

November 20, 2007

Will Harrell, J.D., LL.M.
Chief Ombudsman
Office of the Independent Ombudsman for the
Texas Youth Commission
6400 East Highway, Suite 202
Austin, TX 78723

Dear Mr. Harrell,

This letter responds to your request to our office for an analysis of a proposed Texas Youth Commission (TYC) policy regarding use of force filed with the Office of the Secretary of State on October 22, 2007, which, if adopted, would replace 37 TAC §97.23. You have asked us to provide advice to you in support of your statutory responsibility under Texas Code §64.101(a)(1), to “review the procedures established by the commission and evaluate the delivery of services to children to ensure that the rights of children are fully observed,” and under §64.101(a)(7), to “recommend changes in any procedure relating to the treatment of children committed to the commission.”

In a previous letter dated September 17, 2007, we provided to you an analysis of: TYC General Administrative Policy 97.23, Effective Date 11/1/06; a draft of a policy that would replace GAP.97.23; and TYC Executive Directive #2 FY07, effective date August 2, 2007, regarding Use of Force – OC Spray. In this letter we include some of the information contained in our previous letter, but also provide detailed commentary regarding the proposed new version of 37 TAC §97.23. This letter sets forth the applicable federal legal standards and national standards pertaining to use of force in juvenile facilities, briefly highlights relevant points from literature regarding OC spray, provides a detailed discussion of the proposed new policy, and describes some experiences other systems around the country have had with OC spray and use of force reforms.

I. Applicable Federal Legal Standards

Youth incarcerated in state institutions are constitutionally entitled to safe conditions of confinement and protection from unreasonable bodily restraint.¹ Under

Constitutional standards,² these youth have a right to protection from unnecessary and wanton infliction of pain, the unwarranted or excessive use of restraints, and excessive uses of force.³

Few courts have addressed the use of pepper spray or other chemical agents in juvenile facilities. The only federal court to address this issue in Texas determined more than 35 years ago, in *Morales v. Turman*, that chemical agents may not be used in juvenile facilities unless there is an imminent threat to human life or an imminent and substantial threat to property. Use of chemical agents beyond those limitations violates the Constitution.⁴ The United States District Court in South Carolina found the use of chemical spray acceptable only for protection of staff or others when less intrusive methods of restraint are not reasonably available, and did not permit use for protection of property or to “enforce orders.”⁵ That court found that “the use of CS gas upon a juvenile is counterproductive. It causes more anger in the juvenile toward the adults who are supposed to be caring for them.”⁶

II. National Standards

A number of organizations have developed national standards for conditions in juvenile facilities. Some of these standards explicitly forbid the use of chemical agents such as OC spray in juvenile facilities, and also restrict uses of force, restraints and isolation to situations that threaten imminent harm to the youth or others.

For example, the Institute for Judicial Administration/American Bar Association Juvenile Justice Standards on Corrections Administration prohibit the use of chemical restraints in juvenile facilities.⁷ The standards specifically cite the abuses of chemical restraints noted by the court in *Morales v. Turman*. The only narrow exception permitted is in “extreme situations.” Under any circumstances, the standards call for the department to develop regulations governing use: “Such standards should contain stringent controls on access, and provide that chemical restraints may be used only to prevent serious injury to persons or property.”⁸

The American Correctional Association (ACA) standards for Juvenile Training Schools do not specifically address the use of chemical agents, other than to require that written reports be submitted by the end of the tour of duty when there is use of a chemical agent.⁹ The ACA standards do include requirements that instruments of restraint should only be applied as a precaution against escape during transfer; for medical reasons by direction of a medical officer; or to prevent juvenile self-injury, injury to others, or property damage; and should not be applied for more time than is absolutely necessary.¹⁰ Use of physical force is restricted to instances of justifiable self-defense, protection of others, protection of property, prevention of escapes, and to maintain or regain control, and then only as a last resort and in accordance with appropriate statutory authority.¹¹

The Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative (JDAI) operates in more than 80 jurisdictions in 20 states and the District of Columbia. One of JDAI’s core requirements is that sites ensure safe and humane conditions in their juvenile detention facilities. To that end, the Foundation has published Standards for

Facility Self-Assessment, which include several pages of standards on physical force, mechanical restraints and chemical agents.¹² The standards prohibit the use of chemical agents in juvenile detention facilities, and limit the use of physical force and soft or “therapeutic” restraints to circumstances when a youth’s behavior threatens imminent harm to the youth or others. Handcuffs may be used for transportation or facility emergencies under the JDAI standards, but no other hardware is permitted for use in the institutions.¹³ An underlying principle for all uses of force and restraint under these standards is that staff use only the amount of force necessary and only for as long as necessary to bring the situation of imminent harm under control.

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services’ *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* provides relevant guidance regarding seclusion and restraint of adolescents as well. Residential treatment facilities providing psychiatric care for youths under the age of 21 receiving Medicare or Medicaid funds must abide by these regulations. Under those standards, “Restraint or seclusion must not result in harm or injury to the resident and must be used only (i) To ensure the safety of the resident or others during an emergency safety situation; and (ii) Until the emergency safety situation has ceased and the resident’s safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.”¹⁴ Under these standards only physicians or other licensed and trained practitioners may order the use of restraint or isolation, and the length of time of the restraint or isolation is limited.¹⁵

III. Scientific Research on Potential Dangers or Safety of OC Spray

Several articles summarize the research literature on OC spray,¹⁶ so we do not include such summaries or reviews in this letter. There are a few points from this research that are particularly important to keep in mind.

The research on the effectiveness and potential dangers or safety of OC spray is limited. A meta-analysis of pepper spray literature published in English through May 2002 found major flaws in the design of all studies researchers examined, since no study compared effects of pepper spray exposure with a comparison group of non-exposed individuals.¹⁷

No studies have been conducted on either the immediate potential dangers or safety, or the long-term effects,¹⁸ of OC spray use on adolescents. Nor has research been conducted in the context of a locked institution, where the close confines make the air circulation and effects on others in close proximity different from public law enforcement contexts. In addition, confrontations in locked juvenile correctional facilities with youth under extended care are very different from law enforcement situations on the street in which police confront suspects whose histories of violence, mental health problems, and drug use are unknown. There are also no data available regarding the long-term risks to individuals sprayed multiple times.¹⁹ There are few studies on the effects of pepper spray on emotionally disturbed individuals. Researchers caution that individuals who are

mentally ill may have altered perception of or response to pain, and consequently OC spray may actually exacerbate the difficulty of controlling them.²⁰ The experience of being sprayed may worsen their mental health condition.²¹ There is also particular concern about the effects on people who have asthma.²²

It is generally acknowledged that OC spray causes intense pain on contact. There are substantial additional reported dangers of OC spray. Exposure of skin to OC spray causes tingling, intense burning pain, swelling, redness, and, occasionally, blistering.²³ Capsaicin, the active ingredient in OC spray, augments allergic sensitization and worsens allergic dermatitis.²⁴ Capsaicin stimulates heat receptors, causing reflex sweating and vasodilation, and activates cooling; this dual effect increases the risk of hypothermia if victims are decontaminated with cold water on cold days.²⁵ OC spray can also cause burning of the throat, wheezing, dry cough, shortness of breath, gagging, gasping, inability to breathe or speak, and, rarely, cyanosis, apnea, and respiratory arrest.²⁶ Contact with the nose causes sneezing, irritation, and reflex mucus secretion. Inhalation of OC can cause acute hypertension, which in turn can cause headache and increased risk of stroke or heart attack.²⁷

