 733).

OFFENSE	# OF YOUTH	% OF YOUTH
Assault	247	39%
Robbery	223	35%
Homicide	55	9%
Other Sexual Offenses	55	9%
Rape	17	3%
Burglary	16	3%
Kidnap/Extortion	13	2%
Arson	2	0%
Other Offenses	2	0%
Theft (except auto)	1	0%
Auto Theft	0	0%
Narcotic & Drug Laws	0	0%

Table 1. DJJ population by offense, December 2017

Source: CDCR, 2018b.



11 - 16 years old 17 - 19 years old 20 - 25 years old

Figure 2. DJJ population by age group, December 2017

Source: CDCR, 2018b.

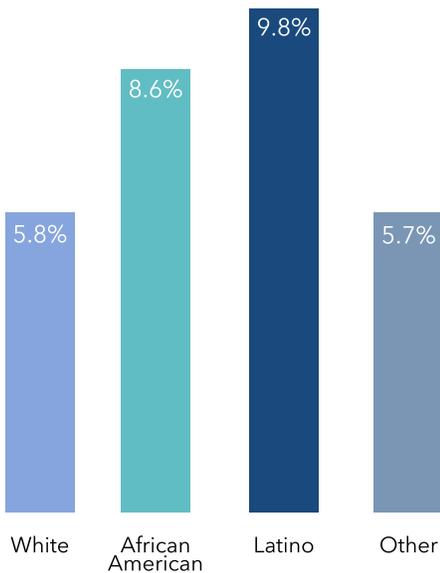


Figure 3. DJJ population as a percentage of violent offense arrests by race, 2017

Source: CDCR, 2018b; DOJ, 2018.

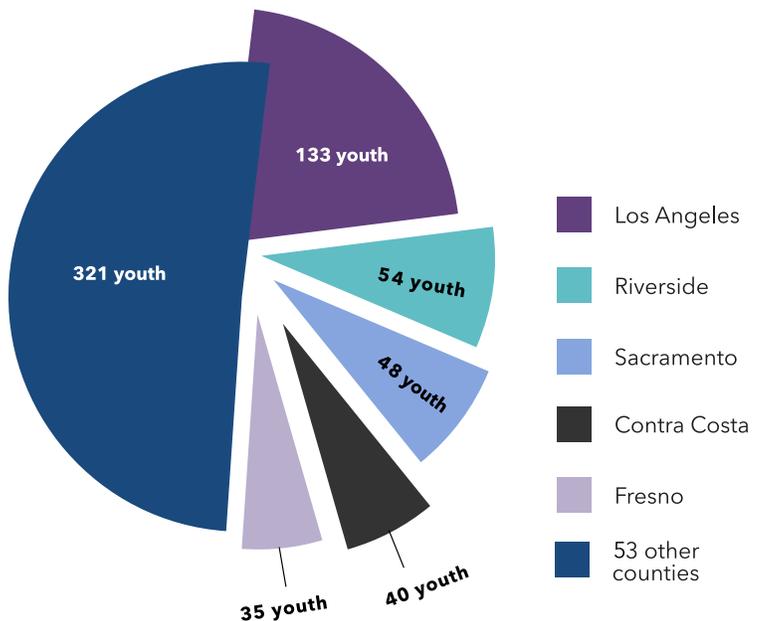


Figure 4. DJJ population by county of origin, December 2017

Source: CDCR, 2018b.

Approximately three-quarters of youth in the facilities on December 31, 2017 were committed for either assault or robbery. Table 1 shows the most common offenses among youth committed to DJJ in December 2017 (CDCR, 2018b).

F. Large facilities and overcrowded living units

DJJ’s population of approximately 650 is distributed across its three correctional facilities and one conservation camp. From January to June 2018, the correctional institutions held an average of 196 (Chad), 174 (O.H. Close), and 188 (Ventura) youth (CDCR, 2018d). Each of these facility populations exceed the standards set by the American Correctional Association (ACA), which recommend that juvenile facilities house no more than 150 total youth (ACA, 2003). This standard reflects research stating that smaller facilities with fewer youth see lower rates of violence and more effective delivery of services (McCarthy et al., 2016). When youth are placed in smaller, home-like facilities, they are better able to access needed services, can develop healthy relationships with peers and staff, and avoid the prison subculture that develops in larger facilities.

Likewise, the ACA recommends that living units in youth correctional facilities do not exceed 25 youth (OJJDP, 1998). Despite record lows in DJJ’s population, the facilities consistently exceed recommended maximum populations in many of their living units, as detailed in Table 2.

BEST PRACTICES	DJJ’S POPULATION
Secure facilities for youth should have a population of no more than 150 (ACA, 2003).	From January to June 2018, DJJ’s correctional facilities had an average population of 196 (Chad), 174 (O.H. Close), and 188 (Ventura) (CDCR, 2018d).
Core living units should house no more than 25 youth (OJJDP, 1998).	In the first six months of 2018, core living units held an average of 27 youth, with monthly populations in core units as high as 38 youth (CDCR, 2018e).

Table 2. A comparison of DJJ’s youth population to best practices

Source: CDCR, 2018b.

These facility standards are grounded in research showing that larger living units increase rates of violence, in part, because they contain a sprawling web of interpersonal relationships (Sedlak et al., 2013). Adding just one youth to a living unit greatly increases the number of relationships within the unit, creating new opportunities for discord and violence. Take, for example, a living unit with the recommended maximum of 25 youth. Although the unit’s population is fairly small, it is composed of 300 unique interpersonal relationships.² Even one negative relationship among 300 could result in violence and jeopardize the safety of all 25 youth. DJJ’s core living units, which have seen recent populations as high as 38, are placing some youth in settings with over 700 interpersonal relationships.

In an analysis of gangs and violence at DJJ, Dr. Cheryl Maxson noted that routine interpersonal conflicts born of close living quarters and boredom often triggered violence at DJJ: “A high proportion of these incidents are about things other than gangs or race. Most often, these ‘other’ incidents are sparked by disrespect or relatively minor issues” (Maxson et al., 2012). Placing youth in smaller facilities and units would alleviate this dangerous phenomenon.

² Youth relationships in a living unit are found by determining the number of combinations of two youth: $\text{Interpersonal relationships} = \frac{\text{living unit size factorial}}{\text{number in a pair factorial}} \times (\text{living unit size} - \text{number in a pair})$ factorial = $\frac{25!}{2! \times 23!}$

FACILITY OPERATIONS

Key Takeaways

- Youth at DJJ are subject to prison-like conditions, which include: high metal fences, razor wire, elevated surveillance stations, and living units lined with cells and metal furniture bolted to concrete floors.
- Deteriorating, poorly-maintained facilities pose health hazards to youth, such as rusted bathroom fixtures and severe water damage; repairs for the deteriorating facilities would come at a high cost.
- DJJ continues to operate open dormitories despite decades-long knowledge that youth are made vulnerable by living and sleeping in a shared area with peers of varying ages and maturity levels.
- DJJ lacks adequate camera and video monitoring throughout its facilities, putting youth at risk of unaddressed violence and abuse.

DJJ's three secure correctional facilities and one secure conservation camp are in isolated areas far from the populous urban centers where most DJJ youth are from. The locations of these facilities reflect an unfounded, 19th century belief that youth must be removed from their homes and placed far from their families in pursuit of "rural purity" with the idea that city life is a cause for delinquent behavior (Mennel, 1973; Shelden, 2012). In reality, such locations make it extremely difficult for youth to stay connected to the support of their families and communities and further complicate the youth's eventual return home.

A. Aging facilities in remote areas

The facilities operated by DJJ today originally opened their doors decades ago. They are rooted in congregate institutional design, which is premised on incarcerating large populations at a low cost and prioritizing control over providing treatment (CCLP, 2018). In 2006, DJJ's Safety and Welfare Remedial Plan, an early product of the Farrell lawsuit, stated that "none of DJJ's existing facilities meet the long-term programmatic needs set forth in the plan," yet no major changes have been made to DJJ facilities since then (CDCR, 2006). Through time, these aging structures continue to deteriorate and have not evolved to meet modern facility standards.

Ventura was established in 1913 as the "Ventura School for Girls" and moved to its current location in 1962³ (CDCR, 2018f). It serves as a reception center-clinic and correctional facility, and is the only DJJ facility located in Southern California (CDCR, 2018g). It is situated in Ventura County approximately 60 miles outside of Los Angeles, its nearest urban center. Ventura is also DJJ's only co-educational facility, with a separate living unit

³ A timeline of California's state youth correctional facilities can be found on page 172 of *After the Doors were Locked* (Macallair, 2015).



Entrance to shared site of DJJ's secluded O.H. Close and Chad facilities.

and school on its campus specifically for female youth. Both male and female youth are housed at the facility in individual cells, with male living units divided into three types (low-core, moderate-core, and high-core units) based on characterizations of youths' behavior and risk (Tour, 2018).

Chad and O.H. Close occupy a joint campus near Stockton in San Joaquin County. For reference, these two facilities are over 50 miles from Sacramento and 80 miles from San Francisco and San Jose, three of the largest nearby cities. Chad is an all-male secure facility established in 1991. Youth in the facility are housed in large living units with dozens of individual cells, many of which are currently unoccupied (CDCR, 2018h). When male youth are initially placed under DJJ's jurisdiction, they proceed to Chad to complete the intake process prior to permanent placement at one of the facilities. At O.H. Close, established in 1966, youth are housed in open dormitories where bunk beds and single beds occupy a shared space in the living unit (CDCR, 2018i).

Pine Grove, established in 1943, is situated in rural Amador County bordering the El Dorado National Forest. DJJ youth who are considered low risk may participate in programming at the conservation camp where they work in firefighting operations (CDCR, 2018j). Youth are housed in an open dormitory setting, but spend much of their time away from the Pine Grove facility performing group tasks for fire suppression and flood control (CDCR, 2018j). The skills that youth develop at Pine Grove, however, often fail to translate into future opportunities as they face barriers to employment in the field after returning home (Youth Interview, 2018).

“

“Violence is structurally endemic to large congregate correctional institutions.”

(Macallair, 2015)

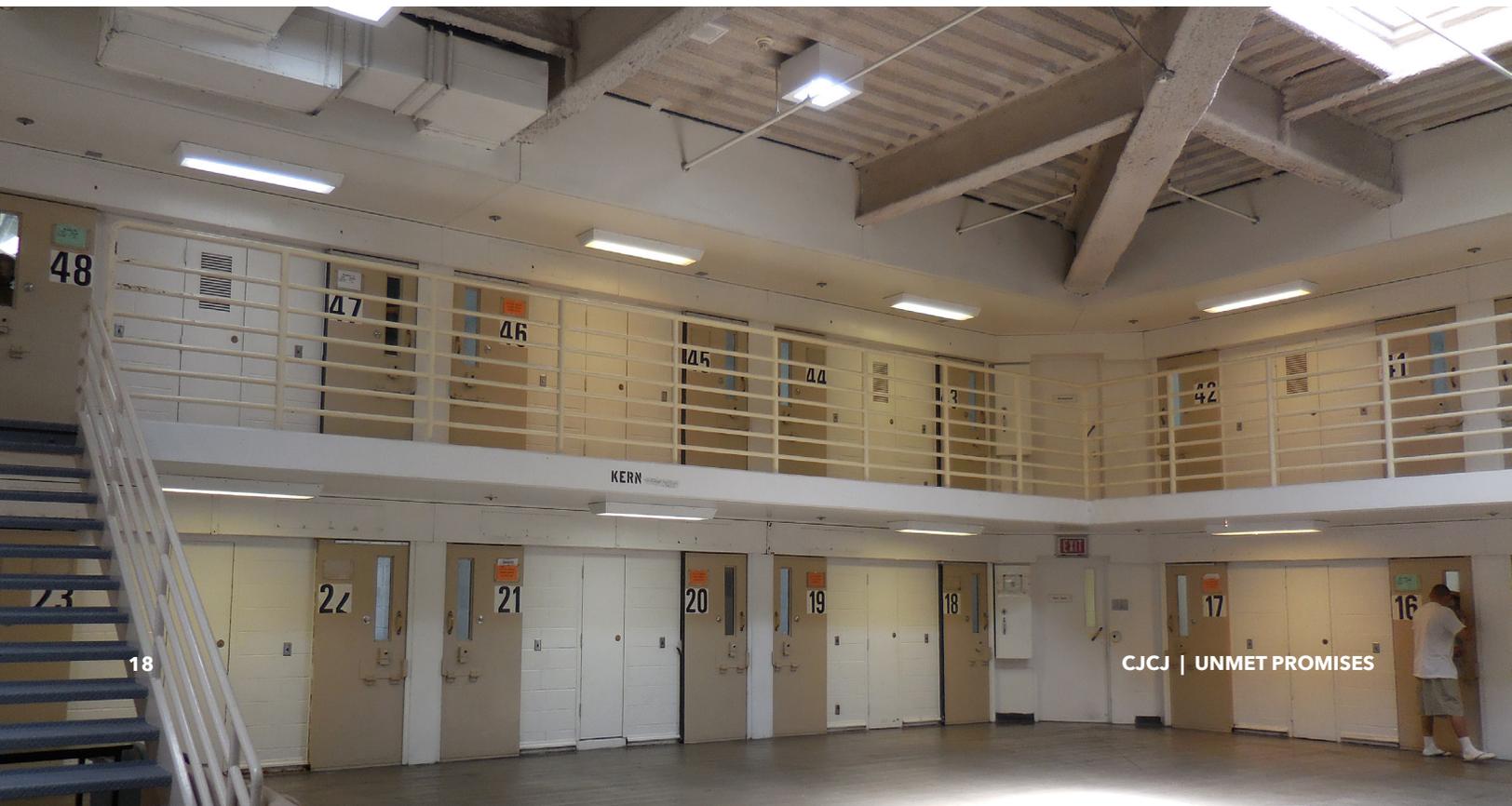
B. Prison-like conditions

Facility design plays a crucial role in safety, operations, and programming. Housing youth in a prison-like facility can foster violence, exacerbate existing trauma, and prevent treatment of a youth's underlying needs. DJJ's large correctional institutions are reminiscent of life in prison, which stands in stark contrast to juvenile justice standards requiring facilities to provide living spaces that "reflect a home-like, non-penal environment" (AECF, 2014, p.159). For decades, DJJ has been criticized for its cold, penal design, which serves as a constant reminder to youth that they are being punished and effectively overrides rehabilitative programming (Lerner, 1982). While a few areas of the facilities have positive qualities including murals, photos, couches, and rugs, the primary and overall structure of the facilities largely follows an adult prison model.

The high security nature of DJJ facilities is evidenced by the elevated surveillance station in all living units where metal chairs and tables are bolted to concrete floors, and rows of cells line the walls. Each cell contains a metal latrine and a thin pad on a steel frame meant to serve as a mattress. In the open dormitories at O.H. Close, a secure surveillance station overlooks rows of metal bunk beds. When youth are outdoors for mandatory large muscle exercise, they are surrounded by high metal fences and razor wire. Near the Behavior Treatment Program (BTP) units, there are isolation cages bolted into the concrete ground with chain link fences on all sides (Tour, 2018). Wherever youth go in the facilities, they are met by elements of a penal environment that undermine attempts to provide treatment or care.

By placing youth in prison-like conditions at large institutions, DJJ exposes them to the trauma of incarceration, risking their immediate safety and limiting the possibility of rehabilitation (Burrell, 2013). The "removal of a child from the home, even for a brief period, is itself a traumatic event," which is furthered by the frequent abuse, fear, and isolation that youth face in DJJ correctional facilities (Burrell, 2013). In addition to the trauma a young person faces when entering a correctional facility, many youth involved in the justice system have already experienced trauma during their childhood. The trauma of confinement compounds over the months and years that youth spend in this restrictive institutional setting.

The BTP unit at Chad, where youth are housed in highly-restrictive conditions.





Toilets in an O.H. Close living unit, which lack privacy provisions (LEFT); A single-cell at O.H. Close with a metal latrine next to an open windowed door (RIGHT)

C. Youth lack safety and privacy in living spaces

The physical structure of DJJ’s open dormitory living units threaten the safety and well-being of youth. Open dormitories, which are communal sleeping spaces generally outfitted with rows of bunk beds, have long been criticized given that they “foster competition, deepen factions, and further gang problems” (Newell & Leap, 2013). In fact, open dormitories have such an undisputed record of harm that the Office of Juvenile Justice and Delinquency Prevention (OJJDP) advised that open dormitories be eliminated from juvenile correctional facilities altogether over two decades ago (OJJDP, 1994). Yet O.H. Close maintains living arrangements in a large open dormitory layout that leave youth susceptible to harm (CDCR, 2018i). When youth of various ages and maturity levels are placed in close proximity to one another, with no personal space or privacy during sleeping hours, younger or less sophisticated youth are left particularly vulnerable to violence and manipulation by others on the living unit (Macallair, 2015).

Youth in both single-cell and open dormitory living units should have privacy when using showers and toilets (AECF, 2014, p. 168). Many living units at DJJ facilities fail to meet these basic standards. Single-cell units at Chad are equipped with a window on the door for staff to monitor youth inside, and youth are not permitted to cover the window at any time (Tour, 2018). With the metal latrines in each cell situated near the door, youth using the bathroom are visible through the window. Youth describe feeling uncomfortable and wary of voyeurism by staff (Youth Interview, 2018). A lack of privacy also exists at O.H. Close, where living unit bathrooms have large glass windows that leave youth showering in the bathroom within full view of their peers and custody staff who monitor the unit from the central desk (Tour, 2018). Both the low metal privacy screen behind the shower area and the short metal dividers to the right and left of each toilet are inadequate in providing coverage for youth (Tour, 2018). In contrast, showers at Ventura are equipped with privacy curtains that have clear gaps at the head and feet to allow staff to monitor youth safety (Tour, 2018). The Superintendent of Ventura explained they had purchased curtains for the showers in each unit, a simple and inexpensive solution that allowed the



Segment of an open dormitory living unit at O.H. Close



Showers in a Ventura living unit, equipped with privacy curtains (LEFT); An open shower in an O.H. Close living unit, which fails to protect youths privacy (RIGHT)

facility to comply with facility standards. With such an accessible solution available to ensure safety and privacy for youth in DJJ’s care, it is unclear why these modifications have not been made in the northern facilities.

D. Poorly-maintained structures

DJJ’s poorly-maintained facilities show signs of serious neglect and structural deficiencies that are harmful to youths’ health and safety. Numerous areas of Chad and O.H. Close contain troubling health hazards, which include: rusted showers, hand dryers, and AC units, and numerous non-operational sinks and toilets (Tour, 2018). At Ventura, deteriorated roofing in its classrooms, chapels, and multiple living units caused significant water damage and required a proposed budget allocation of \$11.2 million for repairs in Fiscal Year 2018-19 (DOF, 2018c). Addressing the present levels of deterioration at DJJ facilities would require considerable investment by California’s taxpayers, adding to the already-hefty budget of the agency.

In addition to poor building maintenance, DJJ facilities remain -technologically outdated. Standards require that security measures such as cameras and video technology be used to monitor living units and other areas of the facility (AECF, 2014, p.149). A lack of monitoring puts youth at risk of abuse by staff or other youth, and severely limits investigations into violent incidents. Notably, Chad appears to only have cameras at the exterior entrances of each unit and at the main security gates; living units, kitchens, and dining rooms are not equipped with cameras (Tour, 2018). Similarly, an administrator at Ventura noted during our tour that there are virtually no cameras throughout the facility, and some of the few cameras present are not functional (Tour, 2018). Such serious neglect of building maintenance and monitoring technology results in an unsafe environment that is highly susceptible to health hazards and unaddressed violence.

STAFFING

Key Takeaways

- Candidates for custody staff positions, which are responsible for much of DJJ's programming, often come from backgrounds in corrections. Candidates can substitute required education with experience in correctional institutions, while areas such as social work and youth development are not emphasized.
- Despite historically low populations at DJJ facilities, staff-to-youth ratios on core units fail to comply with best practices; core units averaged 1:20 staffing ratios during sleeping hours, which exceeds the 1:16 standard.
- DJJ facilities averaged 133 vacant staffing positions, a 15 percent vacancy rate, from June 2017 to June 2018.
- Administrators acknowledge staff reluctance to adopt the IBTM model, a core reform during Farrell, as DJJ has not achieved genuine collaboration among treatment and custody staff.

On average, approximately 770 employees worked at DJJ's four facilities, with an average vacancy rate of 15 percent, between June 2017 and June 2018 (CDCR, 2018k). Staffing at DJJ includes custody staff who are responsible for maintaining security, teachers, psychologists, clinicians, and administrators. The qualifications among staff, the training they receive, and the ways in which they engage with other staff, play a significant role in shaping the day-to-day lives of youth at DJJ facilities.

A. Emphasis on corrections experience

Youth Correctional Officers (YCOs) are entry-level peace officers tasked with supervising youth throughout the day. YCOs are the equivalent of correctional officers in the adult system and are primarily responsible for custody and security. Another entry-level custody staff position, Youth Correctional Counselors (YCCs), are peace officers tasked with leading youth resource groups in addition to maintaining discipline. However, these positions require no counseling experience nor education related to youth development (CDCR, 2018l). The YCC designation is unique to the youth corrections system and has a higher pay grade than the YCO.

YCO and YCC positions may be filled by candidates age 21 or older who complete a series of examinations (e.g., physical fitness, background investigation, psychological evaluation) prior to employment and a 16-week training program at the beginning of employment (CDCR, 2018l). Applicants meet the minimum qualification for a YCO position if they have a high school diploma, or have passed either the General Education Development (GED) or California High School Proficiency tests with a similar option available for YCC applicants (CDCR, 2018l). YCOs'

and YCCs' starting monthly salaries of approximately \$4,400-\$7,400 and \$4,900-\$8,100 after training, respectively, offering a competitive salary for entry-level workers with minimal education (CDCR, 2018l).

The YCC position has slightly greater requirements, with various qualifying combinations of education and experience.⁴ Notably, candidates can substitute graduation from a 4-year college or university with one year of experience as a peace officer in California overseeing adults or youth in a correctional facility (CDCR, 2018l). This is out of step with best practices, which place far greater importance on experience working with youth and the ability to relate to the young people in their care (AECF, 2014, p.147). No emphasis is placed on counseling, social work, or youth development in DJJ's requirements for custody staff. The pathways to employment as a YCO and YCC exemplify a historical emphasis on corrections experience rather than child development, rehabilitation, or counseling.⁵ This hiring practice is especially problematic given that YCCs lead most group programming for youth, which are intended to offer rehabilitation and support youths' healthy development (Tour, 2018).

DJJ administrators are responsible for setting the institutional culture and practices, which have powerful implications for youth. Qualifications for administrative positions vary by role, but many current members of the administrative leadership have risen through the ranks at DJJ. In fact, both the current superintendent at the Northern California Youth Correctional Center and the current superintendent at Ventura have served in several positions at DJJ, including as custody staff members, with their tenure beginning in the 1990s (CDCR, 2017d). Some have lengthy careers at DJJ dating back to the height of its abuses. Not only have many DJJ administrators climbed the ladder from custody positions, but it appears that staff may even be rewarded with promotions after involvement in institutional cover up (See Code of Silence Among Staff and Youths subsection for details). A non-custody staff member describes the relationship between administrators and current custody staff as a "green wall," with a shared corrections-based mentality, sense of camaraderie, and willingness to do whatever is needed to protect other custody staff, regardless of the needs of youth (Staff Interview, 2018).