While a small study on law enforcement officers conducted for the National Institute of Justice found no harmful effects of OC spray use, only a handful (eight) of the officers in the study had any history of smoking, asthma or other respiratory problems. All the officers were reported to be generally healthy, and none were reported to have active symptoms prior to use of the spray. None were reported to have mental illness or be pregnant. This study did not examine long-term effects of single or repeated use, nor did it replicate the stresses of actual conflict situations.²⁸ The study did confirm that blood pressure is significantly elevated after exposure to OC spray.²⁹

Reports reviewing custodial deaths to determine whether pepper spray contributed to the deaths have resulted in contradictory findings, with one study finding that pepper spray figured significantly in the deaths reviewed,³⁰ and another partially overlapping study finding no contribution from pepper spray.³¹ A 1993 death in North Carolina (a 24-year-old man with pre-existing florid bronchiolitis/bronchitis and cardiomegaly found at autopsy) was attributed to "asphyxia due to bronchospasm precipitated by pepper spray" by the attending pathologist and the North Carolina Chief Medical Examiner.³² Subsequently some law enforcement officers challenged training practices requiring that they be sprayed in the face to learn the effects of OC spray. In 1996, the Division of Epidemiology of the North Carolina Department of Health and Human Services and the Occupational Safety and Health Section of the North Carolina Department of Labor began to investigate training practices involving intentional exposure to pepper spray. Based on review of training programs and a review of the literature, they concluded that exposure to OC spray constituted an unacceptable health risk.³³

IV. Specific Concerns Regarding TYC's Proposed New Use of Force Policy

We understand that TYC is considering significant changes to 37 TAC §97.23 because of a concern over the number of injuries to staff and youth during physical

restraint. Executive Director Dimitria Pope's Executive Directive of August 2, 2007 stated, "While the Texas Youth Commission's (TYC's) overall philosophy that force should only be used as a last resort remains unchanged, we must change the way force is applied to reduce the number and severity of injuries to youth and staff." The directive cited 446 worker's compensation claims due to restraint-related incidents, and another 95 claims due to assaults by youth. Between September 1, 2006 and June 30, 2007, 913 youth were injured due to physical restraint. The administration is hopeful that use of pepper spray prior to resort to physical restraint will reduce injury to staff and youth.

However, the new draft policy has both specific and general flaws that we believe will cause harm to youth without resolving the underlying reasons why so many uses of force and concomitant injuries have occurred. The policy's provision for uses of force on insufficiently defined "disruptive" youth and its allowance of use of force to "gain compliance" permit use of force in circumstances where it may not be necessary in order to protect youth. At the same time, the policy's significant loophole allowing staff to use "more practical" methods than those approved by TYC provide an opportunity for staff to use inappropriate methods of force with far too much discretion. We discuss these and other concerns about the draft policy in detail below.

The proposed Use of Force policy raises several concerns. The preface to the new policy includes a **determination by the Chief Financial Officer** that there is insufficient data to estimate whether the change would have a significant fiscal impact on state government. There may very well be economic cost from lawsuits by incarcerated youth harmed as a result of staff compliance with this policy. Excessive use of force by JCOs may subject the state and individual JCOs to liability for compensatory and even punitive damages.³⁴

The "**Policy**" statement on page 2, section (a), states that "The Texas Youth Commission (TYC) prohibits the use of force as punishment or discipline and sanctions its use only as a control measure to reasonably ensure the safety and welfare of youth and staff. Force will be used only when necessary and only to the extent necessary to gain compliance and/or prevent harm. Physical restraint is to be used as a last resort and only for purposes justified under this rule." While the policy begins with an important statement that it prohibits use of force as punishment or discipline, it provides too much discretion in the second sentence by allowing use of force to "gain compliance." Combined with other provisions later in the policy such as the broad definition of "disruptive," this provision may lead staff to believe that they are permitted to use force where its use is not needed to prevent harm to youth or staff, for example when a youth refuses to participate in exercise routines or does not do a school assignment. Use of force in such circumstances is not necessary and would violate professional and legal standards.