BEST PRACTICE

"The facility hires staff to serve as positive role models for youth. Employees are qualified for their positions by education, experience, and ability to relate to young people, with minimum qualifications including 2 years of college, or a high school diploma or equivalent and 2 years' experience working with youth."

(AECF, 2014, p.147)

B. Training focuses on security over treatment

Following the hiring process, all DJJ staff members must undergo training, which includes monthly training, on-the-job training, and general training for education and mental health staff (CDCR, 2018m). Best practices emphasize that staff responsible for direct care and supervision of youth must have at least 40 hours of training before beginning any job responsibilities, followed by additional training hours during each year of employment, which does not include on-the-job training or 'shadowing' (AECF, 2014, p.150). Incoming YCCs and YCOs must complete a 16-week training program at the Basic Correctional Juvenile Academy (BCJA) near Stockton (CDCR, 2018l).

⁴ Candidates can qualify with a college degree or through a combined completion of two years of college with two years of experience working with youth (CDCR, 2018l).

⁵ DJJ's emphasis on corrections experience is not new in their hiring practices. In 2010, many new custody staff members "had traded their badges in city police and county sheriff departments for DJJ shields," after budget cuts to local agencies forced them to make mid-career changes (CDCR, 2010).

Best practices require all staff in secure juvenile facilities be provided training on an array of psychosocial topics for proper treatment of youth. The BCJA consists of courses on correctional and treatment skills, including: nearly 50 hours of training on use of force, crisis intervention and conflict resolution (32 hours), and an introduction to chemical spray (16 hours)(CDCR, 2018m). While it also incorporates some of the best practices in training, including brief courses on disability awareness and sexual abuse/harassment, it does not include a module on the rights of incarcerated youth, gender-specific needs, or how to support and protect LGBTQI youth within the facilities (AECF, 2014, p.150-153; CDCR, 2018m).

Effective implementation of staff training requires knowledgeable trainers and engaging training materials. In 2012, the Special Master report observed training procedures that “were literally policy pasted into PowerPoint slides that were read verbatim for hours by trainers” and lacked the design and curriculum necessary for effective training (PLO, 2012). Today, many of these trainings may continue to lack relevance to working with youth. For example, one staff member stated that the On-the-Job Training Modules consist of worst-case scenarios, such as youth escapes, which have little to no applicability to their role at the institution (Staff Interview, 2018). Without relevant training, staff are ill-equipped to support youth.

C. Staffing levels on living units put youth at risk

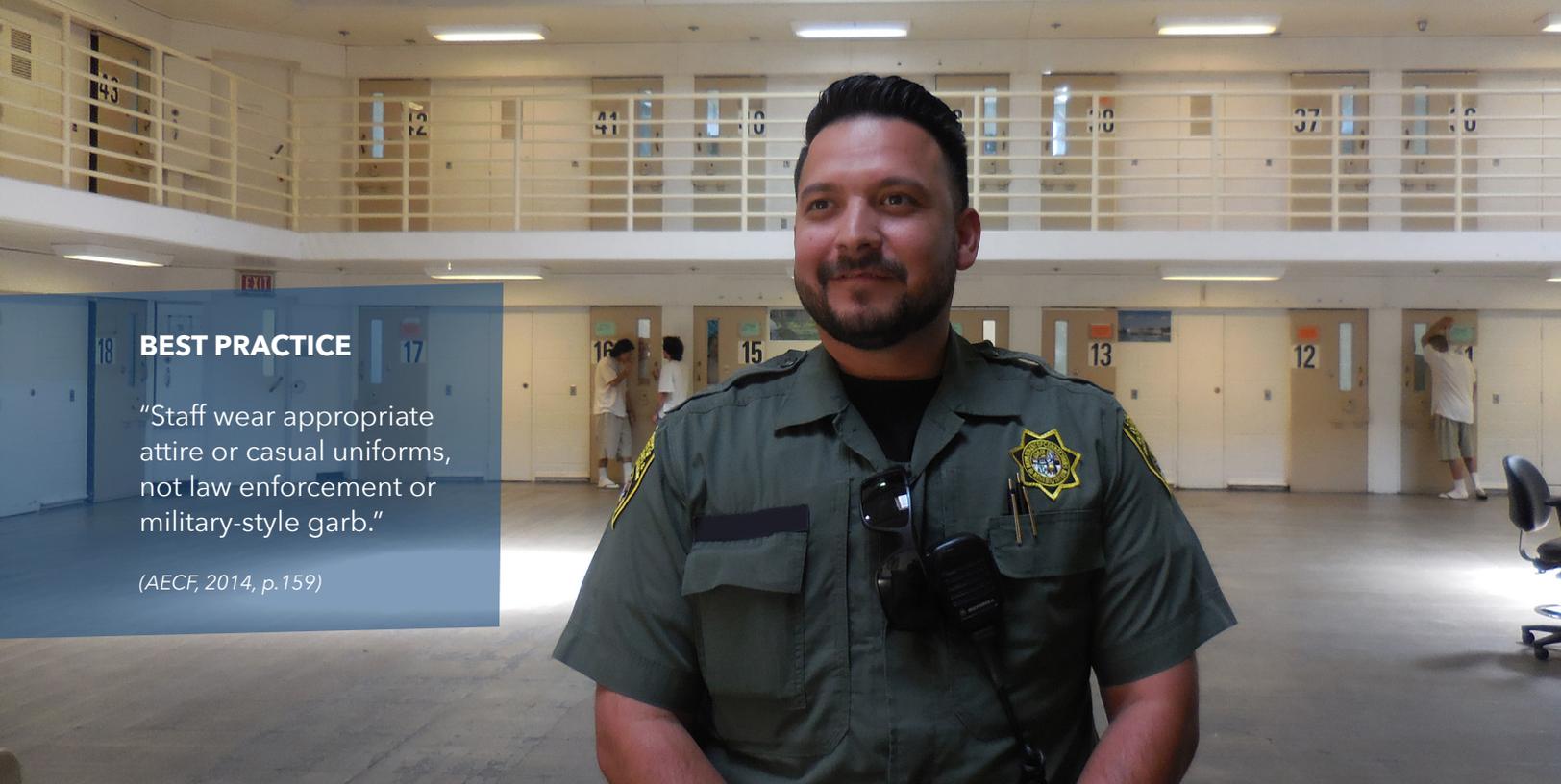
Staff in the living unit of a youth correctional facility can play a critical role in youths’ wellness and safety. Positive social interactions with adults who model healthy, functional lifestyles can help a young person feel respected and supported as they develop their own identity and social skills (OJJDP, 1996). Contrary to this best practice, youth-staff relationships in the DJJ facilities are hampered by high rates of violence and frequent use of force by custody staff (See Violence section for more details). Rampant violence shows a failure to maintain even the most basic safety for youth, let alone foster positive relationships between staff and youth. Whereas best practices call for staff to view themselves as the adults that youth can count on for support and safety, and “demonstrate a consistent level of tolerance of normal adolescent behavior,” youth at DJJ often experience staff as disrespectful and disengaged (AECF, 2014, p.159; Youth Interview, 2018). In the context of daily violence and ongoing fear, distrust builds and a divide between youth and staff corrodes any institutional efforts at rehabilitation.

Low staff-to-youth ratios at secure juvenile facilities can help to ensure youths’ safety and security. Widely-accepted standards within the field require at least a 1:8 ratio of direct care staff to youth when youth are awake, only including direct care staff that can see, hear, and speak with youth to offer supervision rather than those in control towers (AECF, 2014, p.148). At night, the ratio of staff to youth may double to 1:16 when youth are asleep. It should be noted, however, that these minimum ratios do not factor in special units such as mental health and behavioral treatment programming, in which more intensive staffing is generally necessary (AECF, 2014, p.148).

Given the historically low population at DJJ and the high level of overall staffing in the facilities, it is surprising that DJJ fails to consistently meet the minimum supervision ratios needed to ensure youth and staff safety. From June 2017 to May 2018, DJJ staffing ratios⁶ were reportedly in compliance with standards during waking hours, averaging 1:5 in all general population core units at Chad, 1:5 in all core units at O.H. Close, and 1:7 in all core units at Ventura (CDCR, 2018m). Nighttime ratios, however, averaged above minimum standards of 1:16 with an average 1:20 ratio in core units (CDCR, 2018m). During the same period, Pine Grove⁷ had substantially worse staffing ratios than other DJJ facilities with an average of 1:33 at night and 1:10 during the day, which can create opportunities for violence (CDCR, 2018m). Minimum staffing ratios differ in specialized units. For example, the BTP units at O.H. Close, Chad, and Ventura maintained a combined average staffing ratio of 1:1.5 during the day

⁶ Staffing ratio calculations include custody staff; it is unclear whether this includes staff in monitoring towers (CDCR, 2018m).

⁷ At Pine Grove, all youth at the facility are part of the “Main Camp” in which they live and sleep in an open dormitory.



BEST PRACTICE

“Staff wear appropriate attire or casual uniforms, not law enforcement or military-style garb.”

(AECF, 2014, p. 159)

Law enforcement-style uniform worn by custody staff member defies best practices.

and 1:8 at night (CDCR, 2018m). For more information on staff-to-youth ratios by unit type and time of day, see Appendix A.

In 2006, the Safety and Welfare Committee set forth a plan that would bring DJJ facilities in compliance with modern standards. One of the plan’s primary priorities was the development of smaller living units as well as enhanced staffing, which would “allow more time for interaction with the youth, quicker response to misconduct, and more opportunities for individual interaction” (CDCR, 2006). Despite the institution’s need to redesign all living units in order to comply with staffing recommendations, living units at DJJ facilities remain largely unchanged.

D. Staff shortages and transitions

Staffing shortages risk the safety, security, and rehabilitation of youth in correctional institutions. At Ventura, one administrator acknowledged that insufficient staffing levels limit the programming that can be implemented at the facility and have led to a reliance on volunteers for some rehabilitative activities (Tour, 2018). Between June 2017 and June 2018, filled staff positions at DJJ’s four facilities (approximately 767) consistently fell below the 905 positions that the facilities’ budgeted in Fiscal Year 2017-18.⁸ At Chad and O.H. Close, 23 percent of staff hired in Fiscal Year 2015-16 left within two years of hire. Of the 14 staff members who left, half were teachers or instructors (CDCR, 2018m). High staff turnover creates inconsistency for youth, inhibiting effective education and programming. DJJ facilities averaged 137 vacant positions, which translates to a 15 percent vacancy rate from June 2017 to June 2018 (CDCR, 2018k). This continual lack of adequate staffing points to challenges the institution may have in attracting and retaining staff, and ultimately results in an environment in which youth do not have access to consistent supportive adults at DJJ facilities.

⁸ Total staffing allocations exceed 1,000 positions due to administrative staff not assigned to a facility (DOF, 2018a).

E. Lack of staff collaboration

As DJJ implemented remedial plan requirements to comply with the Farrell lawsuit, administrators selected the Integrated Behavior Treatment Model (IBTM) as a framework through which all services for youth were to be delivered (CDCR, 2018m). Under this new model, custody staff and mental health staff should collaborate to provide comprehensive, cohesive treatment for youth. In its core aims, this model aligns with best practices, which recommend that mental health professionals work directly with custody and non-clinical staff to provide guidance on managing youths' behaviors and addressing their various psychosocial and developmental needs (AECF, 2014, p.117). However, the IBTM's current implementation is described by staff as not being centered on collaboration (Staff Interview, 2018; Tour, 2018).⁹ One mental health staff member noted that custody staff consistently emphasize security needs, which are viewed as most important, while treatment priorities are often disregarded (Staff Interview, 2018). Alternatively, administrators and some custody staff members in the Ventura facility describe a "180 degree shift" toward caring interactions and relationship building (Tour, 2018).

On the whole, DJJ has not achieved genuine collaboration among treatment and custody staff, a core component of the IBTM, and administrators acknowledge that staff reluctance has remained an obstacle to the model's roll-out (Tour, 2018). In the final years of the Farrell lawsuit, several Special Master reports noted a consistent lack of staff buy-in to the IBTM model and difficulty achieving collaboration among treatment, education, and custody staff in developing treatment plans or providing behavioral consequences and rewards, particularly at the Chad facility: "The Special Master can only conclude that either the managers are not in the units, do not support the Defendant's agreed-upon direction and/or do not understand the IBTM well enough to ensure fidelity to it" (PLO, 2015).

The dismissal of the Farrell lawsuit in early 2016 ended official monitoring of the IBTM, leaving little publicly-available information about whether DJJ has adhered to its core principles. Yet, in the face of challenges with implementation, administrators tout the effectiveness of the model citing more superficial changes in the institution's culture (Tour, 2018). For example, DJJ looks to have achieved a laudable language shift among staff, with many displaying comfort with terms such as trauma-informed, motivational interviewing, or cognitive-behavioral therapy. During a training observed at the northern facilities, all staff in attendance readily identified themselves as part of a youth's treatment team (Tour, 2018).

However, new terminology does not signify a transformation in mindset. Routine use of the phrase trauma-informed, for example, belies the institution's inadequate program offerings and its culpability in deepening youths' trauma by subjecting them to harsh, prison-like conditions. In fact, with a truly trauma-informed approach, staff recognize that young people must feel safe and supported before treatment can take place (Burrell, 2013).

BEST PRACTICE

"Dedicated program staff and lasting relationships between youth and staff are essential for developing feelings of 'belongingness,' which many disconnected youth lack."

(Butts, Bazemore, & Meroe, 2010)

⁹ The custody-treatment conflict has been present within prisons for both youth and adults for more than 100 years, with ample historical documentation (e.g., Barnes, 1930; Rothman, 1971; 1980).

VIOLENCE

Key Takeaways

- Violence affects nearly every youth during their confinement at DJJ. Since the end of the Farrell lawsuit, an average of 33 youth per 100 in the DJJ population were directly involved in a violent incident each month.
- Rates of riots and beatings have increased since the dismissal of the Farrell lawsuit.
- Some youth are placed in the lockdown unit (BTP) for more than a year, with maximum stays of 13 months at Chad, 20 months at O.H. Close, and 23 months at Ventura post-Farrell lawsuit.
- Use of force by DJJ staff has increased threefold compared to the one-year period during which the Farrell lawsuit was dismissed. The Inspector General identified the O.H. Close school area as the site of the eighth most use-of-force incidents in the entire California prison system, placing it on par with maximum security adult facilities.

A youth's experience at DJJ is defined, above all, by their sense of safety and well-being in the institutions. A culture of physical violence and gang conflict requires staff and youth to subordinate treatment and educational aims to security concerns, which compromises rehabilitation and exposes youth to trauma. Youth in large, congregate facilities, like DJJ, find that the hyper-vigilance needed to stay safe during their confinement leaves them unprepared for life after release. Simply sleeping through the night or bonding with a loved one is made more difficult by years spent in a violent institution (Shelden, 2012; Youth Interview, 2018).

Data, interviews, and tour observations indicate that rehabilitative efforts at DJJ are hampered by ongoing threats to youth safety, a consistent feature of the state's youth correctional system throughout its history (DeMuro, et al, 1988; Lerner, 1982; 1986; Macallair, 2015). Youth in the institutions see high rates of violence, an entrenched gang culture, easy access to drugs and other contraband, and significant deficiencies in basic privacy and sexual violence protections—all of which are tolerated, or even abetted, by members of the staff. This culture of fear extends well beyond official statistics and affects all youth in the institutions regardless of whether they are the direct victims of violence.

A. Increasing violence

Dangerously high levels of violence have persisted in each of the DJJ institutions since the end of the Farrell lawsuit. In the 30-month period since the dismissal of the suit (February 2016 to July 2018), an average of 33

“

“ Violence is heavy in there and it keeps the whole place bound.”

(Youth Interview, 2018)

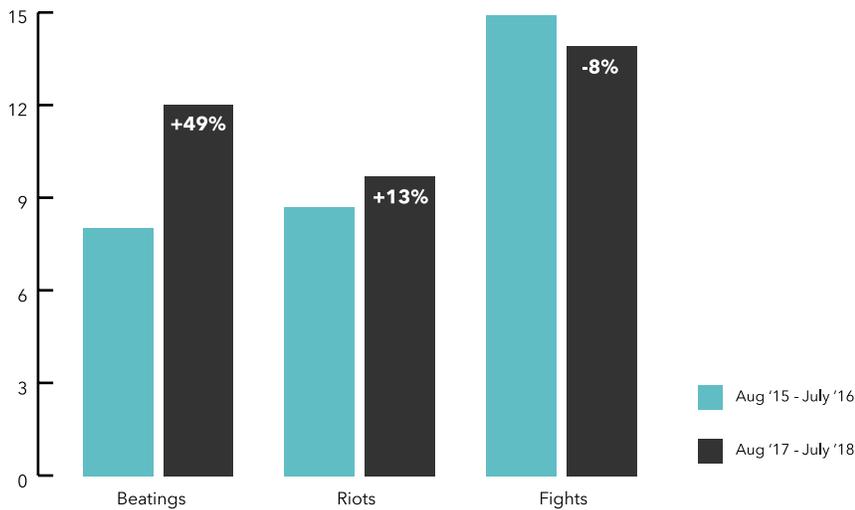


Figure 5. Average number of youth involved in a violent incident each month, per 100 youth in the facility, August 2015-July 2016 vs. August 2017-July 2018

Source: CDCR, 2018k.

youth each month per 100 in the facilities were involved¹⁰ in some kind of violent incident, including riots (termed “group disturbances”), fights (“mutual combat”), beatings (“batteries”), and forced sexual acts (CDCR, 2018k).¹¹ These statistics show that violence continues to be a part of daily life in the institutions and affects nearly every youth during their confinement.

Since the dismissal of the Farrell lawsuit, rates of recorded violence at DJJ have generally increased. Compared to the one-year period during which DJJ was released from the Farrell lawsuit, August 2015-July 2016, the most recent one-year period, August 2017-

July 2018, has seen a 12 percent increase in the average rate of youth involvement in violence each month per 100 youth in the facilities (CDCR, 2018k). Included in this statistic is a 49 percent increase in the rate of youth subject to beatings, a 13 percent increase in the rate involved in riots, and an 8 percent decline in the rate involved in fights (Figure 5)(CDCR, 2018k).

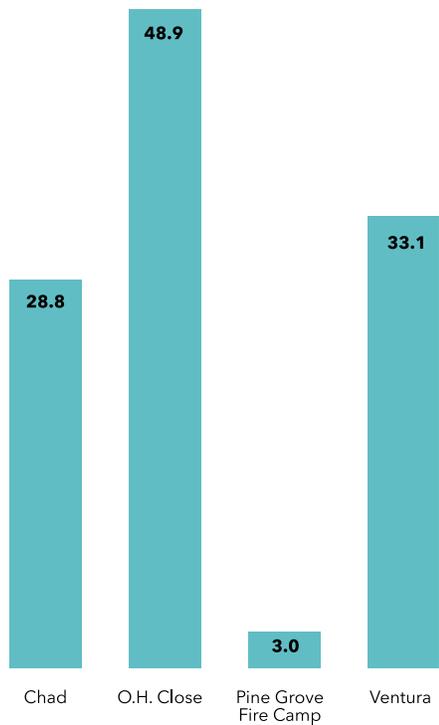


Figure 6. Average number of youth involved in a violent incident each month, per 100 youth in the facility, post-Farrell (February 2016-July 2018)

Source: CDCR, 2018k.

Among DJJ’s three large facilities, O.H. Close has shown the highest rate of overall violence since the end of the Farrell lawsuit with an average of 49 youth involved in violent incidents each month for every 100 youth in the facility (Figure 6)(CDCR, 2018k). This rate, which mirrors O.H. Close’s concerning injury data (See Medical Care & Mental Health section for more details), may be attributable to its archaic open dormitory design, which, as discussed earlier, is associated with greater risk to youth safety. The Pine Grove facility consistently shows the lowest levels of violence, with just three youth involved in violent incidents each month for every 100 in the facility and an average of just one violent incident—beating, riot, fight, or forced sexual act—every four months (CDCR, 2018k).

Total violence in Chad, O.H. Close, and Ventura appears to have gradually

¹⁰ The number of youth involved in violent incidents includes those who were the victim of a beating or a participant in a fight or riot.

¹¹ DJJ defines batteries as “any willful and unlawful use of force or violence upon the person of another.” They define group disturbance as “the disruption or interference of normal facility operations resulting from six or more youthful offenders participating in a large scale fight.”

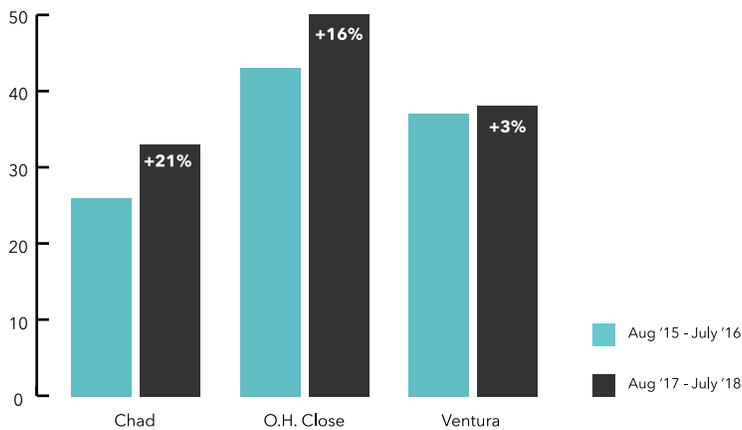


Figure 7. Change in the average number of youth involved in a violent incident each month, per 100 youth in the facility, August 2015-July 2016 vs. August 2017-July 2018

Source: CDCR, 2018k.

trended upward since February 2016, with the steepest increase seen at Chad, where, on average, one additional youth has been involved in violence each month for the last 30 months (February 2016-July 2018) (CDCR, 2018k). Compared to the one-year period during which Farrell was dismissed (August 2015 through July 2016), the most recent one-year period (August 2017 through July 2018) has seen a 21 percent increase in the rate of youth involvement in violence at Chad, a 16 percent increase in the rate at O.H. Close, and a 3 percent increase in the rate at Ventura (Figure 7)(CDCR, 2018k).

DJJ’s published statistics on violence, though alarmingly high, certainly undercount the number of violent incidents that occur in the facilities as some violence may go unreported by staff, while other incidents may escape their

notice entirely. Importantly, the effect of violence at DJJ extends far beyond those directly involved in a recorded incident. Youth who observe violence, see heightened tensions in the lead-up to a riot or fight, or overhear threats experience fear and further trauma.

When riots or other serious violent incidents occur at DJJ, staff place the affected unit, and sometimes other units in the facility, on Limited Program, which is a form of lockdown. Limited Program curtails youths’ access to school, religious services, or other programming, and places them in their cells for much of the day (CDCR, 2018n; Staff Interview, 2018; Youth Interview, 2018). In the one-year period from August 2017 to July 2018, there were 260 total days of Limited Program within living units at DJJ, which averages to five days on Limited Program for each locked down unit, or the equivalent of a week of school (CDCR, 2018k). During the same period, nearly 968 class periods were canceled due to “safety and security” reasons (CDCR, 2018k). Interrupting services so frequently jeopardizes the education and treatment of all youth at DJJ.

Data from August 2017 through July 2018 indicate that Chad relies more heavily on DJJ’s Limited Program policy than the other DJJ facilities, locking down an average of two units each month for a total of 98 lockdown days for the year (CDCR, 2018k). An email sent to Chad staff in October explained that only youth in the MHRU or Sexual Behavior Treatment Program (SBTP) units should attend school that Monday as all other living units were on Limited Program (Staff Documents, 2018). A lockdown of that scale suggests that group punishments are commonplace at Chad and that youth are being denied educational services and programming under the guise of “safety and security.”

“

Fights happen during movement and by the door [of the classroom]. In the living unit, youth don’t mix. School is where they see each other. If they have business to do, they will do it at school.”

(Staff Interview, 2018)

BEST PRACTICE

“The facility shall not admit youth whose safety cannot be protected.”

(AECF, 2014, p.94)

Youth and staff explain that violence occurs with greater frequency at key times and locations within the facilities. For example, youth housed at Chad during their confinement identify the intake unit, McCloud, as the most common site for riots, explaining that violence at McCloud would sometimes affect programming in other units: “You’re on a different unit and you’re getting punished for this unit over here. We’d be mad, we’d be like ‘come on McCloud!’” (See Intake & Unit Assignment section for more information on violence during intake)(Youth Interview, 2018). In addition to intake, other sites of frequent violence include the school area during transition times (called “movement”) and areas of the facility that are outside of camera range or without clear egress, such as fenced spaces or hallways within living units (Staff Interview, 2018; Youth Interview, 2018). Violence also intensifies when youth are

placed in direct contact with those from other gangs or living units. School and work transitions and the morning walk to receive medication are common opportunities for youth from different living units to interact, and are known by youth and staff as flashpoints for violent disputes (Staff Interview, 2018; Youth Interview, 2018).

Although riots and serious violence occur far less frequently at Pine Grove than at the three correctional facilities, one of the few recent riots that was publicly reported took place at the conservation camp. The June 2017 incident became known outside of DJJ because staff lost control of rioting youth and called outside law enforcement agencies for support, which resulted in modest press coverage (Mitchell, 2017). A memo from the DJJ Director following the incident described it as a “group disturbance involving 31 African American and Hispanic youth” that ended with a “youth outside as well,” indicating that a youth was found outside the bounds of the camp (Staff Documents, 2018). Youth witnesses described the riot as a gang conflict that resulted in all involved youth being removed from the facility and transported to Chad, while remaining youth were handcuffed and placed on the ground for several hours (Staff Documents, 2018; Youth Interview, 2018). As a result of the incident, four African American youth were charged as adults in Amador County (Amador County District Attorney, 2018). Staff in the northern facilities speculated that DJJ’s response to the Pine Grove riot eclipsed those of similar incidents at other DJJ facilities because it represented a public embarrassment to the institution and occurred at a facility that administrators often tout as a model (Staff Interview, 2018).

Though DJJ can be an alternative to adult prison, it can also serve as a pathway into the adult criminal justice system. Since the end of the Farrell lawsuit in February 2016 through June 2018, 33 youth have been charged for incidents that occurred in a DJJ facility. The majority of these charges were filed in Ventura County and stem from incidents at the Ventura facility (25 youth charged), though four youth were charged in San Joaquin County for incidents at the Chad or O.H. Close facilities, and four were charged as a result of the Pine Grove riot (Amador County District Attorney, 2018; San Joaquin County District Attorney, 2018; Ventura County District Attorney, 2018).

Violence disparately affects certain populations of youth in the DJJ facilities. For example, youth are vulnerable to violence when they affiliate with certain institutional gangs or desist from gang activity altogether. The Fresno Bulldogs, one of the smallest gangs at DJJ, are in active conflict with several other groups in the institutions, resulting in frequent fights and beatings when they are placed on core living units

“

“Sex offenders are the most hated. They go through a lot in there. If you’re a sex offender, you have a hit on you. You’re scared.”

(Youth Interview, 2018)



The fenced area outside of a Chad living unit.

(Maxson et al., 2012; Staff Interview, 2018; Youth Interview, 2018). During a 2017 tour, a staff member explained that the Chad lockdown unit, the BTP, was functioning as a de facto living unit for youth affiliated with the Fresno Bulldogs because, according to staff, they could not program safely with other youth (Tour, 2017). A youth recently released from the institutions described DJJ’s shifting philosophy on gang segregation: “The Bulldogs weren’t integrated with the Northerners for many years and then they made a new rule and started moving the Bulldogs from O.H. Close to Chad and it caused so many fights” (Youth Interview, 2018). To house a youth in this lockdown unit indefinitely subjects them to traumatizing living conditions without opportunities for socialization, normalcy, or a full range of programming.

Youth on the SBTP unit also experience a higher risk of harassment or assault by other youth as a result of stigma surrounding their committing offense. They are branded “sex offenders” by the other youth and occasionally “greenlighted” or singled out for violence by other youth. The targets of “greenlighting” are well known throughout the facility and may be victimized at any time by a large number of other youth. For youth in SBTP, this violence and harassment typically occurs when they encounter the general population during school, work, or at religious services, and, according to one youth, acts of “greenlighting” correspond with shifts in a gang’s power structures,

with emerging “shot callers” showing a propensity for greater violence when they first assert control (Youth Interview, 2018). A youth recently released from DJJ explained that, “Sex offenders get persecuted so bad in there,” and another recounted, “SBTP [youth] are greenlighted. I’ve seen sex offenders get beat up” (Youth Interview, 2018).

The fear of attack experienced by youth in the SBTP unit or those in certain institutional gangs violates basic safety standards governing the protections of special populations. According to best practices, staff should “develop individualized plans to provide for the safety of particular youth. Staff do not use room confinement as a means of ensuring their safety” (AECF, 2014, p.102). When touring the Ventura facility, CJCJ learned from staff that some youth who have been “greenlighted” are being placed in locked cells on the high core unit in relative isolation as a means of protecting them from violence. The staff member explained that youth are slowly reintegrated into the general population, beginning with small group sessions until they can return to regular programming (Tour, 2018). This approach violates the standard requiring staff to protect youth from harm without the use of isolation (AECF, 2014, p.102).

Some DJJ staff place the responsibility for protection in the hands of youth themselves. A youth who had lived in the SBTP unit during his confinement at DJJ described the response his unit received from an administrator after learning of a threat against them. They were told, “If wards on SBTP were attacked, we had every right to defend ourselves and we wouldn’t be written up.” The youth explained that this policy was a departure from the standard practice of preparing a behavioral report for each youth involved in a violent incident, regardless of their role as an aggressor or victim (Youth Interview, 2018). In sanctioning self-defense, the administrator was abdicating his responsibility for keeping youth safe and demonstrating that DJJ staff believe that some youth violence is inevitable. This attitude is echoed in the Youth Rights Handbook, which offers tips for youth on avoiding sexual assault (CDCR, 2018n).

Youth adjudicated for sexual offenses often require extensive therapy and healing to prepare for a return to their families and communities. However, at DJJ, true rehabilitative progress is impeded by the challenges of navigating a prison-like facility, including the threat of physical harm. Despite the routine targeting of youth adjudicated for sexual offenses at DJJ, counties continue to commit young people to the state under the assumption that DJJ offers superior treatment, without consideration for the effects of a hostile environment on the efficacy of their treatment.

DJJ’s inability to quell violence stems from the fundamental challenge of maintaining safety in a large, prison-like institution. Placing many of the highest needs youth from communities across the state in common facilities inevitably leads to conflict. Research has shown that youth housed with others who have committed serious offenses tend to emerge more, not less, prone to violence (Dodge, Dishion, & Lansford, 2006).

B. Gang influence and segregation

The most recent assessment of gang influence at DJJ was conducted during the Farrell lawsuit and released in 2012. It found that 46 percent of surveyed male youth in the DJJ facilities affiliated with a gang, although this measure differed substantially from DJJ’s own assessment, which designated 72 percent of youth as involved in an institutional gang (Maxson et al., 2012). Surveyed youth fell into one of several primary organizations, including Norteños, Sureños, and “Blacks.” These organizations remain the primary institutional gangs described by youth and staff today (Staff Interview, 2018; Tour, 2018; Youth Interview, 2018).

During the Farrell lawsuit, DJJ implemented a gang intervention program called Incarcerated Men Putting Away Childish Things (IMPACT), which promised to reduce “gang/racial related misconduct” (CDCR, 2018o). However,



Cells in the BTP unit at O.H. Close.

during CJCJ's July 2018 tour, we learned that administrators have since suspended the intervention. For the time being, youth in the facilities were not receiving a gang intervention program, though administrators were reportedly seeking a replacement (Tour, 2018). A common response to gangs at DJJ appears to be segregation, although administrators officially deny that youth are segregated (See Intake & Unit Assignment section for more description of DJJ's segregation practices). Youth who identify as Norteños are almost never confined at the Ventura institution in Southern California, while those affiliated with Fresno Bulldogs are part of an integration experiment at Chad that has resulted in frequent detentions in the BTP. According to staff at Ventura, this approach reduces the number of gang-related conflicts, but leads to disputes along racial or ethnic lines, typically between African American and Latino youth (Tour, 2018). During CJCJ's tour of Ventura, we heard staff refer repeatedly to the race and ethnicity of youth, and one asked a youth directly, "did you mix well with the blacks?", suggesting that youths' race is a primary consideration in their placement and socialization (Tour, 2018).

C. Extended isolation

In large measure, DJJ's reliance on isolation—including Limited Program, a restriction on daily movement and programming; room confinement, the temporary separation of youth in a locked cell; and BTP, DJJ's long-term lock-down unit—is a product of its failed attempts to tamp down on violence and gang activity in the facilities. Using isolation as a behavior management technique exposes youth to undue trauma and limits their progress in programming and education.

Research shows that isolating individuals in a single cell without social interaction can be physically and psychologically harmful (Cloud et al., 2015; Grassian, 2006; Morris, 2015). Isolation rapidly degrades mental health and has been associated with suicide and suicide attempts among youth in custody (AACAP, 2017). In light of research on the harms of solitary confinement, the California Legislature passed Senate Bill 1143 in 2016, prohibiting the use of “room confinement” in DJJ or local juvenile facilities for more than four hours without a review by administrators (SB 1143, 2016). However, the bill did not apply to “normal sleeping hours” and allowed “brief periods of locked room confinement necessary for required institutional operations.” The “required institutional operations” exemption allows DJJ’s single-cell facilities—Chad and Ventura—to continue placing youth in locked cells for extended periods as part of their daily routine, including in the hours before bed or during the day for high school graduates choosing to remain in their cell (Staff Interview, 2018; Youth Interview, 2018). As described earlier, a youth’s out-of-room time can be severely restricted during Limited Program, sometimes for days, though these lockdowns are not included in DJJ’s room confinement statistics (Staff Interview, 2018; Youth Interview, 2018; CDCR, 2018k).¹²

BEST PRACTICE

“Youth are out of their rooms except during sleeping hours and for brief periods of transition, such as shift changes. For the majority of time that youth are out of their rooms, youth participate in structured recreational, cultural, or educational activities. Staff provide youth with some unstructured free time as well.”

(AECF, 2014, p.139)

A year after SB 1143 took effect, DJJ began to collect data on its use of room confinement, including the number of youth placed in locked cells and the duration of their confinement. Data obtained from DJJ for the five-month period from January 2018 to May 2018 show relatively low rates of official room confinement, with an average of 13.8 unique youth confined each month across all facilities, 1.8 of whom were confined more than once during that period. Reported room confinement duration averaged 4.8 hours per confinement incident, but the maximum confinement period was 29.2 hours at Chad, 6.03 hours at O.H. Close, and 46.8 hours at Ventura (CDCR, 2018m).

“

“They’re warehousing guys in [the BTP].”

(Staff Interview, 2018)

Nowhere is the connection between isolation and deepening trauma more evident than in DJJ’s lockdown units, the BTP. Each of DJJ’s large congregate facilities operate a BTP, which “provides treatment to youth who demonstrate repeated or serious violent, aggressive behavior, as well as youth who threaten violent behavior and/or encourage others to be violent” (CDCR, 2018n). After being placed on the BTP, youth are expected to progress through a series of levels (Entry, Stabilization,

Progress, and Transition) to qualify for a return to their assigned core living unit and must demonstrate consistent positive behavior and participation in programming to successfully transition back (CDCR, 2018n). During CJCJ’s July 2018 tour of Chad, staff we spoke to could not recall the official names of the levels, suggesting that the level descriptors are not used to motivate youth or discuss their progress. In the one-year period from August 2017 through July 2018, an average of 3 percent of DJJ’s BTP population was in the Entry stage, 77 percent in Stabilization, 14 percent in Progress, and 7 percent in Transition (CDCR, 2018k).

12 SB 1143 permits youth to be locked in their cells for an “extraordinary, emergency circumstance that requires a significant departure from normal institutional operations, including a natural disaster or facility-wide threat that poses an imminent and substantial risk of harm to multiple staff, minors, or wards,” but further inquiry is needed to determine whether the justification for placing a unit on Limited Program also meets SB 1143’s threshold for an “extraordinary emergency circumstance” (SB 1143, 2016).

Youth on the BTP receive all meals, education, and programming on their unit and do not interact with youth elsewhere in the facility (Staff Interview, 2018; Tour, 2018). The exception is Ventura's BTP, which allows youth to return in stages to their living unit (Tour, 2018). During our tours, we visited each of the BTP units and observed some youth gathered in the day room, while others were locked in their cells (Tour, 2018). Youth in their cells were typically lying in bed (Ventura), yelling through the narrow glass windows on their doors (O.H. Close), or attempting to talk with youth in the day room (Chad). In the O.H. Close BTP, some youth shower in locked, rusty cages and are placed in outdoor cages for their recreation time, preventing them from interacting with other youth (Tour, 2018).

Staff on the BTP unit at Chad explained that some youth in the unit will fight with other BTP youth if placed in the same room. For that reason, staff explained that they operate a staggered schedule, with youth released from their cells for recreation and programming at different times throughout the day. One staff member mentioned that every youth is out of their cell for at least seven hours per day, though some youth receive their recreation and programming time alone (Tour, 2018). For youth, isolation from peers for extended periods of time can be harmful to their health and social development (Hall-Lande et al., 2007). Furthermore, placing youth in an outdoor cage without access to meaningful social contact, as we observed at Chad and have confirmed with staff and youth, undermines the institution's goal of healing and rehabilitation for its youth (AECF, 2014, p.139; Staff Interview, 2018; Tour, 2018; Youth Interview, 2018).

Data on DJJ's BTP units indicate that some youth are spending dangerously long periods of time on this restrictive unit. For the 28-month period from February 2016 (when the Farrell lawsuit was dismissed) through May 2018, DJJ reported maximum stays of nearly 13 months at Chad, more than 20 months at O.H. Close, and approximately 23 months, or nearly two years, at Ventura (CDCR, 2018m).¹³ Length of stay data do not capture the extent to which youth cycle in and out of the BTP unit, which can add up to even longer periods of total confinement on the lock-down unit. DJJ did provide data showing that, on average from February 2016 to May 2018, 1.4 youth were returned to the BTP unit within 30 days of their release, indicating that some youth are seeing episodic confinement on the units and their cumulative lengths of stay are not captured in the data (CDCR, 2018m).

D. Prevalence of contraband

Youth and staff interviewees report that contraband is widespread in the DJJ facilities. From December 2016 (when data were first reported) through July 2018, the most common contraband items discovered by DJJ staff were "other contraband" (50%), which includes cell phones, followed by drugs (45%), and weapons (5%) (CDCR, 2018k). For youth, access to drugs in a confined setting can create new dependencies or deepen existing substance use disorders. One youth described smoking marijuana in his living unit and explained that, "We are young, we are teenagers. They are going to do what they're going to do. If you bring shit into a facility, it's going to spread like wildfire and everybody is going to do it" (Youth Interview, 2018). Staff members described smelling marijuana while walking through the Chad facility and encountering youth who appeared visibly under the influence of drugs (Staff Interview, 2018).

Youth offered varying theories about how contraband is entering the DJJ facilities, though none could provide specifics on the process (Youth Interview, 2018). A staff member speculated that other staff may be responsible for the inflow of contraband, explaining that their bags are searched randomly, not routinely, which provides them with the opportunity to pass illicit items to youth (Staff Interview, 2018). In 2015, a staff member at Ventura was

¹³ During this period, the average length of stay in the BTP was 43 days at Chad (nearly 1.5 months), 32 days at O.H. Close (approximately one month), and 74 days at Ventura (nearly 2.5 months).

criminally prosecuted and jailed after administrators discovered that he had been smuggling cell phones into the institution (Ventura District Attorney, 2018). On our tour, a staff member expressed hope that the case would set an example for others in the facility (Tour, 2018).

E. Lack of privacy and vulnerability to sexual abuse

As described in the Facility Operations section, DJJ’s design denies youth their basic privacy rights, placing them at risk of sexual abuse. These rights are codified in federal law through the Prison Rape Elimination Act (PREA) of 2003, which seeks to “prevent, detect, and respond to sexual abuse” in youth and adult correctional facilities (PREA, 2003). In implementing PREA, the United States Department of Justice developed a set of standards governing conditions in juvenile facilities, which include guidelines around the collection, reporting, and investigation of allegations of sexual abuse (USDOJ, 2012a).

To comply with PREA, DJJ must ensure that its facilities and procedures are designed to prevent sexual abuse and respond appropriately after abuse takes place. Every three years, DJJ and facilities across the nation, receive an inspection by PREA auditors to ensure compliance with the DOJ standards. The results of an audit of the DJJ facilities released in 2017 found that Chad was out of compliance with nearly half of the 40 applicable standards, (19 out of 40), including the requirement that facilities develop a policy to protect victims of sexual abuse from retaliation (CDCR, 2017). The auditor cited Chad for repeatedly failing to provide documentation of the facility’s disciplinary response to a staff member who was accused of an inappropriate relationship with a youth (CDCR, 2017). Without a review of the incident, auditors could not determine whether youth in the facility were still at risk. O.H. Close, Pine Grove, and Ventura were out of compliance with five, five, and two standards, respectively (CDCR, 2017a; 2017b; 2017c). Notably, in early 2019, auditors followed up on their 2017 review of Chad and found that the facility met 40 out of 43 of the applicable standards (CDCR, 2019).

Youth in many of the DJJ living units are unable to shower, change their clothing, or use the toilet without being seen by staff members, visitors, or other youth. In O.H. Close, both male and female staff can observe youth from a guard station at the center of the unit that overlooks the bathroom and sleeping areas (Tour, 2018). Youth

described the experience of showering and using the toilet as dehumanizing, explaining, “In the morning, everyone’s using the restroom, you’ve got 20 guys on the toilet and



Open showers in an O.H. Close living unit, which fail to protect the privacy of youth.

BEST PRACTICE

“Facilities must ensure that youth can shower, perform bodily functions, and change clothing without being viewed by opposite gender staff.”

(USDOJ, 2012, p.12; AECF, 2014, p.168)



A cage in the recreation yard at the Chad BTP unit.

you've got women walking in and out of there. And that's so uncomfortable towards us. I should be able to go to the restroom and do my own thing without having to worry about [being seen]" (Youth Interview, 2018). Another youth echoed this sentiment: "I've seen female staff walk up to a ward using the restroom. The stalls are like this high. They need privacy. You're taking a sit down and you can see your buddy's head" (Youth Interview, 2018). These practices appear to contravene the PREA prohibition on "an invasion of privacy of an inmate, detainee, or resident by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions" (USDOJ, 2012, p.9).

The single-cell facilities at Chad and Ventura have metal latrines in each youth's cell, which afford slightly more privacy than O.H. Close's open dormitory bathroom (See Facility Operations section for more details)(Tour, 2018). However, youth describe feeling uncomfortable with staff peering into their toilet area through the cell window or observing them changing their clothes in the cell (Youth Interview, 2018). In a DJJ cell, youths' metal latrines are just feet from their bed and located beneath the observation window, offering no area for privacy.

Youth also describe the extreme discomfort of strip searches, which are sometimes performed in open areas of the facility that are visible to other youth and staff (Youth Interview, 2018). A youth recounted, "They strip you naked at times in places where you don't feel comfortable. They'll make you take your clothes off in visible areas" (Youth Interview, 2018). For young people, the process of being stripped in front of staff or peers can be traumatic and dehumanizing, and the vulnerability of the strip search process places youth at risk of physical or sexual abuse (See Staff Abuse and Misconduct subsection for more details).

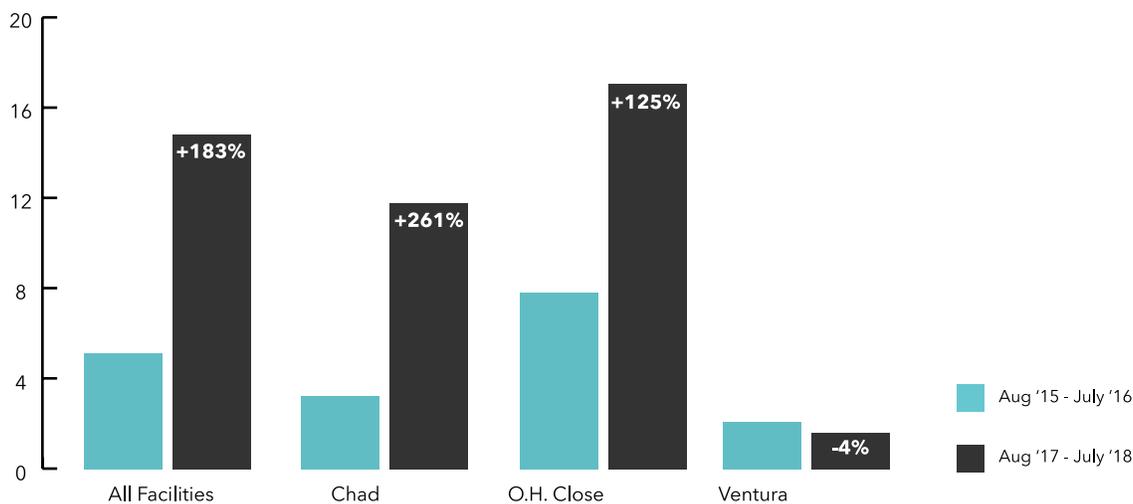


Figure 8. Change in the average number of use-of-force incidents each month, per 100 youth in the facility, August 2015-July 2016 vs. August 2017-July 2018

Source: CDCR, 2018k.

F. Staff abuse and misconduct

Use of force by DJJ staff has increased considerably since the end of the Farrell lawsuit and are comparable, in some places, to California’s adult prisons. Compared to the year-long period from August 2015 to July 2016, the use-of-force rate from August 2017 to July 2018 was nearly three times greater: rising from 5.2 monthly incidents per 100 youth in the facilities to 14.8 monthly incidents per 100 youth (Figure 8)(CDCR, 2018k).

Nearly every youth we interviewed could describe an inappropriate use-of-force incident that he or she had witnessed or experienced. These accounts included descriptions of youth having their legs kicked out or being placed in a headlock during a strip search and being physically assaulted by staff while handcuffed (Staff Interview, 2018; Youth Interview, 2018). In addition to incidents directly witnessed by youth, several youth and staff described rumors about staff beating youth in transport vans or in unseen corners of the facility, including the ice machine areas in the Chad living units (Staff Interview, 2018; Youth Interview, 2018). Although we could not confirm these accounts, their circulation throughout the facilities and across social networks is a clear indication of the widespread climate of fear, rampant violence, and distrust of staff that exists among youth at DJJ.