The **definition of "Disruption of Program" on page 2, section (c)(2)** is curious. Normally in policies and other documents, the definition section defines only phrases that appear in the rest of the document. While "substantially disruptive" and "disruptive situation" appear in the document, "disruption of program" does not. Even if it were

changed to reflect one of the terms actually in the document, the definition is so broad that it justifies use of force for any behavior that “interrupts” the current program if the youth does not respond to one request to comply. On **page 4, section (f)** the policy allows for **use of force for** “(7) Movement of a non-compliant youth within the security unit when the youth’s behavior is substantially disruptive and the youth refuses to follow a reasonable request to comply; and (8) Movement of a non-compliant youth from a dangerous or disruptive situation when immediate compliance is necessary.” This means that a youth speaking out of turn in class, or a youth who does not give up the basketball immediately in the gym, or a youth who talks while waiting in line for a meal could be subject to a use of force, perhaps after a single request to comply, or even, under provision 8, when someone deems it “necessary” that the youth comply immediately.

Such behaviors are common among adolescents, inside and outside of locked institutions. In a locked facility such behaviors may be disruptive and staff consequently may direct youth to stop them, but under this policy staff are required to use OC spray and then physical restraint to stop the behaviors, if “physical presence,” “verbal interventions,” and mechanical restraints are unsuccessful. Such significant uses of force for minor misbehavior would not comply with national standards and would likely be deemed unwarranted or excessive, in violation of the law.

The **definition of “Reasonable Force” found on page 3, section (c)(9)**, both allows for use of force in too many circumstances and leaves open questions about whether staff is adequately trained at TYC to decide when force is “reasonable.” Reasonable force is defined in this provision as “the degree of force which a reasonable, trained juvenile corrections staff, in like circumstances, would judge to be reasonably necessary to control and overcome unlawful resistance, protect self, protect third parties, protect youth from self-harm, protect property, compel movement and maintain order and safety.” The only time that the phrase “reasonable force” is used in the policy is in **(d)(1) on page 4**. It provides that “Staff will use only the least amount and type of reasonable force necessary to control and overcome unlawful resistance, protect persons, protect property and maintain order and safety.” In addition to the problem of using the word being defined in the definition, the definition actually broadens the circumstances under which force is permissible, conflicting with (d)(1) by permitting use of force to “compel movement.” That piece of the definition should be removed because it might lead staff to believe that use of force would be permissible to force a youth to sit down, get in line, or move more quickly, when such demands do not warrant use of force. In addition, TYC should define “reasonable force” in a way that does not use the word “reasonable.”

In addition, this policy raises the question as to who is a **“reasonable, trained juvenile corrections staff.”** A staff member assigned to care for youth in a juvenile justice setting should receive training on a wide variety of issues that are directly relevant to his or her duties, including: adolescent development, conflict management, crisis intervention, cultural competence, methods of communicating with adolescents, symptoms and behavioral consequences of mental illness and mental retardation, histories of trauma among juvenile justice populations, disabilities (especially those common among adolescents), side effects of psychotropic medications, and emotional

and physical consequences of use of force, mechanical restraints, OC spray and full body restraints. In fact, failure to train staff to equip them for their duties may subject the agency to liability for damages.³⁵ We do not know whether staff at TYC are receiving training in these topics.

In **(c)(9)** and **(d)(1)**, and in several other provisions in this draft policy, staff are permitted to use force to **protect property**. While we understand that there are many circumstances under which youth destruction of property can create dangerous situations for youth, we suggest that provisions permitting use of force for protection of property (such as **(f)(4)**, which permits use of force for “Protection of property from imminent damage”) are not necessary. If the destruction of property is significant enough to risk harm to youth, then use of force would be permitted under the provisions allowing use of force to protect the youth or others, such as (f)(1-3). As it is drafted, this policy would allow uses of force when a youth is tearing up a styrofoam cup or removing a page from a magazine. These are circumstances under which force is unwarranted.

The **General Provision on page 4, section (d)(2)**, is a very good policy. It reads, “Any staff member must intervene, if a reasonable opportunity exists, when he/she knows or should know that another staff member is using force that is unjustified and/or excessive. Staff must report any violations of this policy before the end of the current shift.” We recommend that policy provide for facility administrators to review these reports regularly, as well as youth reports of inappropriate uses of force; that disciplinary action be taken against staff who use excessive force; and that action be taken against staff who see excessive force being used but who fail to report it.

The **Use of Force Continuum set forth on page 4, section (e)(1)** changes the order of use of force to allow for use of OC spray before physical restraint. Physical restraint is defined in this policy on page 3, section (c)(13)(A)(iii) as “restricting a youth’s freedom of action by using physical restraint methods.” (Again, the word should not be defined with the use of the same word.) We do not have information about which physical restraint practices are used in TYC, or how much training is provided to staff, but we have observed other systems which are able to use methods of crisis intervention and conflict management that limit injuries to staff and youth without inflicting the significant pain caused by OC spray. We encourage TYC to reconsider this change in the type of force to be used, to avoid the risk of injuring youth who are not involved in the misconduct as well as avoid inflicting this significant pain on youth. This issue is discussed in greater detail later in this letter.

Under the exception **to the Use of Force Continuum on page 4, section (e)(2)**, staff are permitted to skip lower levels of force: “Under circumstances where following the continuum poses an unwarranted risk of imminent harm, the necessary level of force may be used without the use of all prior levels of the continuum.” The use of “unwarranted” in the policy is confusing, because staff are expected to decide which risks of imminent harm are warranted and which are not, which leaves them without guidance as to when the skipping of levels is appropriate. The policy should more clearly define the circumstances under which staff may skip levels. In addition, if staff are allowed to

skip levels in situations of imminent harm, they should be required to justify in detail why the circumstances did not allow them to try lower levels of force first.

Section (g) describes Threat Assessment Prior to Implementing Force, requiring that, “Prior to the implementation of force, a threat assessment should be conducted to evaluate the youth’s opportunity, ability, and risk to do harm.” However, the policy does not explain how this assessment relates to the rest of the policy, or is to be used in determining when and how much force to use. While the enumerated considerations are reasonable ones for staff to think through, the policy should be explicit about what staff must do with the information.

On **page 5, section (h)(2)(A)** allows for a dangerous **departure from accepted, approved force methods.** It allows for use of “other non-prohibited methods of physical restraint that under the totality of circumstances existing at the time: (A) are more practical than the agency-trained method of physical restraint, taking into account the youth’s and staff’s particular vulnerability to harm; (B) involve a use of force that is measured and progressive to a degree no greater than that reasonably necessary to achieve the objective; and (C) do not unduly risk serious harm or needless pain to the youth or staff.” These “methods” of physical restraint are left undefined. The policy allows far too much discretion to staff to determine what is “practical.” For example, staff might decide that a dangerous method is more “practical” because it more quickly subdues the youth, or because it requires fewer staff members to complete it. By allowing staff to use their own forms of restraint, the policy puts youth at risk of harm and the agency at risk of liability.

On **page 5, section (i) governs Implementation of Force.** It provides that, “When practicable, strategy should be planned in advance and directed by a security staff who is not physically involved. When practicable, the entire use of force should be recorded, including efforts to reason with the youth. In all cases, staff must provide justification for the force applied.” This policy raises the following: If there is time to plan the strategy, there should be time to allow a mental health practitioner to attempt to defuse the situation, and time for extensive verbal de-escalation. This should be provided in policy. Also, the policy should make clear what recording equipment should be used and where it should be kept. Either in this policy or another appropriate policy, there should be provisions for regular review of the video recordings by facility administrators and mental health professionals to determine whether staff handled the situations properly. In addition, staff should be required to explain why lower levels of force such as verbal de-escalation did not work, how long they were tried, what the justification for a planned use of force is, and why additional attempts at de-escalation are no longer appropriate.