In 2018, the Office of the Inspector General (OIG) released a report on use-of-force incidents across all CDCR facilities and discovered high rates in some locations at DJJ (OIG, 2018). The report found that, in 2017, the O.H. Close school area was the site of the eighth highest number of use-of-force incidents in all of the CDCR system, placing it on par with high security adult prisons, including the California State Prison, Sacramento, the California Correctional Institution, and the California State Prison, Los Angeles County (OIG, 2018). Although DJJ youth compose roughly 0.5 percent of the population of CDCR-run facilities, DJJ represented 7.5 percent of the CDCR-reviewed use-of-force incidents in 2017 and 10.5

BEST PRACTICE

“Staff do not use corporal punishment, or cruel or degrading punishment, either physical or psychological, at the facility.”

(AECF, 2014, p.183)



The ice machine area in a living unit at Chad, the site of rumored staff beatings.

percent of the individuals subject to use of force that year, meaning that DJJ youth were approximately 20 times more likely than adults in state prison to have experienced reported use of force by staff (CDCR, 2018b; 2018p; OIG, 2018).

ALLEGED MISCONDUCT

“On August 2, 2017, an officer allegedly choked a ward, two other officers allegedly punched and kicked the ward, and one of the second two officers allegedly deployed pepper spray on the ward, all without cause.”

(OIG, 2018a)

The OIG analysis of use-of-force incidents also found that DJJ was out of compliance with use-of-force policies at higher rates than the adult institutions. In 2017, 45 percent of reported incidents at DJJ were found to be out of compliance due to inconsistent application of departmental policy or inadequate follow up, compared to 37 percent of incidents in adult institutions. Further, the analysis found that in 3 percent of cases at DJJ, the force itself was found to be in violation of standards, compared to 2 percent in adult institutions (OIG, 2018).

ALLEGED MISCONDUCT

“On December 23, 2016, an officer allegedly punched a ward four times and failed to report the use of force. A sergeant allegedly witnessed the officer’s use of force and failed to report it.”

(OIG, 2018a)

Thorough investigations of use of force are limited by the absence of working cameras in the DJJ facilities (See Facility Operations section for more details). Video evidence is crucial to assessing these incidents, but with few working cameras, investigations depend on the reliability of witnesses, which may include other staff. Youth and staff we interviewed explained that in many cases, including use-of-force incidents, a staff member’s account is given more weight than a youth’s: “They would get away with [misconduct] because it always came down to their word against ours, and they are definitely going to believe theirs” (Staff Interview, 2018; Youth Interview, 2018). An administrator at Ventura explained that the lack of camera footage available after use-of-force incidents makes it difficult for administrators to assess the incident and determine whether staff acted reasonably (Tour, 2018).

In addition to outright use of force by staff, our interviewees recounted the ways staff members perpetuate gang divisions and enable violence between youth at DJJ. Nearly every individual we interviewed described situations in which staff would let youth “fight it out” (Staff Interview, 2018; Youth Interview, 2018). One common example was the Crisis Intervention (CI) process, which is a DJJ-wide conflict resolution method designed to help youth solve interpersonal problems (Tour, 2018). As described to us by interviewees, CI centers on two youth who are in active conflict with one another and begins with both handcuffed across from one another in an empty room.

The dining area at Chad’s BTP unit, where some Crisis Intervention sessions are said to take place.



Multiple staff members explained that, despite CI's ostensible emphasis on conflict resolution, mental health staff are not permitted to engage in or even observe the process (Staff Interview, 2018). While in handcuffs, the youth discuss their conflict and pledge not to fight. The second stage of CI occurs later, when the same pair of youth are placed together without handcuffs. Interviewees shared that the uncuffed portion of CI is framed as a test to determine whether youth will fight, but, predictably, many of the sessions devolve into violence (Youth Interview, 2018). Though accounts differed, some interviewees shared that during uncuffed CI sessions, staff permit the fights to continue for some time before intervening. Others alleged that staff watched the uncuffed CI process from the guard station in the expectation that youth would fight (Staff Interview, 2018; Youth Interview, 2018). One youth explained, "CIs are all set-ups" (Youth Interview, 2018). These accounts contain echoes of the "gladiator fights" organized by DJJ staff prior to the Farrell lawsuit when "guards would test the readiness of inmates to be sent to the facility's general population by forcing them to confront other inmates, often rival gang members, in what were referred to as 'the Friday night fights'" (Gladstone, 1999).

Youth and staff recounted other instances when staff members arranged fights between youth, including one incident involving Norteño and Sureño youth in the Chad school area and another in the showers (Staff Interview, 2018; Youth Interview, 2018). Interviewees offered a range of explanations about possible staff motivations for arranging or permitting fights, from an opportunity to let youth "blow off steam," to acting out grudges against particular youth, to an attempt at reducing their workload by allowing a conflict to escalate in order for a gang or group of youth to be locked down (Staff Interview, 2018; Youth Interview, 2018).

Interviewees also described frequent disrespect and verbal harassment by staff. They explained that staff use derogatory terms when referring to some youth in an apparent attempt to elicit a reaction. They recalled staff calling youth "a bitch," referring to them with racial epithets, or calling youth in the SBTP unit "sexos" or "chomos," which is shorthand for "child molesters" (Staff Interview, 2018; Youth Interview, 2018). A youth and a staff member each recalled a separate serious incident involving a psychologically distressed youth that stemmed from repeated verbal harassment by staff (Staff Interview, 2018; Youth Interview, 2018).

Interviewees described other acts of disrespect by staff, including staff who would toss a youth's cell while they were in the shower, stick their fingers in a youth's food, destroy or confiscate their papers or photographs, and give arbitrary write-ups on a Friday with the knowledge that the youth was expecting a visitor that weekend, hindering their ability to visit with loved ones (Staff Interview, 2018; Youth Interview, 2018). One youth revealed that a staff member who showed kindness towards youth on his unit was called "ward lover" disparagingly by other staff (Youth Interview, 2018).

BEST PRACTICE

"Staff do not conduct searches of youth, youth rooms, or visitors as harassment or for the purpose of punishment or discipline."

(AECF, 2014, p.168)

ALLEGED MISCONDUCT

"On July 29, 2016, an officer allegedly inappropriately accessed pictures of wards and placed the pictures with inappropriate drawings on an office window visible to other wards. On August 5, 2016, the officer allegedly allowed two wards to take a third ward to another room and failed to report it. On August 7, 2016, the officer was allegedly dishonest when he had a ward sign that he attended counseling sessions that did not take place."

(OIG, 2018a)

Interviewees provided numerous accounts of inappropriate and unprofessional conduct by staff. Several youth described viewing pornographic videos with staff in the day room or in staff offices (Youth Interview, 2018). Others named female staff who routinely touched male youth inappropriately or in sexually suggestive ways (Youth Interview, 2018). Youth also described staff looking through the windows of their cells in an attempt to observe them engaged in “intentionally sustained masturbation without exposure,” after which staff would threaten youth with transfer to the SBTP unit (CDCR, 2009; Staff Interview, 2018; Youth Interview, 2018). These criminal acts by staff may go unreported due to fear of retaliation.

G. Code of silence among staff and youth

There are indications that some DJJ staff are empowered to behave inappropriately or unlawfully because they remain protected by a code of silence. The code, which has been a feature of DJJ’s staff culture since its inception, relies on a tacit agreement among staff to overlook misconduct and, in extreme cases, falsify evidence or testimony to protect a colleague (Macallair, 2015). Several OIG incident reports, highlighted in this section, describe allegations investigated by the OIG of attempts by staff to conceal wrongdoing. A staff member explained that among staff, “speaking out [against other staff] is a dishonor and you’ll pay the price” (Staff Interview, 2018).

ALLEGED MISCONDUCT

“On May 30, 2017, a sergeant allegedly placed handcuffs too tightly and unreasonably pushed two wards, failed to report the incident, placed the handcuffed wards in vans and failed to supervise them, and failed to complete disciplinary reports for the wards. A second sergeant allegedly witnessed the incident and failed to report it, and a senior youth counselor was informed of the incident and allegedly failed to initiate an inquiry or report it. On July 19, 2018, the second sergeant allegedly lied during an inquiry regarding the incident.”

(OIG, 2018a)

In 2004, a YCC, Linda Bridges, joined colleagues in drafting a false report after witnessing the brutal beating of youth by two other staff members (Smith, 2006). Ms. Bridges was among several staff who witnessed the incident but did not intervene. As a member of the so-called “Chad Six,” Ms. Bridges was briefly suspended from her duties, but returned as a Senior YCC at O.H. Close. Since then, she has steadily risen through the DJJ administrative hierarchy and is now one of the highest-ranking staff members in the division, serving as the Superintendent of the Northern California Youth Correctional Center, which includes both O.H. Close and Chad (CDCR, 2017d). Ms. Bridges’ professional success following her involvement in a notorious cover-up suggests that, rather than being penalized for upholding the code of silence, DJJ staff can see their loyalty rewarded.

Youth and staff explained that the code of silence sometimes extends to young people as well (Staff Interview, 2018; Youth Interview, 2018). One staff member recalled that a gang’s “shot caller” was given the task of adjudicating peer grievances for his unit. The youth used his influence to dissuade others from filing certain grievances and, in one case, tore up a grievance in front of its author (Staff Interview, 2018). Another youth described filing a grievance to advocate for his disability rights and, soon after, receiving a request from two staff members to rescind the grievance and resolve the issue informally (Youth Interview, 2018).

ALLEGED MISCONDUCT

“On April 3, 2017, a lieutenant allegedly grabbed a ward’s arm and forced the ward to the ground, breaking the ward’s wrist, and called the ward a derogatory name. Two officers allegedly threatened the ward and dissuaded him from reporting the use of force.”

(OIG, 2018c)

Youth explained that certain living units were known for discouraging youth from filing grievances and that youth in many of the O.H. Close units were not comfortable filing grievances (Youth Interview, 2018). Data on outreach to the DJJ ombudsman supports this assertion. In 2016, 44.6 percent of complaints to the Ombudsman originated from Chad, 50.8 percent from Ventura, and just 4.6 percent from O.H. Close, which houses 28 percent of the DJJ population (CDCR, 2017e). This disparity is all the more concerning given O.H. Close’s high rate of violence, injuries, and use of force (OIG, 2018).

A similar pattern emerges when examining complaints submitted to the Youth Grievance System that specifically allege staff misconduct. In the one-year period from August 2017 to July 2018, 42 percent of staff misconduct grievances originated from Chad, 38 percent from Ventura, and just 20 percent from O.H. Close (CDCR, 2018k). Importantly, the staff misconduct grievance form is a different color from the regular grievance form (blue vs. white), making it easily distinguishable from afar, including the distance from the guard station to the grievance form box (Tour, 2018). In their training materials, staff are instructed to discourage frequent use of the grievance process, learning that, “Grievance abuse is characterized by excessive, frivolous or repeat filing. Abuse can result in use of the system being temporarily restricted” (CDCR, 2018m).

Best practices on safety in institutional settings dictate that “youth feel safe from victimization by staff and youth, including abuse, threats of violence, bullying, theft, sexual abuse, sexual harassment, and assault” (AECF, 2014, p.188). Yet DJJ’s statistics on violence and staff conduct and accounts from youth and staff suggest that the institutions are failing in their basic obligation: keeping youth safe from harm and abuse.

H. Deficiencies in the behavior management system

In light of DJJ’s long history of violence, the Farrell lawsuit and ensuing consent decree prioritized gang intervention and violence reduction, naming “safety and welfare” as one of the six key areas for improvement in the institutions (CDCR, 2006). Among the most sweeping changes was DJJ’s overhaul of its behavior management system and adoption of the IBTM (introduced in the Staffing section). To be implemented effectively, the IBTM required DJJ to shift from a punishment-focused institution to one premised on staff collaboration, individualized treatment, and positive reinforcement (CDCR, 2018o).

There are indications that adoption of IBTM principles is uneven and arbitrary, although it has created opportunities for motivated staff to effect change in pockets of the institutions. Youth interviewees explained that DJJ’s approach to consequences and positive reinforcement, which is comprised of a system of negative and positive checks that are recorded by staff in an online database, felt arbitrary and, at times, was perceived as an instrument of staff favoritism. For example, several youth explained that staff working the evening shift

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“The culture of the institution emphasizes rewarding success in lieu of focusing on or punishing failure.”

(AECF, 2014, p.142)

on their unit would dole out negative checks without informing youth of the reason for the penalty, resulting, unexpectedly, in the loss of one hour of time out of their cells after dinner, called the “Late Night Incentive Program” (Youth Interview, 2018). Failing to provide a justification for a youth’s negative check directly undermines the effectiveness of a behavioral system that relies on immediate feedback. It also violates DJJ’s stated policy of providing warning to youth before issuing a negative check by beginning with “direct instruction, prompting, verbal counseling, or a time out” before escalating to a write-up (CDCR, 2018n).

Similarly, staff mentioned that some YCOs and YCCs working during the evening shift refused to recognize checks, whether negative or positive, that were given during the day. Without consistent follow-through, youth began to lose trust in the system of consequences and rewards, which negatively affected their behavior (Staff Interview, 2018).

“Once you get written up, it makes people bitter and upset and they’d keep doing it because they didn’t see a point in trying to work back to their incentive level.”
(Youth Interview, 2018)

In addition to immediate rewards and consequences, DJJ uses a level system to provide an incentive for youth to participate in rehabilitation and maintain good conduct over a sustained period. The level system runs from A, the highest tier of incentives, to D, the lowest. After intake, all youth begin on Level D and can begin ascending to Level A after demonstrating a period of good conduct and high participation in programming (CDCR, 2018n). In the 20-month period from December 2016¹⁴ through July 2018, an average of 12 percent of youth were on Level A, 24 percent on Level B, 33 percent on Level C, and 30 percent on Level D (CDCR, 2018k). Youth on Level A are granted access to special privileges, including time in an incentive room—a cell on their unit with a small television, video games, and a plush mattress (which differs from the dense, fibrous sleeping pad found on youths’ own beds)—or, for a limited time, an incentive lounge outside of their unit, which allows them to sit on couches as they create art,

listen to music, or play games (CDCR, 2018n; Tour, 2018). With just over one in ten youth at DJJ on Level A, the vast majority of young people are excluded from the basic comforts and activities afforded their peers on the outside.

A write-up for more serious conduct affects a youth’s incentive level and can negate weeks or months of progress (CDCR, 2018n). Youth interviewees explain that the level system is only motivating for those with a clean behavioral record. When a youth is demoted to a lower level, they tend to disengage from the incentive system and are less likely to try to improve their behavior (Youth Interview, 2018).

Though DJJ administrators credit the IBTM with promoting positive change in the facilities, the program has not been subjected to a rigorous independent evaluation to assess its effect on youth. When the IBTM was first introduced during the Farrell lawsuit, Safety and Welfare Expert Dr. Barry Krisberg was skeptical of its effectiveness, citing the absence of evidence-based approaches shown to be successful in a youth correctional setting and deeming it “an ‘act of faith’ that programs that have been evaluated with probationers, minor offenders, or in private therapy settings can be easily adapted to DJJ” (Krisberg, 2011).

14 Data on all four incentive levels were first reported in December 2016.



A cell at Ventura with a thin sleeping pad on a metal frame (LEFT); An incentive room at Ventura, which includes a spring mattress as a special privilege (RIGHT)

During Fiscal Year 2018-19 budget discussions, the Legislative Analyst’s Office (LAO) underscored this critique in its assessment of the Governor’s proposal to expand DJJ to a new population of young adults (DOF, 2018d). Noting the absence of an assessment to determine the effectiveness of DJJ’s programming, including the IBTM, the LAO wrote, “DJJ does not currently evaluate whether its programs actually operate in the same manner as the programs they are based on because it does not conduct reviews of its programs known as ‘fidelity assessments.’ In addition, DJJ has not completed an evaluation of the actual effect of its programs on youth” (LAO, 2018).¹⁵ To date, DJJ has not undertaken an assessment of the extent to which its approach aligns with proven models—a crucial and well-recognized first step in certifying the effectiveness of any treatment and behavior management system (Fisher et al., 2014).

15 In 2012, the LAO endorsed a proposal to end new admissions to DJJ and close the facilities over a period of years (LAO, 2012).

INTAKE & UNIT ASSIGNMENT

Key Takeaways

- The intake unit's population is constantly in flux, requiring youth to compete for dominance before being transferred to the general population. The result is high levels of violence and frequent riots.
- Studies of DJJ's primary assessment tool, the CA-YASI, have questioned how well it measures risk and anticipates a youth's treatment needs.
- Youth are not always placed in the facility closest to their homes, but may be assigned to a facility based on their presumed gang affiliation, placing them hundreds of miles from loved ones.

For youth newly committed to DJJ, adjusting to life at the facilities can be disorienting and dangerous. Upon admission, each youth is placed in a central reception center alongside a cohort of other recent arrivals from across the state. Youth often find the surroundings and routines unfamiliar and note that the social hierarchy of the reception center shifts rapidly and unpredictably. This heightens their sense of alienation and serves as a reminder of their physical separation from home and loved ones (Youth Interview, 2018).

All male youth committed to DJJ begin at the McCloud Reception Center at Chad, while female youth are placed on the Alborado unit at Ventura where they will remain for the duration of their confinement. The intake process lasts approximately 45 days, during which time youth are introduced to DJJ rules and procedures and undergo a battery of assessments (CDCR, 2018o; Tour, 2018).

Immediately upon intake, youth receive a health screening, an assessment of their risk of suicide, and an interview to determine their street gang affiliation (CDCR, 2018o; Tour, 2018). Providing youth with immediate health and mental health assessments aligns with best practices that require, "All youth receive a full health assessment soon after admission, and in no case later than one week after admission" (AECF, 2014, p.110).

A. Danger during intake

Although youth are under threat of physical violence during much of their time at DJJ, danger is often greatest during the intake process. The reception center houses youth from communities across California and its population changes on a weekly, if not daily, basis. As a result, youth are driven to continually assert dominance, creating the conditions for sustained violence (Youth Interview, 2018). Youth explain that the intake unit serves as a testing ground for social standing throughout the rest of the institution. An interviewee stated, "They're trying to prove themselves, make a name for themselves for the high core units and the mainline [core units]. So what they do is go into intake and rep hard. It's detrimental to live in there. You have to make yourself be known in intake so that when you get to mainline, they've heard of you" (Youth Interview, 2018).

Given DJJ’s practice of segregating by gang, the McCloud Reception Center is one of the only units that brings youth together from all of the major institutional gangs, increasing instability on the unit. One youth described his time in McCloud as extremely violent, highlighting an incident he witnessed in which two youth who affiliated with a gang that was in conflict with all other major gangs at DJJ were attacked during recreation: “I watched these two kids get beat up, kicked in their face, get stomped out...they could have gotten killed” (Youth Interview, 2018).

The challenge of maintaining youth safety during intake is exacerbated by the large population in McCloud, which generally exceeds the ACA-recommended maximum population of 25 youth per living unit. From February 2016, when the Farrell lawsuit was dismissed, through June 2018, the male intake unit has held an average of 32 youth, with monthly populations as high as 41 youth. For 24 of the 29 months of this period, the population of DJJ’s McCloud intake unit has exceeded the recommended maximum (CDCR, 2018e). This practice violates standards requiring facilities to “provide youth with heightened supervision until they have collected the information necessary to fully classify youth” (AECF, 2014, p.99). By placing large numbers of youth in a single intake unit for more than a month, DJJ fails to address the vulnerabilities of youth most in need of protection.

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“[During intake], I felt disoriented. I felt misguided, deluded. I was just like a sheep lost astray.”

(Youth Interview, 2018)

B. Medical discontinuity during intake

Youth who were reliant on a prescription medication before arriving at DJJ may see a lapse in their treatment during the intake and assessment process. Although DJJ administrators claim that youth who received medication before arriving at DJJ will continue it during intake, a defense attorney expressed concern about continuity of care, citing a recent client who had been prescribed a psychiatric medication prior to his arrival at DJJ (Attorney Interview, 2018; CDCR, 2018n). The client explained that he was not provided with any medication during intake and was told that prescriptions were not available during the intake period. Even after transferring to his permanent living unit, the client said that he could not receive medication because he had failed to file a formal request. Requiring any youth with mental health needs to advocate for their own medication or treatment defies best practices, which stipulate that, “Youth on prescription medications have their medications continued without interruption” (AECF, 2014, p.110).

C. Flaws in assessment and case planning

During their time on the intake unit, youth receive the first of several evaluations using the California Youth Assessment and Screening Instrument (CA-YASI), a cornerstone of DJJ’s treatment model (CDCR, 2018o). The CA-YASI is meant to evaluate each youth’s risks and needs and is used throughout a youth’s confinement at DJJ to inform treatment and living unit assignment. Several recent studies have evaluated the validity of the YASI, with some identifying shortcomings in its ability to accurately measure risk and determine a youth’s treatment needs. For example, a 2013 study by National Council on Crime and Delinquency found discrepancies between the risk scores of female youth and their actual recidivism rates, with some female youth receiving a “high risk” designation while showing very low rates of recidivism upon release (NCCD, 2014). In light of this finding, DJJ’s reliance on the CA-YASI to assess female youth and determine their treatment needs is problematic as it could result in a treatment plan that is ill-suited to the youth’s actual risk and needs or prescribes overtreatment, which can be harmful.

In 2012, Farrell Safety and Welfare Expert Dr. Barry Krisberg advised DJJ against the use of the CA-YASI, explaining that the instrument “seems a poor investment” and recommended that the institution “quickly replace CA-YASI with a truly evidence-based assessment process” (PLO, 2012a). Findings from a series of studies conducted by researchers at the University of California, Berkeley align with Dr. Krisberg’s critique, indicating that 40 percent of DJJ staff could not reliably score the CA-YASI and, even when scored correctly, the tool was not generating treatment recommendations that accurately targeted youths’ needs. The study’s authors found, “Very limited evidence that the CA-YASI domains...assess the risk factors they are meant to assess” (Skeem et al., 2013).

During intake, a youth’s treatment team, which includes YCCs and mental health practitioners, develop a case plan based on their initial assessment results and the CA-YASI recommendations. Case planning is meant to identify the suite of programming that would best address each youth’s underlying needs and prepare them for release. However, case plans often lack specificity or recommend treatments that DJJ is unable to provide. These shortcomings were made clear in the final Special Master report in which Farrell Mental Health Expert Dr. Bruce Gage identified ongoing deficits in the case planning process (PLO, 2016).¹⁶

D. Segregation during facility assignment

After approximately a month and a half in the reception center, all youth are transferred to their long-term facility and living unit. For male youth, this transition may mean remaining at Chad or being placed at the O.H. Close or Ventura facilities. DJJ administrators explained that a youth’s home county, whether in the northern or southern half of the state, as well as their need for specialized treatment, determines their facility placement (Tour, 2018). However, administrators also acknowledged that, in some cases, youth are assigned to facilities based on their gang affiliation, explaining that youth are separated with the goal of reducing gang violence (Tour, 2018). During facility placement, gang factors can supersede considerations about a youth’s distance from home and family (Tour, 2018). One DJJ administrator provided an example of a youth from Sonoma County who was placed at the Ventura facility due to his affiliation with the Sureños—a distance of more than 400 miles (Tour, 2018).

Data from December 2017 confirm that a number of youth are not being placed in the facility that is closest to their home county. For example, the Ventura facility, which does not have any specialty programs for male youth that are not also available in the northern facilities, reported that 20 youth, or 14 percent of the facility, is from a northern county, including Alameda, Sacramento, and Solano, which neighbor San Joaquin County, the location of the Stockton facilities (CDCR, 2018b). These data suggest that some youth are being placed hundreds of miles from their family and natural supports.

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“Intake is the most dangerous place in DJJ. That’s where most of the fights happen because people are from different neighborhoods. In McCloud it’s riots, riots, riots. That place is known for riots.”