On **page 6, (i)(1)(C) governs safety in mechanical restraints.** It provides, “When mechanical restraints are employed, staff will ensure the youth’s safety by: (i) checking the youth for adequate respiration and circulation every 15 minutes until termination of the restraint; (ii) providing continuous visual supervision; and (iii) providing assistance, as appropriate, during transportation to the security unit and until

the restraining devices have been removed.” The policy should also provide limitations on the amount of time mechanical restraints may be used, to avoid abusive use of these measures. **Section (D)** provides for extensions of the time, but the policy does not say what initial time is being extended. It should also define the circumstances under which an extension would be appropriate.

On **page 6, section (i)(2)(D)(v and vi) allow supervisors and JCOs to carry pepper spray**. It is our experience that allowing JCOs to carry OC spray increases the likelihood that they will use it. In contrast, when JCOs must justify their reasons for using OC spray to supervisors, they are less likely to use OC spray when lower levels of force would be sufficient.

Although the draft use of force policy prohibits use of OC spray on youth with respiratory problems, there are circumstances in which such youth may end up exposed to spray despite such prohibitions. While TYC has not yet studied whether its precautions are carried out in every instance, experience from other jurisdictions suggests that it is difficult to ensure that all staff know which youth may not be sprayed. There are administrative challenges associated with keeping all staff informed about which youth have no-spray orders, especially in large facilities with several shifts of staff who may rotate between units.

In addition, while the specifications for the CHIEF MK-3, 4 and 9 OC spray projectors (the OC spray delivery devices used in TYC) indicate that they are non-vaporizing and target-specific (thereby minimizing the exposure to other bystanders who were not misbehaving), the experience with similar devices in other systems suggests that when several officers respond and use OC spray at once, other people in the room or vicinity sometimes are exposed to the spray. This may inflict unnecessary pain on youth who were not engaged in dangerous behavior, and may make it more likely that youth with no-spray orders are exposed anyway.

Neither the current policy GAP 97.23 nor the new draft policy requires the weighing of OC spray canisters to ensure that all uses are reported and excessive amounts are not used. This administrative measure should be employed if TYC plans to use OC spray at all.

We have not been informed about current or future plans for administrative review of force incidents. If it would be helpful, we can provide examples of methods for reviewing force incidents and, importantly, the circumstances leading up to those incidents, so that supervisors can provide feedback to staff about their handling of those incidents. Effective review requires examination of staffing and staff location, precipitating factors that led to an incident, activities of the youth prior to the incident, attempts at de-escalation, which staff were involved in attempting de-escalation, whether de-escalation and restraint techniques were used appropriately, and whether youth received needed medical, mental health, decontamination and other care following the incident. Such review can be central to a process of continuous quality improvement with regard to use of force.

On **page 7, section (i)(3) provides Restrictions on Use of OC Spray. Part (A)** provides that, “Unless necessary to prevent loss of life, imminent damage to property, or imminent bodily injury to person, OC spray should not be used against a youth who has a mental health diagnosis until a mental health staff has been contacted and has attempted to control the situation.” As noted earlier, it is inappropriate to use OC spray to prevent damage to property that does not present a safety risk, especially on a mentally ill youth.

Part (3)(B) on page 7 provides: “Unless necessary to prevent loss of life, property from imminent damage, or imminent bodily injury to persons, OC spray is not authorized for use on a youth who has been identified by a medical staff as: (i) having a known allergic reaction to OC; or (ii) currently receiving treatment for seizures or asthma; or (iii) having any other obstructive pulmonary condition.” This policy allows use of OC spray on youth with known allergies to OC, seizures, asthma, and other pulmonary conditions, merely to prevent imminent damage to property. The safety risk in use of OC spray on such an at-risk population solely to protect property is unjustifiable. The exceptions intended to protect these youth swallow the rule by permitting use of OC spray in many of the circumstances in which it would be permissible for the rest of the population. This is especially unnecessary when physical restraint remains an option. This policy requires staff to use OC spray on youth who could be gravely harmed, rather than using other available means of force. It should be rewritten to protect youth with such conditions from use of OC spray unless no other option is available to prevent serious and imminent harm to the youth or others.