(Youth Interview, 2018)

¹⁶ Dr. Gage urged DJJ to make the following improvements: Case plans should clearly identify medical, mental health, and dental needs; agency culture should recognize the importance of case planning; psychologists should be present at all case conferences and meetings; and case plans should be specific and include behavior targets and actionable steps for youth to achieve them.

Segregation reinforces gang identity and contravenes DJJ's stated goal of cultivating cooperation among youth and requiring them to live, work, and learn alongside those from differing backgrounds (Tour, 2018). Moreover, placing youth far from their home county due to a real or perceived gang affiliation imposes a great burden on families, making it more difficult for them to travel for visits. Excessive distance can erode the supportive relationships that are key to youths' well-being and an essential component of their successful reentry (Mitchell et al., 2016).

Several youth recently released from DJJ's northern facilities explained that Pine Grove was the only facility where youth were actively integrated. In their view, the practice of segregation that they witnessed at Chad and O.H. Close resulted in more intense conflicts between gangs than would have occurred had staff "dealt with it in the first place by integrating people" (Youth Interview, 2018).

E. Arbitrary unit assignment

In addition to receiving a facility designation, youth at DJJ are placed in a living unit that is meant to address their treatment and behavioral needs. Those diagnosed with a mental health disorder may be placed in a MHRU or, if they require the highest level of mental health care, they may be assigned to Chad's IBTP.

Mental Health: DJJ administrators claim that their mental health units are not designed as long-term placements. However, moving youth from more to less intensive services requires them to leave the relative safety of the mental health unit and quickly adjust to life in a general population unit, which can be traumatizing and disruptive to their treatment (Tour, 2018). In some cases, youth are transferred directly from the MHRU to a high core unit where they receive far less psychological support and must navigate gang politics and ongoing threats of violence (Staff Interview, 2018).

A youth's stay on the mental health units, and even their diagnostic results may depend on factors unrelated to their mental health, including their conduct and compliance. A staff member recounted instances in which staff on the mental health units at Chad referred to more docile youth as "good beds," and evaluated those youth as having continued mental health needs in order to retain them on the unit (Staff Interview, 2018). Conversely, youth with clear mental health needs who behaved defiantly towards staff—even when those behaviors stemmed from a diagnosable mental health disorder—could be prematurely returned to a core unit, or even placed on the BTP, in order to remove them from the unit's caseload. Disregarding genuine treatment needs in order to limit a living unit's behavioral challenges defies best practices, runs counter to DJJ's professed therapeutic aims, and places youth at risk.

Sexual Behavior Treatment: Male youth who are adjudicated for a sexual offense are placed in SBTP units at O.H. Close or Chad. Female youth who are placed at DJJ for a sexual offense receive an individualized Sexual Behavior Treatment curriculum on the female unit at Ventura (CDCR, 2009). The male SBTP units are relatively self-contained, with youth living and receiving treatment alongside other youth on their unit, and interacting with the general population only during school hours or when at work (Tour, 2018).

While most youth on the SBTP unit are placed there for a prior adjudicated sex offense and are assigned to the unit upon arrival, DJJ also reserves the authority to transfer youth into the SBTP for sexual offenses or acts that occur within the facilities. This transfer policy is detailed in the SBTP handbook, which explains that several noncriminal sexual behaviors prompt a review that could result in transfer to the SBTP (See Staff Abuse and Misconduct subsection)(CDCR, 2009).¹⁷

¹⁷ The following acts trigger a mental health referral, which could result in placement in the SBTP: "Making body contact of a sexual nature, not including battery; exposure of genitals; masturbation with exposure; and intentionally sustained masturbation without exposure."

Unlike the mental health units, the SBTP generally houses youth for the entirety of their stay at DJJ. In some cases, a youth's release from the facilities is predicated on their success in SBTP-specific programming, which moves youth through a series of "levels." Success on the SBTP, however, requires youth to acknowledge and discuss their offense in a group setting. An attorney explained that in one instance, a youth client was required to accept responsibility for a past allegation for which he was not adjudicated delinquent (Attorney Interview, 2018). Knowledge of this allegation resulted in ridicule from staff and youth that continued throughout his confinement at DJJ.

Core Units: DJJ's core units house the population of youth not assigned to a specialty unit. Core units consist of high core, moderate core, and low core units, with a youth's initial assignment determined based on a set of static factors, such as his adjudicated offense, which is assessed through the CA-YASI upon intake. Youth deemed highest risk are placed in the most restrictive unit—high core—while those found to be lowest risk are assigned to a moderate or low core unit. DJJ staff reportedly re-assess youth every 90 days and update their case plan at that time. With each subsequent administration of the CA-YASI, staff may take into account a youth's dynamic risk factors, such as their conduct at DJJ, and may consider assigning them to a more or less restrictive unit (Tour, 2018). Staff noted that some youth are moved to a new unit or even a new facility without input from their full treatment team (Staff Interview, 2018; Youth Interview, 2018).

DJJ's reliance on continual assessment suggests a level of precision and knowledge of individualized needs that is not reflected in their program offerings (See Programming section for more details). Although staff collect substantial data on youth in an attempt to pinpoint treatment needs, programs tend to be facilitated by custody staff rather than trained specialists, short-staffed, offered in a group setting, and disconnected from the real world, rendering them less effective at meeting a youth's needs (See Programming section for more details)(Staff Interview, 2018; Youth Interview, 2018). Arguably, the specificity of the CA-YASI belies the structural deficits in DJJ's treatment model.

Moreover, grounding consequential decisions about a youth's treatment plan or living unit assignment in a risk assessment instrument, which is susceptible to bias,¹⁸ can result in the disparate treatment of youth. Data on the unit assignment of youth show some racial and ethnic differences, though an understanding of equity issues with the instrument or its application at DJJ would require more extensive study. For example, in the one-year period from June 2017 to May 2018, Latino youth made up 57 percent of the mainline DJJ population, but were overrepresented in high core units (61% of youth) and underrepresented in the less violent low core units (48% of youth) (CDCR, 2018m). Troublingly, Latino youth constituted 76 percent of the BTP population during this period (CDCR, 2018m).

18 Research has questioned the predictive accuracy of risk assessment instruments (Elkovitch et al., 2008; Miller & Lin, 2007; Mills et al., 2007; Shook & Sarri, 2007). One study found that probation officers used their own set of criteria that had little to do with predicting recidivism (Lin et al., 2008). On the other hand, some instruments have been proven to be of value in predicting recidivism among individuals following release from incarceration (Bechtel et al., 2007).

MEDICAL CARE & MENTAL HEALTH

Key Takeaways

- Since the dismissal of the Farrell lawsuit in February 2016, there have been 28 attempted suicides in the institutions, 20 of which occurred at Ventura.
- DJJ facilities reported a total of 1,338 injuries to youth, about three injuries per day, from June 2017 to June 2018. Of those injuries, about half were caused by other youth and 51 required outside medical attention.
- Youth describe experiences in which their medical needs go unaddressed, including: delays in seeing a nurse, genuine symptoms being dismissed, and misdiagnosis.
- DJJ's mental health care model focuses on the acute needs of a small population of youth, while disregarding the broader population and the benefits of therapeutic programs.

Proper medical care and mental health services are critical to the overall health of youth at DJJ facilities. At DJJ, a youth's medical and mental health needs are addressed at intake through an initial screening process. A Suicide Risk Assessment Questionnaire (SRSQ) is to be conducted within one hour of a youth's arrival, and, in low-risk cases, a general assessment with a psychologist is to be completed within two working days. Additionally, a registered nurse is to screen each youth within one hour of their arrival, followed by a complete physical examination by a physician or nurse practitioner within seven days (See Intake & Unit Assignment section for further details)(CDCR, 2018o). DJJ claims to provide ongoing health care during a youth's commitment based on their disabilities, specified needs, and any health-related incidents that occur during their time at DJJ. In practice, some youth experience barriers to maintaining proper treatment and disability accommodations. A youth with a disability described numerous incidents in which their safety was put at risk due to staff reluctance and non-compliance with mandated accommodations (Youth Interview, 2018).

A. Injuries to youth

In the 13-month period from June 2017 to June 2018, a total of 1,338 injuries to youth were reported by DJJ facilities (the equivalent of over three per day). Of those injuries, 667 (50 percent) were caused by other youth and 51 required outside medical attention (CDCR, 2018k). Violence resulting in injuries varies by facility: sixty percent of injuries (345 total) at O.H. Close within the 13-month period were caused by other youth, while Ventura and Chad showed slightly lower rates with 45 percent and 43 percent of youth injuries caused by other youth, respectively (Table 3).

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“If you weren’t bleeding
or dying, you wouldn’t get
medical attention.”

(Youth Interview, 2018)

	CHAD		O.H. CLOSE		VENTURA		PINE GROVE	
	Monthly Avg	Total						
Injuries to Youth	30	390	44	575	26	316	4	57
Injuries to Youth Requiring Outside Medical Care	1	12	1	12	1	7	2	20
Injuries to Youth by Other Youth	13	169	27	345	12	142	1	11

Table 3. Injuries to youth by facility, June 2017-June 2018

Source: CDCR, 2018k.

Medical personnel respond to the majority of youth injuries within the confines of the facilities. In Fiscal Year 2016-17, the most recent year available, DJJ maintained a total of six physician positions and 74 nurse positions, including Registered Nurses, Nurse Practitioners, and Licensed Vocational Nurses (DOF, 2018). There are approximately 17 youth for each physician or nurse position at DJJ’s three correctional facilities. At Pine Grove, there is only one nurse position for the approximately 60 youth (DOF, 2018; CDCR, 2017f). Pine Grove shows the greatest dependence on outside medical care with 35 percent of youth injuries being treated outside of the institution (DOF, 2018). This may be due to the dangerous nature of youths’ daily activities during fire camp and/or the camp’s lack of a physician on staff.

B. Barriers to receiving medical attention

Interviewees noted challenges they or their peers experienced when seeking medical attention, including: delays in seeing a nurse, symptoms being shrugged off, and misdiagnosis leading to irreparable damage such as a bone healing incorrectly (Youth Interview, 2018). In order to receive health care services for a non-urgent matter, youth are required to fill out and submit a Health Care Services Request form via the “sick box” in their living unit (Tour, 2018). According to administrators at the Ventura facility, a night nurse collects and reviews the slips every night. The nurse then creates forms for appointments for youth whose requests are approved and summons youth for health care services (Tour, 2018). Youth in BTP units, which are highly restrictive and do not allow writing implements as a safety precaution, may need to request a pen or pencil from a custody staff member in order to fill out a sick form. This practice is out of step with standards, which require that only medical staff be involved in the process for youth to request medical attention (AECF, 2014, p.113). In the case of more urgent medical needs, staff are instructed to contact the facility’s health care providers and pursue immediate attention (Tour, 2018). However, youth recall instances in which staff were slow to respond to the urgent medical needs of their peers (Tour, 2018; Youth Interview, 2018).



Medical room at Ventura, which offers minimal daylight.

Certain medical and dental needs require youth from DJJ’s O.H. Close and Chad facilities to be transported to the Ventura facility, a distance of over 300 miles, for medical attention. At Ventura, youth can have minor procedures done by a surgeon on staff at the facility (Tour, 2018). Additionally, Ventura maintains DJJ’s only contract with an off-site oral surgeon, so youth are sent to the Ventura facility if they need oral procedures. Youth in recovery after procedures are housed in dedicated medical rooms at Ventura, which are bare aside from a hospital bed and a cart with medical supplies (Tour, 2018). Recent examples include a youth needing a root canal and multiple youth who suffered from broken jawbones being sent to Ventura for the proper procedures, sometimes for weeks (Tour, 2018). In one case, a youth was put in isolation following a fight that resulted in their jaw breaking, as they could not return to the original unit without risking an “accidental” injury (Tour, 2018).

C. Gender-responsive health care

Female youth at DJJ require certain medical care beyond the general population. At Ventura, where all female youth are committed, they have access to menstruation hygiene products (both pads and tampons) for free with a supply kept in the living unit and available upon request (Tour, 2018). If a youth is experiencing pain or cramping during menstruation, they can request to receive an over-the-counter pain medication such as ibuprofen. Healthcare staff can provide an order for pain medication for a two-month period, after which the youth must renew their request as needed (Tour, 2018). Additionally, all nurses present at the time of the tour were female and girls can have exams with a gynecologist as needed (Tour, 2018).

BEST PRACTICE

“Pregnant girls receive prompt prenatal care, including physical examinations, nutrition guidance, childbirth and parenting education, counseling, and provisions for follow up care.”

(AECF, 2014, p.114)

The need for gender-specific medical care is exacerbated in the case of pregnancy or parenthood. At the time of CJCJ's tour, there were no pregnant youth at DJJ, but there were two to three female youth who were mothers (Tour, 2018). Previously, counties would send girls to DJJ when they were well into their pregnancy. In some cases, girls would begin their DJJ commitment when they were eight months pregnant. The last pregnant girl at DJJ, which was approximately 1-1.5 years ago, arrived during her second trimester. She received prenatal care as well as mental health support during her pregnancy, and wore a pink uniform shirt to signal special protection, namely, from force used by custody staff (Tour, 2018). No information was provided on provisions of follow-up care and parenting education.

D. Increase in suicide attempts

At intake, all youth are to be assessed for suicide risk within one hour of their arrival at DJJ. Youth who show higher risk during the initial questionnaire are then referred to a staff psychologist as an emergency referral, which may result in Suicide Intervention status for the youth (CDCR, 2018o). If a youth shows suicidal ideation or attempts during their commitment, they may be placed on Suicide Intervention, Suicide Watch, or Suicide Precaution status.

Attempted suicides, which include suicidal behavior, self-injuries, and self-harm, have increased since the dismissal of the Farrell lawsuit. In the one-year period during the dismissal of the suit (August 2015-July 2016) there were three attempted suicides. In the most recent one-year period (August 2017-July 2018) there have been ten attempted suicides by youth within DJJ. Since the dismissal of the Farrell lawsuit in February 2016,¹⁹ there have been 28 attempted suicides in the institutions, 20 of which occurred at Ventura. Incidents at the Ventura facility are driving the recent spike in attempted suicides. From June 2017 to June 2018, Ventura had the highest number of Suicide Intervention placements of all DJJ facilities at 136 placements—23 percent higher than the other three facilities combined during this same period (CDCR, 2018k).

As part of DJJ's suicide prevention practices, suicidal youth may be placed in rooms that are essentially isolation cells with all items removed (Tour, 2018). These cells are nearly identical to those that high-risk youth are placed in on the BTP and run contrary to the facility standards (Tour, 2018). One staff, when interviewed, recalled an incident in which a custody staff person placed a youth in a suicide room due to threats the youth was receiving from peers on their unit—not because the youth was suicidal (Staff Interview, 2018). After a psychologist assessed and confirmed the youth was not suicidal, and that placement in a suicide room was therefore not appropriate for the youth's safety and well-being, custodial staff ignored the psychologist and the youth continued to be kept in the suicide cell against protocol.

E. Mental health care focuses on acute needs

DJJ adheres to a mental health care model that focuses resources on the acute needs of a small population within the facilities. This practice disregards the mental health needs of the broader population, which could benefit from a therapeutic and trauma-informed approach to care. In particular, PTSD is more prevalent among youth in confinement settings than other samples of adolescents; many more have witnessed at least one act of violence or a traumatizing event in their adolescence

BEST PRACTICE

"Trauma informed care involves providing unconditional respect to the child and being careful not to challenge him/her in ways that produce shame and humiliation."

(Hodas, 2006, p.40)

¹⁹ No data on attempted suicides at DJJ were collected in September or October 2016.



Exterior of a cell for suicidal youth at O.H. Close.

(Steiner, 1997). That being said, all youth can benefit from a trauma-informed approach in which every adult who works with a young person presumes that young person has been exposed to trauma (Hodas, 2006, p.40). This broader view of, and response to, the mental health needs of youth creates positive youth-staff interactions and can ultimately help youth replace harmful or unsafe behavior with healthy coping skills.

Mental health services at DJJ center on youth with diagnosable mental health needs, which are generally based on assessments by mental health clinicians during the intake process.²⁰ In November 2015, three months before the Farrell litigation ended, staff at Chad and O.H. Close did not identify youths' mental health, medical, and dental needs in their initial case plans (PLO, 2016, p.4). At the same time, they noted "a shortage of psychologists [at Chad] with none assigned to core units. Thus, there are essentially no psychological treatment services being provided to youth on core units" (PLO, 2016, p.1). Presently, O.H. Close and Chad jointly rely on only two psychiatrists (Tour, 2018). Chad's MHRU maintains 1.5 psychologist positions, and one assigned to serve two core units (Staff Interview, 2018). At Ventura, mental health staff include 6.5 psychologists and two psychiatric technicians. Ventura maintains 1.5

psychologist positions on the MHRU and two on the female unit—a slight staffing increase from its previous staffing level of just one part-time psychologist (Tour, 2018).

An average of 58 DJJ youth were in mental health program placements at the end of each month between June 2017 and June 2018, with a high of 73 in February 2018 (CDCR, 2018k). During this period, an average of 64 youth were on psychotropic medication at the end of each month, none of whom were involuntarily medicated (CDCR, 2018k). Mental health services are divided into three types of treatment and programming: outpatient

20 During intake, youth are screened through CA-YASI and Substance Abuse Subtle Screening Inventory (SASSI) to identify needs in the area of substance abuse (CDCR, 2018o). From June 2017 to June 2018, DJJ correctional facilities implemented an average of 57 Substance Abuse Treatment Program groups per month (CDCR, 2018k).



MHRU at Chad, where youth are observed sitting idly and watching television.

mental health services,²¹ residential mental health programs, and inpatient mental health programs.²² Youth who are not identified with mental health programming needs are placed on core units, which provide only crisis intervention and do not offer therapeutic services (CDCR, 2018o).

Mental Health Residential Unit: The MHRU is a living unit for youth with mental health needs that impact their ability to participate in a core unit, so the goal of MHRU programming is to prepare youth to transition to a core unit as soon as possible (See Intake & Unit Assignment section for more details)(CDCR, 2018o; Tour, 2018). At Chad, the unit has enhanced staffing with one psychologist, three YCCs during the day, and four staff on duty at night (Tour, 2018). As of June 2018, 23 youth were in the MHRU at Chad and 18 at Ventura (41 total), which marks a 32 percent increase since June 2017 (CDCR, 2018k). DJJ maintains MHRUs at Ventura and Chad with capacity for 48 male youth (24 beds per facility) and 24 female youth (CDCR, 2018o).

Clinical staff provide treatment including psychosocial therapy and group psychoeducational groups (Tour, 2018). Youth who are not diagnosed with mental health needs reportedly seek placement in the MHRU at Chad since it is rich in treatment and therapeutic programming unlike the core units (Tour, 2018). A staff member confirmed this problem of misplacement of youth in the MHRU, but adds that the violence and trauma youth experience in their core units often lead them to seek the relaxed, therapeutic environment provided on the MHRU (Staff Interview, 2018). Administrators intend to resolve this misplacement issue by implementing more programming in the facility's core units (Tour, 2018). However, in a recent tour of the MHRU at Chad, the daytime programming reflected that of core units: most youth were sitting in front of the TV watching a cooking show while a few others

21 Outpatient services (e.g., screenings, assessments, medication management) are provided in DJJ core units as a supplement for youth with mental health needs that are not addressed in their assigned programming (CDCR, 2018o).

22 Inpatient mental health programs are provided by the California Correctional Health Care Services. Ventura primarily relies on the Department of State Hospital inpatient facility in Patton as well as the Correctional Treatment Center (CTC) at the California Institution for Women (CIW), an adult institution run by CDCR (Tour, 2018).

were gathered together at a metal table playing cards (Tour, 2018).

Intensive Behavior Treatment Program: DJJ maintains a residential IBTP unit, which is intended for youth unable to function or receive services in a non-mental health or MHRU setting. The IBTP is located at Chad, serving only males, with capacity for 16 youth (CDCR, 2018o). As of June 2018, seven youth were in IBTP (CDCR, 2018e). The program is reserved for youth with the most serious mental health conditions such as mania, psychosis, and suicidality (Tour, 2018). Although IBTP is intended to prepare youth for reintegration into core living units, daily life in an IBTP unit is restrictive and isolated. From June 2017 to June 2018, IBTP youth experienced an average of 9.5 hours out of their cell daily, which is approximately 1.5 hours shorter than the 11 hour average of all youth at DJJ correctional facilities (CDCR, 2018k).

“

“ They’re supposed to be Youth Correctional Counselors and they’re not counseling.”

(Youth Interview, 2018)

Sexual Behavior Treatment Program: DJJ’s SBTP is located in three residential units at O.H. Close and Chad serving a population of approximately 60 youth (CDCR, 2018e). At a maximum, each SBTP unit can house 36 youth (Tour, 2018). The SBTP is intended for youth who have been placed at DJJ for a sexual offense and/or have a history of sexual offenses. Additionally, youth who engage in sexually inappropriate behavior while at DJJ, which may include a consensual sexual act between youth, are at risk of SBTP placement (See Intake & Unit Assignment section for more details)(CDCR, 2018n, p.6,14). Educational and vocational programming for these youth are integrated with the general population, which has been reported to result in the mistreatment of SBTP youth at school by their peers (See Violence section for more details)(Staff Interview, 2018; Tour, 2018).²³

²³ Just as in adult prisons, a sex offender label can have severe consequences for youth at DJJ, including harassment and assaults by staff and other youth (Staff Interview, 2018; Youth Interview, 2018).

PROGRAMMING

Key Takeaways

- Prison-like conditions, paired with perfunctory implementation by custody staff, render programming ineffective.
- Very little programming exists at DJJ beyond school and work, resulting in excessive idle time that can contribute to violence and negative health impacts.
- DJJ relies on outside groups to provide critical programming, and participation is limited.

Intervention programming at DJJ is largely structured in a group setting led by custody staff on the youths' living unit. Resource groups emerged in the 1960s as part of the reform period of that time and promised to rehabilitate youth through positive programs that focused on social-emotional skills (Macallair, 2015, ch.3). Today, these programs are promoted as the key ways in which DJJ rehabilitates youth in its care, but questions remain about the effectiveness of such programming. Successful delivery of services is compromised by DJJ's prison-like institutional setting paired with the insufficient qualifications of custody staff who are responsible for facilitating group interventions. DJJ offers no measures of success for its programs beyond the outcomes youth experience after leaving DJJ, which are characterized by high rates of recidivism (See Release Process & Outcomes section for more details). The problems youth face post-commitment render DJJ's rehabilitative programs largely irrelevant.

A. Superficial group interventions

An allegation in a 2018 report by the Office of the Inspector General raised concerns about the reliability of DJJ program data, finding that "a senior youth counselor allegedly falsified group intervention sign-in and reporting forms" from January to April 2017 (OIG, 2018a). On March 7, 2017, the same Senior YCC allegedly falsified documentation for advanced treatment group counseling and instructed an officer to obtain signatures from youth to indicate they received programming that they, in fact, did not (OIG, 2018a).

Any emphasis DJJ might put on group work is stunted by a culture of violence and distrust in the institution (See Violence section for more details). Youth cannot be expected to express and acknowledge vulnerability within a group when they continue to be impacted by routine incidents of violence and abuse in the facilities. One youth describes these programs simply as a curriculum that the "higher-ups," or administrative leaders, develop: "Even the staff on the floor are like, 'What is this? How are we going to help guys out with this kind of stuff?' It has nothing to do with the challenges we face on the outside" (Youth Interview, 2018).