Part (3)(C) disallows use of **OC spray on a youth in a secure cell** or who is properly secured in mechanical restraints, but then once again the policy sets forth so many exceptions that it swallows the rule, including allowing use of OC spray for protection of property. It is especially unjustifiable to use pepper spray on a youth already secured in mechanical restraints. This practice is analogous to assaulting an inmate who is handcuffed, which the United States Supreme Court has ruled may be a violation of the 8th Amendment.³⁶

On **page 8, section (i)(4)(E)** allows for the use of **physical restraint to remove clothing** from a youth who displays suicidal ideation or behavior after verbal attempts to gain compliance have failed. There is a significant difference between suicidal ideation (merely considering suicide) and suicidal behavior (active attempts at significant self-harm). Such use of force should be much more clearly limited. Lindsay Hayes, the country’s leading expert on suicide prevention in correctional and juvenile justice facilities, recommends that youth who are suicidal be engaged in programming with other youth to the extent that it is safe to do so. For youth who must be isolated due to their level of suicidality, constant staff in-person supervision is essential. Mr. Hayes recommends that such youth not be required to remove their clothing unless they are actively engaged in using the clothing for self-harm. If verbal attempts to encourage the youth to stop the behavior have failed and there is imminent danger of self-harm, then physical intervention to remove the item may be used and the youth may be given protective clothing to wear.³⁷ A decision to remove a youth’s clothing should generally

be made by a mental health professional as part of a comprehensive suicide prevention program.

On **page 8, section (i)(5)(A) lists prohibited techniques of physical restraint.** This is a very good list of prohibitions. We recommend inclusion of blows to the head in the list of prohibited practices.

On **page 9, section (i)(6)** provides for use of **Full-Body Restraint** for prevention of serious self-injury at facilities that operate programs for youth with mental illness or mental retardation. It allows for restraints to be applied by staff who have completed specialized training in the use of such restraints. The policy should add these protective elements: Except in a clear emergency, only a qualified mental health professional or physician should authorize the application of full-body restraints. In a clear emergency, where neither time nor availability permit authorization by a physician or qualified mental health professional, senior staff who have been certified by the physician or psychiatrist could authorize full-body restraints, but they should immediately contact a qualified mental health professional for consultation and crisis intervention.

In addition, the provisions for full-body restraint lack other important protections. Staff should have clear instruction to involve mental health professionals to intervene in any incident of attempted self-harm. Also, because part (e) does not list full-body restraint in the use of force continuum, the policy does not make clear that lower-level uses of force such as physical presence, verbal de-escalation, and other steps should be used prior to full-body restraint. OC spray should not be used on a mentally ill youth engaging in self-harm. The policy should be clear that staff should attempt verbal de-escalation and involve mental health professionals prior to physical intervention except in clear emergencies.

On **page 9, section (j)** provides that following the use of OC spray or physical restraint, a **post-restraint screening** will be conducted by a non-involved staff member to assess the youth's emotional status. The post-restraint screening should be conducted by a mental health professional. Youth may not report emotional trauma or may attempt to disguise it because they fear retaliation. A staff member who is not a mental health professional may not be able to detect significant signs of trauma.

In neither the current nor proposed policy is there any provision to restrict the use of mechanical restraints, full-body restraints or OC spray on **pregnant girls**. Use of shackles and belly chains should be explicitly prohibited absent extraordinary circumstances, for obvious reasons that include loss of balance, discomfort and the lack of necessity for such hardware to be used on a pregnant girl. Because OC spray has not been tested on pregnant women, its safety has not been proven, and its use on this population should be prohibited.