The general population at DJJ participates in intervention groups including Aggression Interruption Training (AIT), CounterPoint™, and Skill of the Week exercises. Skill of the Week, which highlights a specific social-

emotional skill each week, is conducted in large groups led by YCCs (CDCR, 2018o). Skill of the Week groups have been observed during CJCJ tours as a perfunctory practice with a YCC simply reading the “skill” description aloud without meaningful discussion or skill-building opportunities (CDCR, 2018o; Tour, 2016). AIT is meant to focus on anger control and moral reasoning, while CounterPoint™ is designed to address anti-social attitudes and influences (CDCR, 2016a). One gender-responsive program called Girls...Moving On™ is provided at Ventura for the female unit, which focuses on girls’ unique personal histories and emotions. It was noted in 2012 that “females in DJJ receive far fewer services—of almost every type—than males” (Maxson et al., 2012). The Girls...Moving On™ program continues to meet about twice weekly, and is the only gender-responsive intervention program available at DJJ (CDCR, 2018k).²⁴

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“Bring in that mentoring aspect to be able to have that intimacy, to show them that there’s a person that’s willing to sacrifice time to be their individual person.”

(Youth Interview, 2018)

In 2011, DJJ’s space limitations and prison-like environment were noted as a barrier to successfully improving the quality of care at the facilities (Krisberg, 2011). Programming today continues to be implemented under the same conditions and has been criticized as “treatment behind razor wire” (Krisberg, 2011). Further, observations of intervention groups (AIT, Advanced Practice, CounterPoint™, and Girls...Moving On™) used to be carried out regularly, but were discontinued in November 2017 (CDCR, 2018k). Without any measures of success during youths’ stay at DJJ, the impacts of these interventions remain unclear.

B. Access to outside programs

Community-based organizations provide culturally responsive and effective programming for justice-involved youth in their communities. In 2018, DJJ developed an Innovative Grants Program to bring community-based approaches and youth development supports into its institutions, offering one-time grants that would require programs to secure alternative funding to sustain their services (CDCR, 2018q). Funded programs include the El Joven Noble program, the Marin Shakespeare Company, and Inside Gardens programs (Tour, 2018). The Innovative Grants Program begins to address youths’ needs for more mentoring, particularly by formerly incarcerated and justice-involved mentors (Maxson et al., 2012). Nevertheless, programming in a restrictive setting lacks the essence of support in a community context.

Additionally, youth at DJJ may participate in religious services offered at the facilities (CDCR, 2018k). A majority of youth at Ventura and Pine Grove took part in religious meetings from June 2017- June 2018, whereas participation at Chad and O.H. Close hovered at 20 percent (Table 4). Youth generally agree that religious services are available for a wide range of religious beliefs (Youth Interview, 2018). Previous reports acknowledge religious service provisions and documentation as well done, which is critical for young people seeking support and guidance that aligns with their beliefs during their stay at DJJ (Krisberg, 2011). Far fewer youth participate in community organization meetings, with the lowest participation rate averaging 15 percent of the facility population at Ventura (Table 4).

²⁴ Traditionally, girls have faced barriers to receiving adequate programming (Chesney-Lind & Shelden, 2013).

	CHAD		O.H. CLOSE		VENTURA		PINE GROVE	
	# Youth	% ADP*	# Youth	% ADP*	# Youth	% ADP*	# Youth	% ADP*
Youth attending religious meetings	43	20.0%	34	20.4%	121	66.2%	25	47.2%
Youth attending other community organization meetings	74	34.1%	31	18.7%	28	15.3%	19	36.0%

*ADP refers to the Average Daily Population for the associated month at each facility.

Table 4. Youth involved in religious and community meetings, monthly averages, June 2017-June 2018

Source: CDCR, 2018k.

DJJ’s northern facilities have a Foster Grandparents program, which has been operating since 1965 to provide mentoring and tutoring to youth (Tour, 2018). Ventura also partners with the Citizens Advisory Committee (CAC), a volunteer-based nonprofit that visits the facility three times weekly for programming (Tour, 2018). The CAC provides scholarships to youth, facilitates a book club with peer-to-peer reading for youth, and holds monthly lunches for youth and volunteers (Tour, 2018). One volunteer with the organization notes that the one-on-one mentoring program has been discontinued and would benefit youth if reinstated (Tour, 2018). These programs, run largely by volunteers, show genuine commitment to the wellness of youth, but also point to DJJ’s reliance on outside groups for critical programming despite its sizeable budget.

C. Recreation

Daily life for youth in DJJ’s three correctional facilities generally consists of waking up at about 6 am for a count, having breakfast soon after, and spending much of the remaining time in the living unit’s day room unless enrolled in school or work. Day room activities included in a sample schedule are listed as cards, board games, and dominos (Tour, 2018). These offerings fall short of facility standards, which require “a range of choices for recreational activities in dayrooms” including opportunities to draw, paint, listen to music, create music, read, and write letters (AECF, 2014, p.139). The Safety and Welfare Remedial Plan established a “Program Service Day” to maximize out-of-room time at DJJ according to best practices by creating a coordinated schedule at each facility (CDCR, 2006). This was developed to reduce reliance on unstructured activities with minimal staff interaction, but youth report that the implementation of programming remains largely the same (CDCR, 2006; Youth Interview, 2018).

Daily programming, including out-of-room and outside recreation time, is contingent on safety and security conditions within the facilities (See Violence section for more details). Youth reported frequent cuts to programming, or Limited Program, due to violence or security incidents elsewhere in the facility, which they viewed as attempts by staff members to minimize their professional responsibilities (Youth Interview, 2018). Unstructured and unsupervised time plays a role in the likelihood of fights between youth, with significant amounts of idle time in a unit’s day room often leading to conflict between youth (Maxson et al., 2012). Youths’



Youth play cards together in Ventura's BTP unit.

programming is negatively affected by unresolved issues of violence on living units.

Youth in the general population at DJJ facilities, excluding Pine Grove, received an average of 11 hours out of their cells each day between June 2017 and June 2018 (CDCR, 2018k). With this, youth spend approximately 5 hours of non-sleeping time in their cells each day. During recent facility tours, which took place during the summer break from school, most youth were unoccupied and indoors (Tour, 2018). CJCJ staff observed youth occupying themselves in the day rooms by watching TV in rows of seats, playing cards with peers and/or a staff member, or sitting in their cells. Consistent with observations during these tours, one staff member expressed concern for the mental health and social development of youth, stating that a lack of programming leads youth to sleep in their cells throughout the day (Staff Interview, 2018).

EDUCATION

Key Takeaways

- In 2018, just 8 percent of students at Chad, 3 percent at O.H. Close, and 3 percent at Ventura scored proficient in reading, while zero students tested proficient in math, despite per pupil spending nearly seven times higher than the state.
- Classes at DJJ lack rigor and are frequently interrupted by fighting and disorder.
- Special education services are inconsistent and, in some cases, in violation of students' rights.

For youth involved in the juvenile justice system, educational attainment is a key predictor of success after release (Farn & Adams, 2016). However, justice system involvement and detention itself can negatively affect the quality of a youth's education and reduce their likelihood of graduating (Kirk & Sampson, 2013). Although DJJ offers high school, vocational, and community college classes in its facilities, these programs lack rigor and leave youth ill-prepared for further education or employment after their release. Further, classes are frequently suspended or cancelled, interfering with youths' educational progress.

A. Low-performing high schools

Youth who enter DJJ without a diploma are generally enrolled in a high school program, although those with confinement terms too short to allow them to complete the school curriculum are enrolled in the GED program (Tour, 2018). DJJ operates a high school in each of its three large facilities, with some teaching staff assigned to the Pine Grove facility for youth who did not complete the curriculum before beginning their firefighting service (Staff Interview, 2018; Tour, 2018).

Test results from DJJ's three high schools—N.A. Chaderjian High School at Chad, Johanna Boss High School at O.H. Close, and Mary B. Perry High School at Ventura—show consistently low levels of academic achievement. In 2018, only 8 percent of students at Chad, 3 percent at O.H. Close, and 3 percent at Ventura scored proficient in reading, while no students at O.H. Close, Chad, or Ventura scored proficient in math (See Appendix B)(CDE, 2018; 2018a; 2018b).

Youth and staff described the school experience at DJJ as generally unchallenging (Staff Interview, 2018; Youth Interview, 2018). Youth referred to their schoolwork as “a joke” and staff explained that members

BEST PRACTICE

“It is the policy of the state that all youth confined in a facility of the Division of Juvenile Facilities shall have the following rights: To receive a quality education that complies with state law, to attend age-appropriate school classes and vocational training, and to continue to receive educational services while on disciplinary or medical status.”

(WIC § 224.71)

of the faculty have low expectations for students (Staff Interview, 2018; Youth Interview, 2018). Interviewees explained that school is frequently interrupted by fighting and teachers seek to maintain calm in their classrooms by acceding to student requests. This can include watching TV for the duration of class or rewarding youth with candy or other snacks (Staff Interview, 2018; Youth Interview, 2018). A youth explained, “even teachers were reduced to what they could do for us based off the facility and the kickoffs” (Youth Interview, 2018). In classes CJCJ observed during a 2016 tour of DJJ’s Chad and O.H. Close facilities, many students were simply filling out individual paper packets rather than receiving educational instruction.

B. Deficiencies in special education

Similar to schools in other youth correctional facilities, a large percentage of DJJ’s student population is entitled to special education services (NDTAC, 2014). Data from the Department of Education indicate that, in December 2017, 90 youth, or 30 percent of high school students at DJJ, were enrolled in special education (CDE, 2018c; CDE, 2018d). The most common disabilities among youth at DJJ were “emotional disturbance” and “specific learning disability” (CDE, 2018c). Several staff members disclosed that the special education program at DJJ’s schools is failing to provide students with mandated services. Staff described instances of youth being denied necessary accommodations required through their Individualized Education Program (IEP)²⁵ and being asked to sign off on special education hours without receiving services (Staff Interview, 2018).

Youth who have a behavioral issue in a DJJ classroom can be removed and placed in a short-term discipline classroom, the Alternative Behavior Learning Environment (ABLE). However, a staff member with knowledge of the issue believed that students with IEPs were being removed from the classroom and sent to ABLE more often than youth without IEPs, and that some students receiving special education service were being unfairly disciplined for behaviors that stemmed from their disabilities (Staff Interview, 2018). This practice violates standards requiring that, “Facility staff and school personnel do not inappropriately discipline youth for behaviors that are manifestations of their disabilities” (AECF, 2014, p.137).

“

“The school environment in there is poor. The way they do school, you can get your diploma like this [snaps fingers] because the homework is so easy in there. It’s baby homework. They’re not teaching them anything. As long as you show up, you get your credits. And that’s not teaching them stuff.”

(Youth Interview, 2018)

²⁵ An Individualized Education Program (IEP) is a plan for services and supports that must be provided to students with disabilities to ensure that they can access and progress through the school curriculum.



Classroom for youth in Chad's BTP unit.

C. Wasteful spending and opaque decision making

DJJ's three schools form a school district, termed the California Education Authority Headquarters, which serves just approximately 300 students annually (CDE, 2018d). Despite its relatively small student population, DJJ's school district employs an uncommonly large number of administrators and non-teaching staff, including a superintendent and assistant superintendent of the district and a principal and assistant principal at each facility high school. This is concerning given the high and rising cost of education at DJJ, which, at \$24 million in Fiscal Year 2018-19, translates to more than \$75,000 per unique student enrolled in high school or a vocational education program (CDCR, 2018m; DOF, 2018a). By contrast, California spends just over \$11,000 per pupil on its K-12 schools and reports an average student-to-administrator ratio of 315-to-1 compared to approximately 30-to-1 at DJJ (CBPC, 2017; 2018; CDE, 2018d; DOF, 2018; Staff Interview, 2018).²⁶

Although DJJ's schools constitute a district, they are not overseen by an elected school board, but instead centralize decision making with the superintendent and principals, reducing transparency. In most California districts, school boards play a critical leadership role, providing accountability and making strategic decisions for the district (CSBA, 2018). In the absence of a board, DJJ's Superintendent of Education is granted the sole authority to make educational decisions for the district and, according to staff, does not have a process for

²⁶ The student-to-administrator ratio is determined by dividing the population of youth enrolled in DJJ schools in the 2017-18 school year by an estimate of the supervising staff positions authorized in 2017-18, which include two administrators at each school (Chad, O.H. Close, and Ventura), as well as three district-wide administrators (DOF, 2018). Further insight into this hierarchy was provided by a staff interviewee (Staff Interview, 2018).

soliciting feedback from teachers or students (Staff Interview, 2018). For example, the Superintendent recently purchased a project-based learning curriculum for the district and hired trainers from LA County to brief staff on the new approach. However, staff describe slow and reluctant adoption of the new method because, in their view, it is a poor fit for a correctional school environment where class rosters fluctuate and youth may not remain at a facility long enough to complete a multi-disciplinary project (Staff Interview, 2018).

D. Staff and youth absences

During our tour, the Superintendent of Education explained that it is difficult to hire and retain skilled teachers because the facilities are located remotely, which requires staff to commute long distances (Tour, 2018). In Fiscal Year 2016-17, DJJ schools employed 55 high school teachers, not including librarians, administrators, vocational education teachers, and teaching assistants (DOF, 2018). Staff explain that teachers are frequently absent, requiring the schools to rely on substitutes to cover a substantial share of the teaching load (Staff Interview, 2018). Emails staff received from principals and other school leaders support this assertion, showing that multiple class periods each day were being taught by substitutes or staff who were not typically assigned to the class (Staff Documents, 2018).

Data indicate that youth are also absent from school at relatively high rates. In the one-year period from August 2017 to July 2018, Chad and O.H. Close's student absence rate averaged 13 percent, while Pine Grove and Ventura's rate averaged 10 percent (CDCR, 2018k). As a correctional facility with a required daily routine, it is unclear what accounts for these student absences, though they could be attributable to unit lockdowns or youths' refusal to attend school. DJJ notes that some of the absences include youth who are receiving medical treatment or who are in court (CDCR, 2018r).

E. Limited post-graduate opportunities

Across the four DJJ facilities, an average of 53 percent of youth were considered high school graduates or GED recipients during the one-year period from August 2017 to July 2018 (CDCR, 2018k). Generally, once youth complete high school or pass the GED, they may participate in vocational education programs, enroll in community college, or accept a job in the facility. Data indicate that average enrollments in community college programs during the one-year period from August 2017 to July 2018 were fairly low: 18 youth at Chad, 11 youth at O.H. Close, one youth at Pine Grove, and 40 youth at Ventura, which represents just 21 percent of the graduate population at DJJ and shows a lack of emphasis on continuing education (CDCR, 2018k).

Both graduates and non-graduates may enroll in vocational education programs, some of which allow them to earn certificates. In 2017, DJJ provided opportunities for certificates in the areas of forklift operations, food handling, and computer fundamentals (CDCR, 2018m).²⁷ A staff member described the vocational programs at the northern facilities as limited and superficial, providing the example of a cooking class instructor who does not allow youth to cook or handle kitchen equipment (Staff Interview, 2018). Youth who had participated in vocational programs emphasized the speed with which they collected certificates, and one youth described completing a forklift certificate in just a week (Youth Interview, 2018). Seemingly, youth could quickly exhaust their post-graduate educational opportunities.

During CJCJ's tours, we observed the Free Venture program at Chad, which trains youth in refurbishing and recycling computers, and the Code 7370 program at Ventura, which instructs youth in basic coding with remote

²⁷ Despite its younger and relatively small population in 2017, O.H. Close awarded the greatest number of certificates (53) compared to just 24 at Chad, three at Pine Grove, and 23 at Ventura (CDCR, 2018m).

assistance from individuals incarcerated at San Quentin State Prison (Guynn & Diskin, 2018; Tour, 2018). Although both programs appeared highly engaging for youth and entail months-long periods of participation, they can only accommodate a fraction of the population (Tour, 2018). For example, the much-touted Free Ventures program, which pays youth a special starting wage of \$10.50 per hour, is only available to youth who have achieved an incentive level of A or B, approximately 36 percent of the population, though fewer than ten youth were in the program at the time of our tour (CDCR, 2018k; Tour, 2018). Strong vocational programs that equip youth with marketable job skills are essential for success after release, but should be available to all youth as a central component of DJJ’s rehabilitative model.

Given the facilities’ limited post-graduate educational opportunities, some youth and staff explain that youth who have graduated from high school or passed the GED tend to spend significant time each day laying in their beds or sitting in the day rooms inside the unit (Staff Interview, 2018; Youth Interview, 2018). For this reason, there is a perception among interviewees that both staff and students seek to prolong high school to reduce the number of youth with unstructured days (Staff Interview, 2018; Youth Interview, 2018). A staff member explained, “They don’t pass classes on purpose because life gets boring real quick. There are limited opportunities” (Staff Interview, 2018). The result is a population of youth who have not made sufficient progress in their education while confined at DJJ. In 2017, 36 youth over the age of 19 were released from the facilities without having received a high school diploma or GED (CDCR, 2018m). For youth committed to the facilities for years, some until they are 23 or 25 years old, the number of post-graduate educational offerings are insufficient to occupy their time and prepare them for life after release. When youth are not continually engaged in education, they spend their time outside of work watching TV or sitting in their cell or day room. The boredom of unstructured time in close quarters can lead to conflicts among youth and violence on the living unit.

A vocational education classroom at Ventura.



CONTACT WITH FAMILIES

Key Takeaways

- DJJ facilities are far from home: 52 percent of youth at Chad and O.H. Close, 48 percent of youth at Ventura, and 66 percent of youth at Pine Grove are from counties further than 100 miles from the facility.
- DJJ maintains strict visiting policies, including limits on physical contact and holiday visiting policies that are more restrictive than CDCR adult facilities.
- Youth experience extreme isolation at DJJ, with many families unable to visit due to lack of resources and long distances to the facilities. Families that do visit are subject to body searches and other high-security measures.

Opportunities for youth to meaningfully engage with family members are vital to their well-being while at DJJ and their success in the community upon release.²⁸ However, among the youth and family members interviewed for this report, nearly everyone remarked on the challenges and limitations they faced when trying to stay connected.

A distraught mother expressed that she has not seen her son even once in the two years he has been at one of DJJ's facilities (Family Interview, 2018). As a parent facing poverty and relying on public transportation, travelling to a remote facility that is inaccessible by public transit, and hours by car, is simply not feasible. Even families who visited regularly experienced similar barriers: one mother planned extensively with family members to make sure one person would visit her child each week, and struggled to imagine how the many families who lived further from the facility would manage this challenge (Family Interview, 2018). DJJ's remote and highly restrictive facilities fail to support families in building and maintaining relationships.

A. Restrictive visitation

Youth interviewees stated that the majority of their peers did not receive visits, citing long distances, discriminatory practices, finances, and lack of familial relationships as major barriers to family visitation (Youth Interview, 2018). Youth who received visits from their family during their time at DJJ recognized that “a lot of these kids don't have parental support; they don't have that emotional relationship at all with them” (Youth Interview, 2018). Family members that are allowed to visit are limited to parents, step-parents, legal guardian, legal wife, children, and siblings. Other important people in a young person's life, such as a girlfriend or boyfriend, may only visit youth on a higher behavior phase with additional approval (CDCR, 2018o).

A youth's access to visits depends on their behavior phase. This practice treats contact between a youth and

²⁸ The importance of family engagement for a youth's wellness and rehabilitation is evidenced by years of research (Caitlin, 2015; Cochran, 2013; Shelden, 2012).

“

“When I came out, I was different. I couldn't have conversations with people, even with my family. I felt cut off because they isolate you.”

(Youth Interview, 2018)



Ventura's visiting space in a shared cafeteria-like setting.

their family as an incentive for good behavior rather than an asset in the youth's development. At the northern facilities, youth who have maintained an above average program (A Phase) are allowed to receive visits on both Saturdays and Sundays for the full visiting period, but the opportunity for family engagement scales down for youth on D Phase, who are only allowed visitors one day per weekend (CDCR, 2018o). Visiting opportunities are most restrictive when youth are assigned to a BTP unit; they may be allowed shortened visits by appointment only and must meet in a separate space from other youth (CDCR, 2018o; Tour, 2018). This practice is especially problematic given that youth who are having trouble in a DJJ facility are already distressed by isolation and would likely benefit most from familial support.

DJJ correctional facilities hosted an average of 335 visitors²⁹ per month between June 2017-June 2018, which is the equivalent of approximately 80 visitors per weekend at each facility (CDCR, 2018k). This would be concerning in itself given that youth populations are over double that at each facility, but the number of youth who actually receive visits is likely far lower since each youth can receive up to five visitors at one time (CDCR, 2018o).³⁰ Visits are held on Saturdays and Sundays from approximately 9 am to 3:30 pm, and are not held on holidays such as Thanksgiving and Christmas (Tour, 2018). DJJ's visitation policy stands in contrast to that of all other adult prisons in California, which offer visiting hours on Christmas and Thanksgiving among other holidays (CDCR, 2018s). By limiting visitation during holidays, the hardest time of year for many individuals in incarcerative settings, DJJ fails to support youth who are experiencing the pain of separation from their families.

All visits at DJJ correctional facilities are held in multipurpose rooms with tables set up cafeteria-style to accommodate the visiting families in a shared space, a format that defies recommendations that facilities maintain

29 DJJ does not maintain records on the number of unique visitors or youth who participate in visits at Chad, O.H. Close, and Ventura correctional facilities (CDCR, 2018m).

30 From June 2017 to June 2018, Pine Grove hosted an average of 99 visitors per month (CDCR, 2018m). In an average month, approximately half of youth at Pine Grove (34 youth) received one or more visits and only three youth received four or more visits (CDCR, 2018m).

designated space for visits (Sturges & Al-Khattar, 2009). Visits are conducted under supervision, with DJJ custody staff remaining in close proximity to families for sight monitoring (Tour, 2018). For example, the Chad visitation room can accommodate up to twenty families as a staff member monitors visits from a glass-windowed station and a few uniformed custody staff walk around the room to monitor more closely (Tour, 2018). Youth and their families are limited to seated interactions at a relatively low noise level. They may talk and play games together if any are available, which can be rare as games are not provided by the facilities nor allowed to be brought in, but may be donated to DJJ by families (Tour, 2018).

DJJ maintains a set of strict rules and restrictions regarding visitors' behavior, belongings, and clothing,³¹ and may turn away visitors for noncompliance (CDCR, 2018o). In practice, staff reportedly vary in their implementation of policy, leaving families confused by inconsistency in what is considered acceptable and what can result in the termination of their visit. Additionally, outside items such as food and beverages are not allowed so families must rely on costly vending machines at the facilities during visits. Youth and families note that visits at Pine Grove are less restrictive than at the three correctional facilities. Families can walk around together, have more affectionate contact, and socialize with other youth and their families (Family Interview, 2018; Youth Interview, 2018).



Cabinet in Ventura's visiting area containing the few donated toys and games available for use during visits.

When visiting, family members of youth report seeing them frisked by custody staff when they enter the visiting space. A parent describes looking away because they cannot bear to witness their child being searched every time they visit (Tour, 2018). One youth explains a similar pain: "The way they make us look, they make you look like prisoners. Even when you go to see your parents we all have the same things on. We look like we're bound to that [identity]" (Youth Interview, 2018). Visitors at DJJ are also subject to disruptive security measures. They may be randomly searched and must pass through a security

checkpoint, during which they remove their shoes and belt, lift pant legs to show they are not concealing anything, and pass through a metal detector. A parent described the experience as uncomfortable, especially when bringing her young son who was subject to the same high-security customs (Tour, 2018).

The only physical contact that youth are allowed to give or receive is a hug and kiss at the beginning and end of the visit. Other contact during the visit, such as hand holding, hugs, or kisses are prohibited.³² DJJ policies on physical contact are even more restrictive than many CDCR adult facilities, which allow visitors to hold hands

³¹ Inappropriate clothing includes denim, khaki pants, "excessively tight clothing," "oversized pants," or clothes with certain colors such as red and blue (CDCR, 2018o).

³² As an exception, youth at DJJ are permitted to hold their child and/or their visitor's child during the visit (CDCR, 2018o).

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“At Chad, you have to sit down the whole time. You’re not allowed to get up. Your parents can get you food from the vending machine but they’re not allowed to bring food in because of some security thing that happened in the past. It’s super expensive. My mom was forking out 40 or 50 dollars when she was there just to get me some Starburst and snacks.”

(Youth Interview, 2018)

throughout the visit (CDCR, 2018t). Limiting physical contact between a child and a parent or family member negatively impacts family relations and the youth’s well-being amid the many challenges they already face during confinement. Restricted physical contact is further devastating to youth and their families when grappling with difficult experiences, such as the death of a loved one.

Given the low rates of visits youth receive, overcrowding is not frequently an issue during visitation, but DJJ staff are authorized to cut visits short to allow other families to visit if necessary. This policy provides an opportunity for staff to abuse the practice by terminating or cutting visits short for select youth. Some youth have experienced family members being turned away upon arrival, or even suspended from visiting for a period of time, for unclear reasons. Multiple youth described vague reasons for their families’ suspensions, such as a staff member suspecting their car smelled like marijuana—the common belief being that certain families were targeted due to a youth’s lack of favor among staff (Youth Interview, 2018). After a suspension, which youth cite as three months, family members must reapply and re-submit all the paperwork required for visits (Youth Interview, 2018). One youth expressed that

the suspension of his family “played a huge part in [his] stress to the point where it made [him] very angry” (Youth Interview, 2018). Such experiences not only hurt the young people who depend on their families for support, but further discourage family members from visiting regularly, especially those who have spent a significant amount of money and time to travel the long distance to DJJ facilities.

B. Far distances from home

DJJ maintains facilities in remote areas far from the families and communities of youth they most often serve. Juvenile justice standards emphasize that “whenever possible, youth in [out-of-home] placements should remain close to home” (Davis et al., 2014). In June 2018, the majority of youth at DJJ facilities were in placements over 100 miles from their home community (CDCR, 2018c). At this distance, most families would need to commute over three hours round trip to visit by car. Families that rely on public transit, as many with low incomes in urban areas do, face even longer and costlier travel to the facilities. In the face of such challenges, some volunteer groups like Women of Substance Men of Honor (WASMOH) occasionally support youths’ families with visiting Ventura by assisting with the cost of transportation and accommodations, but no consistent DJJ-wide support is offered to families (Tour, 2018).

DJJ isolates youth who are already facing social-emotional issues and prevents their loved ones from engaging in supportive ways. Only 23 percent of youth at DJJ’s northern facilities are from counties within 50 miles of the facilities, while 52 percent are from counties further than 100 miles away. At Ventura, approximately 41 percent of youth are from counties within 50 miles, and 48 percent are from counties further than 100 miles away. Given the particularly rural placement of Pine Grove, 66 percent of youth are further than 100 miles away from their home counties (CDCR, 2018c).

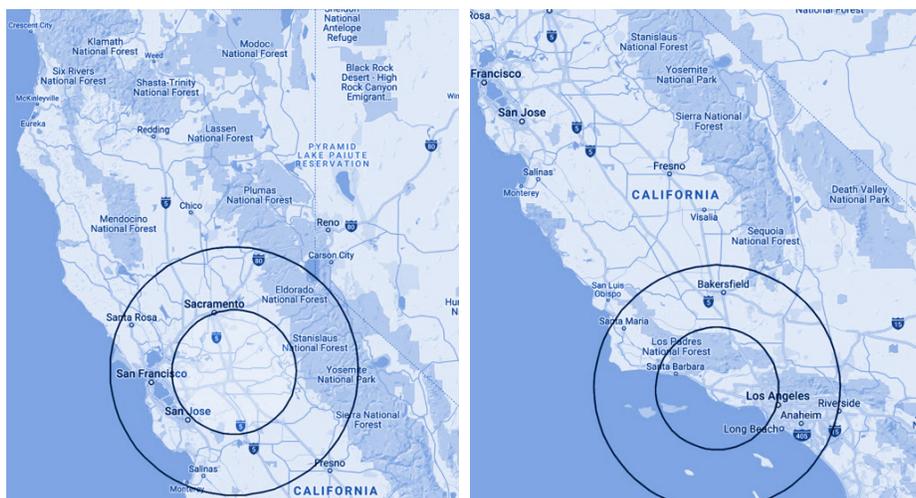


Figure 9. 50- and 100-mile radius around Chad and O.H. Close facilities (LEFT); 50- and 100-mile radius around Ventura facility (RIGHT)
Sources: Google Maps; Mapdevelopers.com.

C. Minimal contact by phone and mail

Given the challenges families face with access to in-person visitation, mail and phone calls are a critical way to maintain contact. Youth can contact family members and supportive adults through mail,³³ although all written communication with family members and friends is reviewed by DJJ staff and may be withheld if the contents of the letter are considered suspicious or non-compliant with letter guidelines (CDCR, 2018n). While not as cost-prohibitive as travelling to the facility, some costs still exist for youth and their families when communicating by mail (CDCR, 2018n).

In addition to letter-writing, youth are entitled to a minimum of four 10-minute collect calls³⁴ to family each month, or one per week (Tour, 2018). Local calls cost about three cents per minute and interstate calls cost about 13 cents per minute (GTL, 2017). Youth may be allowed to make one additional call per month for free, termed a “direct call” at DJJ, depending on their behavior phase. Youth on A Phase are allowed a 20-minute call, youth on B Phase are allowed a 15-minute call, and youth on C or D Phase are allowed one 10-minute direct call to a support person each month (CDCR, 2018n). As with DJJ’s visiting policy, this practice for direct calls actively separates youth on lower behavior phases from the support of their families, leaving those who are going through the most serious challenges with only ten minutes to connect with a family member for free each month.

Due to a lack of staff oversight, the process for accessing the phone on a living unit is largely run by the youth themselves, leading to a structure of favoritism and competition (Youth Interview, 2018). Youth recall staff maintaining a waiting list at times, but generally their peers would “call next” or wait in line. A youth at Pine Grove expressed exasperation at the challenges he faced when trying to access a phone as staff neglected to maintain a fair and orderly system (Youth Interview, 2018). In some cases, youth would continually pass the

³³ Youth are allowed two free stamps per month and must purchase additional stamps at the canteen (CDCR, 2018n).

³⁴ Incoming calls are not permitted and the process for requesting approval for a caller falls largely on youth (CDCR, 2018n).

phone to their friends rather than to others who had been waiting, which caused confusion and frustration among those who were waiting to speak to their families (Youth Interview, 2018). When youth do successfully access a phone, their calls may be monitored by staff and take place in the dayroom in close proximity to other youth where conversations can be overheard (CDCR, 2018n; Tour, 2018).

D. Supplemental family activities fall short

DJJ touts its Family Councils as an opportunity for family engagement, but the reality is that most families cannot manage to participate in these monthly meetings. At Ventura, the Family Council consisted of one family in July 2018 after the facility re-initiated it the year prior, and there has reportedly been very little outreach to other families (Tour, 2018). One parent explained that most families cannot commit to additional Family Council meetings, which focus on issues at DJJ such as education programs and visiting services, due to the long distances they must travel to the facility and the extensive time they already spend visiting on weekends (CDCR, 2018u; Tour, 2018). Additionally, very few youth and their families attend the quarterly family events hosted at DJJ facilities. From June 2017 to June 2018, the number of youth who participated in family events each month they were offered was equivalent to 8 percent of youth at Chad and approximately 13 percent of youth at O.H. Close and Ventura (CDCR, 2018k).

Youth and family members describe feeling constrained by the minimal opportunities for contact with their loved one during a commitment to DJJ. Practices for family engagement are often confusing and inconsistent, information is limited, and burdensome processes make it difficult for families to build and maintain relationships throughout a youth's stay. These challenges continue to impact youth upon reentry into the community, as they struggle to acclimate to life at home after years apart from their families.

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“Visitation at Ventura is depressing to me. There are five guards; none of them smile. It’s a big room with another 6 or 7 guards inside. They’re sitting by the door waiting for something to happen. I think they’re hoping something will happen. They’re bored and you can tell they’re ready to jump up for action. They’re not mean; they’re just not nice. It’s higher security and they’re strict about clothes.”

(Family Interview, 2018)

RELEASE PROCESS & OUTCOMES

Key Takeaways

- Recidivism remains high among youth who leave DJJ, with 74 percent of youth rearrested, 54 percent reconvicted, and 37 percent returned to state-level incarceration.
- Many youth struggle with unemployment and lack of resources when they return from DJJ. A survey of fourteen counties showed that 61 percent of former DJJ youth under their supervision were neither employed nor enrolled in an educational program.
- Release practices vary across counties, often leaving youth unsupported and unsafe. In some circumstances, youth are brought from DJJ to county jails and released in a jail-issued jumpsuit with no support.
- Current DJJ policy points to coordination between DJJ and ICE officials, raising concerns about its compliance with state law and harm to undocumented youth.

Youth often feel they never know when they are getting out of DJJ, and their parents share similar uncertainty (Family Interview, 2018; Youth Interview, 2018). DJJ's Re-Entry Program allegedly includes pre-release planning at intake, partnerships with community organizations, and the development of an Integrated Re-Entry Plan (CDCR, 2018o). Yet, youth and their families expressed confusion with regards to the reentry process.

When a young person is first housed at DJJ, their family receives a Family Orientation and Informational Packet, which includes basic information, such as driving directions to the facilities, a list of programs for youth, visitation guidelines, and information about the reentry processes (CDCR, 2018o). One mother received this packet in the mail when her son was first sent to DJJ but felt, "It's really not saying anything, so I just have to go with the flow with what my son is telling me" (Family Interview, 2018). Another parent emphasized that, although they received the family packet at the beginning of her son's DJJ commitment, there was no follow-up with the family during his release years later (Family Interview, 2018). Without any support, youth and family members struggle to conceptualize, and prepare for, the youth's eventual return to the community.

Reentry is a process that should begin upon a youth's arrival in out-of-home placement rather than as a youth's release date nears, with supports such as family engagement, employment preparation, and connections to the community provided during confinement (OJJDP, 2018). DJJ's haphazard approach to reentry planning and lack of collaboration upon release shows the institution's failure at rehabilitating youth for their return to the community.

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“There should be signs in the facility when you come in that say ‘you’re going to go home one day. We’re here to release you; we’re not here to keep you.’ Staff exercise their power like, ‘I can keep you here longer. You better respect me, you better listen to me.’ They should be preparing us for when we get released.”

(Youth Interview, 2018)

A. Length of stay

The length of time that a youth spends at DJJ depends on the initial Parole Board Date (PBD), whether their case was processed through juvenile or adult court, and any adds or cuts to a youth's commitment length thereafter (CDCR, 2013). In recent years, average lengths of stay for youth have increased due in large part to the passage of Senate Bill 81, which limited youth commitments to DJJ facilities to a set of more serious cases (SB 81, 2007). In 2017, youth with juvenile cases at DJJ had an average length of stay of 2.7 years (Table 5)(CDCR, 2018aa). Youth with criminal court cases, which generally result in a transfer of custody from DJJ to the Division of Adult Institutions (DAI) when the youth turns 18 years of age, generally stayed at DJJ for 2.3 years (CDCR, 2018aa).³⁵

	2015	2016	2017
Male	36.2	32.9	32.5
Female	41.1	27	40.5
Juvenile Court	36.3	32.5	32.9
Criminal Court	-	23.1	27.7
Total	36.3	32.5	32.9

* First Releases refer to youth who were released for the first time from a DJJ institution.

Table 5. Average DJJ length of stay at first releases*, in months, 2015-2017

Source: CDCR, 2018aa.

A youth's disconnection from family, friends, and community impairs their successful reintegration into the community (Mears & Travis, 2004). Further, institutional confinement—especially over prolonged periods of time—exposes youth to trauma with potential long-term mental health impacts, limits opportunities for educational and vocational development, and creates forced dependency (Cauffman et al., 1998).³⁶ At DJJ, youth arrive during the key developmental stage of adolescence and return to their communities after an average of over two years in confinement, during which they experience extreme isolation and exposure to trauma. Youth describe

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“I was a kid when I got locked up and I was an adult when I got out. I had to learn how to drive, get my license, get my ID, do all this stuff. I didn't really have a stable home and I'm on probation and I'm dealing with the adjustment. It was very difficult for me to manage all of that and just to deal with it in a positive way.”

(Youth Interview, 2018)

³⁵ Assembly Bill 1812 allows youth with more serious offenses, and select young adults prosecuted in criminal court, to remain at the facilities until age 25 (AB 1812, 2018). This new law will affect data on lengths of stay in and after Fiscal Year 2018-19.

³⁶ Barriers to successful reentry are well documented. For a review of the literature on this, see p.439-431 of Shelden, 2012.

feelings of fear, isolation, and anxiety in social settings as they acclimate to life outside of the restrictive institution (Youth Interview, 2018). DJJ's continued issues of violence, meager rehabilitative programming, and prison-like conditions exacerbate the challenges faced by youth when they return home.

B. Disjointed release process between DJJ and counties

A youth's release from DJJ is under the jurisdiction of the Board of Juvenile Hearings (BJH), which consists of an executive director and three appointed commissioners. Two of the board's three current commissioners have had long careers as YCCs among other positions at DJJ facilities (CDCR, 2018w). The board composition points to a continued emphasis on correctional experience, as is seen in the hiring of YCCs and YCOs. The BJH is responsible for an initial case review close to a youth's arrival at DJJ, during which a BJH member and casework specialist review the initial case plan with the youth, and annual case reviews thereafter (CDCR, 2018n; CDCR, 2018w). When a youth is nearing the end of their commitment at DJJ, they undergo a Discharge Consideration Hearing by the BJH to determine if they may be released to county probation supervision.

During the release process, procedures between DJJ and local agencies lack continuity and consistency. In 2010, a new law realigned juvenile parole from the state to the counties (AB 1628, 2010). The reform created a system of supervision in which county probation departments, rather than DJJ Parole Services, supervise youth released from DJJ on parole after conditions are set by the court. It was recognized then that DJJ would need to coordinate with counties through a comprehensive aftercare program to ensure youth receive continuous care during reentry in the community (Krisberg, 2011). Yet a disjointed system of release remains between the state- and county-run juvenile justice systems.

The muddled transition from DJJ's jurisdiction to that of a local probation department forces youth to navigate two separate systems on their own while attempting to land on their feet. A youth described the experience as arduous and confusing: "It's like probation doesn't get all of my information. I had to call down [to DJJ] just to get my identification, to get my birth certificate. Since we lived [at DJJ facilities] for so long, we have so much on record there that should be transferred through [to the county]" (Youth Interview, 2018). Even incentives meant to promote youths' successful reentry require young people to navigate complex systems

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"I have been dealing with a lot of stress, a lot of anxiety, a lot of pressure from probation. Everyone knows life is hard, and when you have probation on your back and you have this threat of possibly getting locked up and reincarcerated, it is really difficult to deal with. I have been having mental breakdowns because of the stress and the trauma of that place [DJJ]."

(Youth Interview, 2018)

and advocate for themselves.³⁷ Amid the array of emotional, social, psychological, and financial challenges that young people face during reentry, requiring youth to make up for a lack of coordinated efforts between the state and counties is needlessly disruptive, time-consuming, and potentially costly.

During release, youth who are over the age that their local juvenile justice facilities can accommodate may be temporarily transported to a county jail. The protocol differs by county, but numerous youth reported spending one to three days in county jail with few resources as they awaited release. Their families were not provided with clear information about their release time, despite the family's best efforts to coordinate with law enforcement officials, resulting in the youth being released from the facility—sometimes in a jail-issued jumpsuit—without any support. Youth described feeling overwhelmed and traumatized by the experience (Youth Interview, 2018). One mother was devastated to find her child fearfully hiding outside the jail in an orange jumpsuit, having been released before her arrival (Family Interview, 2018). This uncoordinated release process puts youth in immediate danger and leaves many families unable to properly prepare for their child's return home.

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“I was at a point where I felt like, ‘Do I belong here? Am I meant to be here, or in this system, for the rest of my life?’ That’s how bad the environment and the whole situation is. It made kids feel like that. It did not want to make people build their dreams. It did not rehabilitate me, for sure. If anything it made me worse.”

(Youth Interview, 2018)

C. Undocumented youth in danger of deportation

Current DJJ policy states that all foreign-born youth are screened upon arrival to DJJ for determination of citizenship, and each facility has a direct U.S. Immigration and Customs Enforcement (ICE) contact who is to be notified if there is any concern with regards to a youth's immigration status. ICE may then make the determination that a youth is to be detained rather than released into the community and will place a hold on file with DJJ to coordinate upon release (CDCR, 2018m). A staff member witnessed an undocumented youth picked up by ICE officials on the same day they were scheduled for release, and heard concerns from another youth that he would be detained by ICE after he reached the age of majority (Staff Interview, 2018).

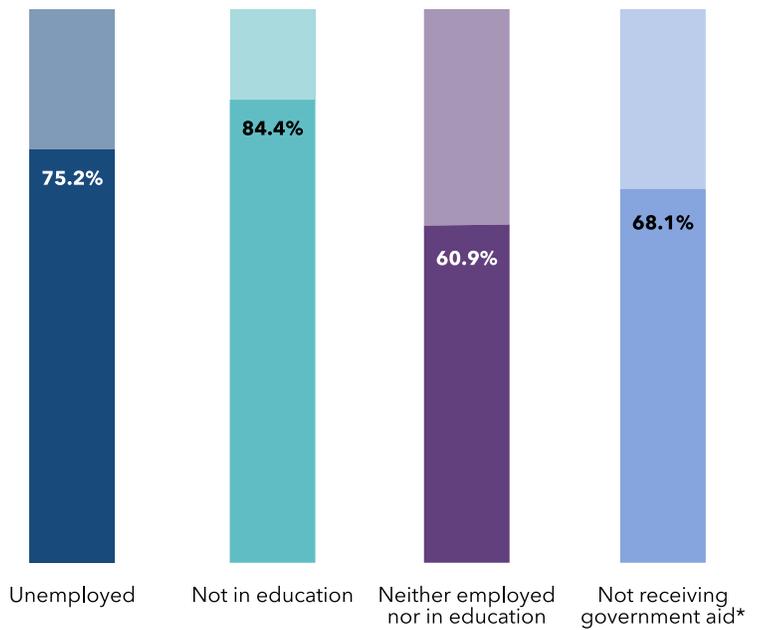
Recent state reforms have changed how law enforcement agencies are allowed to engage with ICE. Last year, Senate Bill 613 repealed a previous provision that required DJJ, among other state institutions, to cooperate with ICE (SB 613, 2017). Further, a law enacted in 2016 protects the confidential information of youth involved in juvenile court proceedings by clarifying that the automatic sharing of such information with a federal official, including ICE, is not permitted (AB 899, 2015). Under current law, ICE officials must petition in court to request

³⁷ A law passed in 2017 created an Honorable Discharge opportunity for youth who have been in the community for at least 18 months and have successfully completed probation after leaving DJJ (SB 625, 2017). In these cases, county probation departments inform youth of the opportunity for honorable discharge, but the youth must petition the BJH for the distinction.

that juvenile information be disclosed and the court must make a decision with consideration of the youth’s best interests. If DJJ is coordinating with ICE through the automatic sharing of undocumented youths’ confidential information, it is harmful to youth and well beyond the requirements of current law.

D. Reentry outcomes detrimental to youth

Without substantial reentry planning nor coordination between DJJ and local probation departments, youth experience high rates of recidivism, unemployment, lack of involvement in education, and stressful living conditions. The poor outcomes that youth face during reentry conflict with DJJ’s claims that it successfully rehabilitates young people and contributes to public safety in California.



*Government aid refers to benefit programs such as Medical and CalFresh.

Table 10. Reentry outcomes for DJJ youth on probation supervision in select counties,³⁸ June 1, 2018

Source: County Probation, 2018.

Commitment Offense Type	Youth Released	Arrest		Conviction		Any State Custody		Return to Prison		Return to DJJ	
		Returned*	Rate*	Returned*	Rate*	Returned*	Rate*	Returned*	Rate*	Returned*	Rate*
Violent	636	469	73.7%	337	53.0%	230	36.2%	186	29.2%	84	13.2%
Property	28	23	82.1%	18	64.3%	15	53.6%	13	46.4%	9	32.1%
Drug	3	3	100%	3	100%	2	66.7%	2	66.7%	0	0%
Other	8	6	75.0%	5	62.5%	5	62.5%	5	62.5%	0	0%
Total	675	501	74.2%	363	53.8%	252	37.3%	206	30.5%	93	13.8%

*"Returned" refers to the number of youth returned to the associated type of justice system involvement, and "Rate" refers to the rate of return for youth in the associated offense type.

Table 6. Three-year recidivism rates by commitment offense type, youth released in Fiscal Year 2011-12

Source: CDCR, 2017g.

³⁸ Ibid.

Youth released from DJJ often struggle to secure employment, enroll in education, and maintain financial stability. A survey³⁹ of 14 counties representing 41 percent of the DJJ population, including Alameda, Kern, Merced, and Sacramento counties, exemplifies these challenges (County Probation, 2018). In June 2018, 61 percent of youth under these counties' supervision were neither employed nor enrolled in an educational program after release from DJJ, and few received any government support to meet their basic needs (Figure 10). These outcomes severely impact the lives of youth after they return home to their communities by hampering their health, housing, and financial stability, and interfering with their access to other basic necessities for themselves and their families.

Recidivism among youth returning home from DJJ remains extremely high. The most recent available data captures recidivism outcomes for 675 youth released from DJJ in Fiscal Year 2011-12 and follows them over a three-year period. During that time, 74 percent of the youth were arrested, 54 percent were convicted,⁴⁰ and 37 percent were returned to state-level incarceration including DJJ and adult institutions (Table 6)(CDCR, 2017g). Of the youth who were ultimately sent to state-level correctional facilities, 64 percent had returned within 18 months of their release from DJJ (CDCR, 2017g). These high recidivism rates among youth point to institutional shortcomings and show that placement in DJJ's care fails to result in positive youth outcomes.

The majority (61 percent) of youth in this sample were between the ages of 20 and 24 at the time of their release (CDCR, 2017g). Some may have been challenged by the process of reuniting with family; others may have been setting out on their own and left without means to attain their independence (e.g., housing, employment, healthcare). Regardless, reintegrating into the community at such a critical stage of young adulthood requires a broad set of supports during a youth's commitment and after their return to the community, neither of which are offered by the state-run youth correctional system.

39 Data were provided by probation departments in response to Public Records Act (PRA) requests in the following counties: Alameda, Kern, Kings, Monterey, Sacramento, San Joaquin, Santa Clara, Tulare, Merced, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura. 14 counties provided data for "Unemployed" (n=109); 13 counties provided data for "Not in Education" and "Neither employed nor in education" (n=64); and 10 counties provided data for "Not receiving government aid" (n=47).

40 78.8 percent (286 youth) of these convictions were for felonies and 21.2 percent (77 youth) were for misdemeanors (CDCR, 2017g).

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“Do you know how weird it was to be able open my own door when I got home? Imagine going for 5 years being told what to do –when to wake up, when to do anything—to stepping out into society. It was overwhelming, you don’t know what to do with that. I’ve been secluded in violence, told what to do, been oppressed, scared for my life, just trying to get through the program and now I’m back in society and having this overwhelming feeling of isolation.”

(Youth Interview, 2018)

OVERSIGHT

Key Takeaways

- The dismissal of the Farrell lawsuit in early 2016 brought an abrupt decline in data collection, reporting, and inspections by expert monitors.
- There are no state monitoring bodies with the authority or scope to serve as primary watchdog of DJJ.
- Prescheduled tours of the facilities do not provide an accurate view of the institutions because visitors are typically guided away from certain areas and presented with a daily routine that can differ from the norm.

Despite its long history of abuses and inadequate care, DJJ lacks dedicated independent monitoring. From 2004 to early 2016, the Farrell lawsuit brought court scrutiny, routine inspections, and quarterly reports by a court-appointed Special Master and a team of experts. In her reports, the Special Master was tasked with addressing six areas for improvement at DJJ: education, health care, mental health, safety and welfare, sex behavior treatment, and wards with disabilities (PLO, 2016a). Under the Farrell lawsuit, the court and Special Master collected and published data on DJJ's conditions, bringing unprecedented transparency to the troubled system (PLO, 2018). Yet with the dismissal of the lawsuit in February 2016, DJJ saw an abrupt decline in data collection, reporting, and the number of experts routinely visiting the facilities.

A. Lack of dedicated monitoring

Though California has a number of prison oversight bodies, including the California Inspector General, the Office of Internal Affairs, and the Office of the Ombudsman, each has a circumscribed set of responsibilities and none serve as a primary watchdog of the DJJ facilities. Moreover, the Office of Internal Affairs and the Hiring Authority, which are responsible for following up on allegations of staff misconduct, and the Office of the Ombudsman, which receives and responds to grievances from youth and families, are housed within CDCR, which limits their ability to deliver independent oversight (Deitch, 2010). The piecemeal approach to monitoring DJJ that has emerged since the end of the Farrell lawsuit makes it difficult for members of the public, or even state lawmakers, to objectively assess conditions within the facilities and identify systemic failings. The following agencies play a role in overseeing conditions at DJJ, though each is limited in aspects of its authority.

The Office of the Internal Affairs and the Hiring Authority

The Office of Internal Affairs and the Hiring Authority are responsible for following up on allegations of staff misconduct within CDCR. The Hiring Authority begins by reviewing each new allegation and determining whether it requires additional investigation by the Office of Internal Affairs. If it does, the Office of Internal Affairs conducts interviews and collects information about the allegation that it then shares with the Hiring Authority.

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“Literally the day after Farrell ended, guards were bragging about going back to the good old days.”

(Staff Interview, 2018)

If the allegations are found to be true, the Hiring Authority determines a fitting penalty, which can include termination, but more often entails a temporary pay reduction or suspension (CDCR, 2018x).

The Office of the Ombudsman

The Office of the Ombudsman is housed within CDCR and is responsible for receiving and responding to grievances from across the CDCR system, including complaints from youth and their families (PEN § 5066). The Office “does not conduct formal investigations; does not change rules, policies, or procedures; does not participate in any formal hearing or grievance process; does not supersede the authority of other CDCR officials” (CDCR, 2018y).

The ombudsman is co-located with other CDCR administrative departments, including the Office of Legal Affairs, Legislative Affairs, and Communications and External Affairs, and its employees work alongside the staff responsible for bettering the agency’s public perception and minimizing its vulnerability to litigation. Without independence from CDCR, complaints made to the ombudsman may not be held securely. On several occasions prior to the dismissal of the Farrell lawsuit, CDCR staff had been accused of retaliating against individuals who made confidential complaints to the Ombudsman (Rhodes v. Robinson, 2005; Tilei v. Wan, 2011).

This structure contravenes national and international ombudsman standards, which recommend that an ombudsman be autonomous, impartial, and free of administrative control. In 2004, the American Bar Association (ABA) identified independence, confidentiality, and impartiality in conducting inquiries and investigations as key characteristics of an effective ombudsperson. The ABA further requires that an ombudsman not claim independence if, “anyone subject to the ombuds’s jurisdiction or anyone directly responsible for a person under the ombuds’s jurisdiction (a) can control or limit the ombuds’s performance of assigned duties or (b) can, for retaliatory purposes, (1) eliminate the office, (2) remove the ombuds, or (3) reduce the budget or resources of the office” (ABA, 2004). The International Ombudsman Association requires that an ombudsman not “be aligned with any formal or informal associations within the organization in a way that might create actual or perceived conflicts of interest for the Ombudsman. The Ombudsman should have no personal interest or stake in, and incur no gain or loss from, the outcome of an issue” (IOA, 2009). These principles are echoed by the United States Ombudsman Association, which calls for ombudsman’s offices to be granted the “authority to criticize governmental agencies and officials within its jurisdiction and to recommend corrective action” (USOA, 2004).

The Office of the Inspector General

California’s Office of the Inspector General (OIG) is responsible for monitoring the state’s prisons and correctional programs, including DJJ (PEN § 6125-6141). In addition to routine oversight, the OIG undertakes formal investigations at the behest of the Governor, the Senate Committee on Rules, or the Assembly (OIG, 2018b). The OIG periodically reviews CDCR or DJJ policies and procedures and monitors personnel investigations conducted by the Office of Internal Affairs and the Hiring Authority. In 2010, an evaluation by the Senate Office of Oversight and Outcomes found that approximately two-thirds of OIG staff were characterized as sworn peace officers, and that the Office had spent thousands of state dollars furnishing them with firearms and ammunition. Moreover, the Senate found that OIG staff were regularly using state vehicles for personal use (SOOO, 2010). In response to these findings, members of the Senate authored legislation that stripped future OIG staff of their peace officer

status, reduced the office's budget, and curtailed their oversight authority, including placing a limit on the OIG's facility audit mandate (SB 78, 2011; SB 87, 2011; SB 92, 2011).

Despite limits on its authority, the OIG remains the primary independent agency responsible for overseeing CDCR and DJJ. The office issues public reports on staff misconduct allegations as well as broader systemic topics, such as use-of-force trends in youth and adult facilities (OIG, 2018; 2018c). The OIG's semi-annual reports detailing the office's review of staff misconduct investigations finds frequent policy violations by administrators, Internal Affairs, or the Hiring Authority, including delays in their referral of incident information.

Prison Rape Elimination Act Auditors

Federal law requires that every locked facility in the nation report specified data on sexual abuse and undergo a periodic audit to assess compliance with PREA. In order to comply with PREA standards, facilities must develop and employ proper procedures for investigating allegations of sexual abuse and conform to staffing, training, and privacy guidelines (See Violence section for more details)(USDOJ, 2012a). PREA auditors review facility policies and data on past cases of sexual abuse, assessing the thoroughness of each investigation, including whether investigative procedures compromised a complainant's confidentiality or placed them at risk of retaliation (CDCR, 2018z).

In 2017, PREA auditors released reports on each of DJJ's facilities, finding deficiencies across all four facilities in the areas of transgender youth, intake screenings, and efforts to eliminate cross-gender strip searches (CDCR, 2017; 2017a; 2017b; 2017c). According to the auditors, DJJ was out of compliance with several of the PREA standards, simply because they had failed to make sexual abuse and investigation data publicly available in a timely manner. Although PREA audits provide valuable insight into conditions in the DJJ facilities in the realm of sexual assault prevention, inspectors are limited to an evaluation of the standards and cannot provide insight into other areas of safety or welfare.

Independent Visitors

In addition to formal monitoring, DJJ regularly hosts tours for judges, county probation departments, staff and members of the Legislature, and representatives from nonprofit organizations. Youth and staff emphasize that DJJ conceals certain parts of its facilities and aspects of its daily routine when visitors are present. For example, youth explain that administrators bring visitors to the units where there are fewer behavioral issues and where visitors are most likely to observe functional treatment and programming, including the MHRU and the SBTP (Youth Interview, 2018). DJJ leaders discourage guests from visiting the high core units where violence and youth behavioral needs are often greatest. Moreover, youth describe changes in their daily routine that accompany visits from tour groups, including new outdoor games and activities (See Programming section for more details), an increase in cleaning responsibilities prior to the visit, and an understanding that youth who speak positively about their experience and model good behavior during the visit will be rewarded with incentives, such as food (Youth Interview, 2018). On CJCJ's 2016 tour of DJJ, staff directed

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“There would be times when the sergeant would see me and send me to my room because I was trying to interact with the tour group.”

(Youth Interview, 2018)

BEST PRACTICE

“The agency provides at least one way for youth to report abuse, neglect, harassment, or retaliation to a public or private entity or office that is not part of the agency that operates the facility. Such entity is able to receive and immediately forward youth reports of sexual abuse and sexual harassment to agency officials and allows the youth to remain anonymous upon request.”

(AECF, 2014, p.183)

certain youth not to speak with tour participants and intervened when visitors approached youth who were not approved to talk (Tour, 2016).

On CJCJ’s most recent tour of Chad, we heard shouts from a youth in the fenced yard area of the BTP while we were entering another unit. Though he was not visible to us, he called out to say that he was hot, thirsty, and locked in a cage. When we subsequently visited his unit, the youth had been brought inside and placed in a cell with “incommunicado” written on the door (Tour, 2018). We later learned from a staff member that the young man is known to be outspoken with visitors and that the sign is placed on his cell door as a way to discourage tour groups from interacting with him (Staff Interview, 2018).

Other U.S. states ensure the safety and health of youth in their juvenile facilities by retaining independent, sometimes non-governmental, watchdogs. In Illinois, the John Howard Association, a nonprofit with special access to the state’s correctional system, routinely inspects youth and adult facilities, observing conditions, following up on complaints, and interviewing staff and incarcerated youth and adults. After each inspection, expert monitors and volunteers compile a report that is released to the public (JHS, 2018). In New York State, several

governmental and nongovernmental organizations monitor facilities, including the Correctional Association of New York, a nonprofit with the legislative authority to inspect and report on conditions (CANY, 2018). Without credible, permanent and independent monitoring of the DJJ facilities, justice system stakeholders, state lawmakers, and the public are unable to access current information about conditions at the facilities.

B. Areas for further inquiry

Although this report seeks to offer a comprehensive overview of life at DJJ since the end of the Farrell lawsuit, there are several key areas of inquiry that remain unaddressed, either due to unavailable data or constraints on the scope of our review. The following list provides a snapshot of the questions that must be asked by policymakers, community members, advocates, and all those who care about breaking the cycle of abuse at California’s state youth correctional system. In the absence of the Farrell lawsuit, no single monitoring body is tasked with providing accountability to DJJ in these key areas, including many that pertain to the essential mandate of the institutions: providing care and rehabilitation to youth.

Physical Plant

1. How will an older population fare in the dormitory-style housing units at O.H. Close? Will this result in even greater violence?
2. How many serious incidents go unreported or inaccurately reported due to the absence of cameras?
3. To what extent does the absence of cameras contribute to violence by youth or use-of-force by staff?
4. How much will each DJJ facility spend on repairs and capital projects over the next five years? Ten years?

Population

1. How will the Young Adult Program change the age profile of youth at DJJ? How will it affect younger youth?

2. How would reducing facility or unit populations affect violence at the institutions?

Staffing

1. What portion of DJJ staff come from a corrections background?
2. What portion of DJJ custody or managerial staff hold a college degree, specifically in studies relevant to supporting youth development?
3. Does training provided to staff align with DJJ reform priorities for improved treatment and care?
4. Can DJJ implement the IBTM in a way that promotes non-custody staff priorities to the same extent as the “safety and security” priorities of custody staff?

Intake

1. Are there equity issues in how youth are assigned to a facility or living unit?
2. Is the CA-YASI an appropriate tool for assigning youth to treatment programs or living units?

Behavioral Management and Safety

1. What has contributed to an increase of violence in some DJJ facilities?
2. How does contraband enter the facilities? Can staff be searched daily for contraband, as all other visitors to the facility are?
3. Can DJJ implement an evidence-based gang intervention program that reduces rates of violence? When will this be implemented and how long will DJJ go without such an intervention?
4. Will a policy of integration or segregation more effectively combat gang influence at DJJ?
5. Do unit- or facility-wide Limited Program schedules meet SB 1143’s threshold for an “extraordinary emergency circumstance”?
6. Are there unreported instances of staff physically assaulting youth?
7. Are there unreported instances of staff having sexually inappropriate interactions with youth?
8. What is being done to encourage reporting of sexual or other inappropriate interactions with youth? How are youth kept safe when making such reports?
9. Do staff routinely arrange or allow fights among youth?
10. Are youth and/or staff dissuaded from speaking out against staff misconduct?
11. What has contributed to the increase in use-of-force incidents in some DJJ facilities?
12. How will DJJ secure and sustain staff buy-in on the rewards and consequences approach to behavior management?

Health

1. Are youth denied basic medical treatment or required to wait for needed services?
2. Would youth be better served by being sent to an outside medical facility for certain ailments?
3. What is the cause of a reported increase in attempted suicides?
4. Is DJJ able to effectively accommodate youth with physical disabilities?
5. Can DJJ implement trauma-informed practices institution-wide to meet the mental health needs of all youth on core units?

Programming and Community Engagement

1. What effect do in-facility treatment and programming have on youths’ success after release?
2. Does the facilitation of intervention groups by custody staff, rather than therapeutic staff, impact effectiveness?

3. Are staff decisions to keep youth in their rooms for significant amounts of time on Limited Program justified?
4. What healthy activities can staff provide to keep youth occupied during the day, aside from playing cards and watching TV?

Education

1. In the absence of a school board, how does district leadership ensure accountability and educational quality within each of its schools?
2. What effect do the facilities' locations and safety have on DJJ's ability to recruit and retain qualified teachers?
3. What accounts for the low enrollments in community college?
4. How effective is DJJ's project-based learning curriculum and how will it be assessed?
5. What share of youth who receive a vocational certificate secure employment in a related field after their release?

Family Engagement

1. Are youth denied rightful access to visitation and/or phone calls?
2. Do the visiting spaces and protocols at DJJ facilities impact the quality of family engagement? What should the visiting space look like and provide to nurture meaningful family relationships?
3. What effect does the location of the facilities have on the number of youth who can receive regular visits?
4. What effect does the procedure and cost for phone call access have on the number of youth who can make regular phone calls to family?

Reentry

1. Would greater involvement from probation departments prior to release improve outcomes for youth?
2. Would greater involvement from community-based agencies prior to release improve outcomes for youth?
3. Is DJJ coordinating with ICE officials for the deportation of youth without documentation upon release?
4. How can DJJ measure the effectiveness of its programs without collecting data on outcomes after release?

CONCLUSION

The lives of youth in DJJ facilities are dominated by overtones of isolation, violence, and institutional opacity. This investigation into DJJ three years after the end of the Farrell lawsuit finds that, across various aspects of the institution, little has changed. In fact, there is strong evidence that matters have become worse, especially with regard to violence in the facilities. In practice, treatment and rehabilitation continue to exist almost as an afterthought amid a culture of fear and violence. Reform at DJJ, fueled by the demands of the Farrell lawsuit, has faced constant resistance from staff. Presently, staff and leaders at DJJ remain rooted in a correctional approach, with many steeped in the institution's history of neglect and abuse.

Past efforts to change correctional institutions by transferring them to other administrative entities have failed to measurably improve the daily lives of youth in the institutions. Institutional practices and routines persevere and quickly reemerge despite even the most determined efforts to re-train staff, implement new programs, or reconstitute the agency itself. As California's leaders recognize the failure of the state-run juvenile justice system and seek opportunities for reform, they must embrace major changes to the institutional design, location, staffing, and culture, which are essential to meaningful reform.

The words of Jerome Miller⁴¹ at the beginning of this report provide an important frame through which to view the fundamental problem of congregate institutions and juvenile justice reform. Correctional institutions, by nature, cannot "sustain reform, no matter what money, what staff, and programs are pumped into them" (Miller, 1991). DJJ's institutional shortcomings continue to put youth in harm's way, despite attempts to rebrand itself, rename existing programs, or change leadership. Its prison-like atmosphere and isolation from youths' home communities renders it ineffective and impervious to change. The repeated failed efforts to reform California's youth correctional institutions over the past century and a half suggests it is time to heed the lessons of history and invest in solutions that are consistent with modern standards and best practices in juvenile justice.

41 Former Commissioner of the Massachusetts Department of Youth Services and founder of the Center on Juvenile and Criminal Justice.

METHODS

This report summarizes data collected through publicly available sources, such as the DJJ Research and Data Analytics site (CDCR, 2018aa) and monthly Compstat reports (CDCR, 2018k), as well as information collected via California Public Records Act request. DJJ, the California Department of Education, the Office of the Inspector General, 14 county probation departments, and the district attorney offices in Amador, San Joaquin, and Ventura counties provided records and statistical information in response to our requests.

To further our understanding of conditions in the DJJ facilities, six CJCJ staff toured the Chad and O.H. Close facilities in Stockton on July 9, 2018 and the Ventura facility in Camarillo on July 13, 2018 (Tour, 2018). During these tours, we spoke informally and in round-table settings with DJJ administrators and staff, including the Director and Deputy Director of DJJ, facility superintendents and assistant superintendents, the Superintendent of Education, and the Chief of Operations for CDCR's Office of Legislation.

While touring Chad, CJCJ visited the vocational education area, the MHRU, the BTP unit, and the visitation space. At O.H. Close, we visited the SBTP unit, the BTP unit, the school area, a high core unit, and the lounge for youth with outstanding behavioral records. At Ventura, we visited the female unit, the coding program (Code 7370), the visitation space, the medical space, a high core and low core unit, an incentive space, and the BTP unit. We spoke with youth, staff, and administrators and kept detailed notes of our conversations and observations. Their accounts and our general observations represent a moment in time at DJJ and may not reflect changes that have occurred since July 2018.

The photographs contained in this report were taken by DJJ staff during CJCJ's tours of Chad, O.H. Close, and Ventura in July 2018 (Tour Photographs, 2018). DJJ administrators consented to our photography request, but asked that photographs be taken and approved by a DJJ staff member before being shared with CJCJ.

In preparation for the release of this report, CJCJ interviewed attorneys, juvenile justice experts, family members of youth currently confined at or recently released from DJJ, current or former staff who have worked in the facilities since the dismissal of the Farrell lawsuit, and youth who were recently released from the facilities (Attorney Interview, 2018; Family Interview, 2018; Staff Interview, 2018; Youth Interview, 2018). We selected individuals to interview based on their availability and desire to share their stories, and we relied on our statewide network of partner organizations to connect with family members and young people in their communities. Many of these sources, namely family members, DJJ staff, and youth, shared sensitive information that could expose them to retaliation. For this reason, we have omitted their names and any identifying information and cite information gleaned from their interviews using generic identifiers, such as "youth interview." In all, we spoke with four attorneys who have represented youth currently or recently at DJJ, four family members of youth currently or recently at DJJ, four staff members currently or recently employed by DJJ, and eleven youth recently released from the facilities.

For the most part, the quotes and accounts included in this report pertain to incidents directly witnessed or experienced by the youth or staff we interviewed. However, where noted, we have included some claims that were part of the DJJ "rumor mill." Though we cannot establish the veracity of these claims, their acceptance as truth among individuals in the institution sheds light on how youth and staff perceive their environment and evaluate information through the lens of their own experiences.

Generally, we only included information in this report that was confirmed by multiple sources. However, in some cases, we have included the detailed account of a single youth or staff member when their information fit with a broader theme noted by others. In those cases, we identify the source explicitly as “a youth” or “a staff member.”

Some youth and staff members followed up on our interviews by providing written documentation of incidents, practices, or policies within the institutions, including emails, memos, and journal entries. Though we have incorporated some of these materials into the report, most were omitted because they contained information that could reveal the identity of an interviewee.

Throughout this report, we highlight state, national, and international standards that govern the treatment and care of youth in juvenile facilities. Primarily, these are drawn from the Annie E. Casey Foundation’s JDAI standards, a comprehensive and nationally-recognized guide for administrators and stakeholders on the proper operation of facilities that detain or confine youth, and the PREA Juvenile Standards, which set requirements aimed at curbing sexual abuse in juvenile facilities. We also highlight requirements in California state law and standards from the ACA. These standards represent a minimum requirement for the safe and humane treatment of youth.

Although this report summarizes our findings on current and recent conditions across a number of facets of life at DJJ, some gaps in our understanding remain. In some cases, these gaps arose when requested data were withheld or not tracked by DJJ. In many cases, we were unable to definitively answer key questions due to our limited authority to investigate allegations. The Oversight section of this report details the challenges inherent in providing comprehensive monitoring of DJJ and includes a list of some of the data gaps that warrant further exploration and investigation.

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APPENDIX A

	MONTHLY AVG.	CHAD	O.H. CLOSE	VENTURA	PINE GROVE
1ST WATCH	Intake	16.06	-	-	-
	High Core	19.85	18.54	18.59	-
	Moderate Core	20.78	20.57		-
	Low Core	19.27	19.88	20.71	-
	BTP	7.73	6.72	9.29	-
	SBTP	14.09	18.61	-	-
	MHRU	11.82	-	11.49	-
	IBTP	5.76	-	-	-
	Pine Grove Main Camp	-	-	-	32.63
2ND WATCH	Intake	4.56	-	-	-
	High Core	5.59	4.70	6.31	-
	Moderate Core	6.29	5.21	-	-
	Low Core	5.44	5.04	7.09	-
	BTP	1.26	1.04	1.71	-
	SBTP	3.96	4.72		-
	MHRU	2.61	-	2.83	-
	IBTP	0.94	-	-	-
	Pine Grove Main Camp	-	-	-	12.97
3RD WATCH	Intake	4.40	-	-	-
	High Core	5.39	4.55	6.05	-
	Moderate Core	6.05	5.05	-	-
	Low Core	5.25	4.88	6.79	-
	BTP	1.62	1.32	2.27	-
	SBTP	3.82	4.57	-	-
	MHRU	2.54	-	2.74	-
	IBTP	1.20	-	-	-
	Pine Grove Main Camp	-	-	-	7.93

*PYCC data reflects its "Main Camp" as it does not maintain different unit types.

Youth-to-staff ratio, by unit, by facility, June 2017-May 2018

Source: CDCR, 2018m.

APPENDIX B

	CHAD		O.H. CLOSE		VENTURA	
	Reading	Math	Reading	Math	Reading	Math
Standard Exceeded: Level 4	7.69%	0.00%	0.00%	0.00%	0.00%	0.00%
Standard Met: Level 3	0.00%	0.00%	2.86%	0.00%	3.33%	0.00%
Standard Nearly Met: Level 2	15.38%	0.00%	11.43%	0.00%	23.33%	0.00%
Standard Not Met: Level 1	76.92%	100.00%	85.71%	100.00%	73.33%	100.00%

DJJ student test scores on the Smarter Balanced Assessment, 2018

Source: CDE, 2018; 2018a; 2018b.

Please note: Jurisdictions submit their data to the official statewide or national databases maintained by appointed governmental bodies. While every effort is made to review data for accuracy and to correct information upon revision, CJCJ cannot be responsible for data reporting errors made at the county, state, or national level.



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