The proposed use of force policy eliminates many of the safeguards on use of force found in current policy:

1. Physical escort. The proposed policy does not mention “physical escort” of youth from one location to another, so that there are no limitations in the policy on this use of force.
2. Approved method of restraint. The proposed policy does not identify any approved methods of physical or mechanical restraints and consequently does not include sufficient guidance regarding the use of such restraints.
3. Planned manual restraints (cell extractions). Despite allowing cell extractions, the proposed policy does not include any provisions governing their use. Current policy, in contrast, requires personal observation of the situation by an administrator; videotaping, including a recording of a verbal description of the youth’s conduct and all warnings provided the youth; specific training for staff participating in such restraints; and at least two warnings to the youth to discontinue the misconduct after the team is assembled and before the room entry.
4. Removal of clothing. The proposed policy provides that physical restraint may be used to remove clothing from a youth who displays suicide ideation or behavior after verbal attempts to gain compliance have failed. (See our discussion above.) It does not include provisions in current policy that require determination by a mental health professional that physical restraint is necessary to remove clothing, approval by the facility administrator or designee, removal of clothing in a private location, at least one staff removing the clothing is the same gender as the youth, and termination of the restraint and issuance of protective clothing once the youth’s clothing has been removed.
5. Monitoring of youth in mechanical restraints. The proposed policy does not include current restrictions on use of mechanical restraints, including the limitation on use to 15 minutes, with 30 minute extensions granted only by the facility administrator or designee.
6. Use of OC spray. The proposed policy eliminates a full page of requirements in existing policy regarding use of OC, including identification of the limited circumstances in which OC is approved, approval only in TYC high restriction institutions and high restriction contract care programs, requirement of TYC training for staff who use it, and limitation on those who routinely carry OC to top facility administrators and security personnel. For reasons we explain in detail below, we believe that the elimination of these limitations is not the way to reduce injuries at the facility. Reducing need for uses of force through comprehensive reform strategies could achieve the same goal without inflicting excessive pain on youth.
7. Full-body restraints. The proposed policy provides that that the only justification for full-body restraints is the prevention of serious self-injury, limits their use to programs for youth with mental illness or retardation, and requires specialized training in the use of such restraints. The proposed policy eliminates current requirements which specify that such restraints must be cloth or leather, that the restraint must be in a face-up position, requirement of authorization by the facility administrator or assistant and validity for one hour only, evaluation of the youth during the hour by a mental health

professional, approval from a physician or licensed doctoral psychologist to continue the restraint for longer than one hour, additional mental health professional assessment to extend the restraint beyond four hours, regular checks of physical condition of the youth by a nurse, opportunity for motion and exercise for at least 5 minutes each half hour, regularly scheduled meals and drinks, regularly prescribed medications, opportunities for elimination of bodily wastes at least every two hours, a room of adequate size with appropriate ventilation and heat, continuous visual supervision by staff, and no continuation of the restraint beyond 12 hours without written order of a physician. Such protections are important to protecting youth from excessive restraint. We want to note that even the current policy provides for restraint beyond a point where it is appropriate for a youth to remain in a juvenile justice facility. JDAI standards, for example, provide for a youth to be sent to a mental health facility if full body restraints are necessary for more than four hours.

8. Intervention by staff members. The proposed policy eliminates the requirement that staff members intervene when they see another staff member using force that is unjustified or excessive. This requirement is important to protect youth from harm. We have seen far too often around the country situations in which staff members fail to intervene while another staff member treats a youth inappropriately. Explicit mandates that staff protect youth in their care are helpful to remind them of their responsibilities.
9. Medical examination and documentation of youth injured during restraints. The proposed policy eliminates the requirement that youth injured shall be assessed by nursing staff immediately and documentation provided in the electronic medical record. TYC has an obligation to ensure that youth with medical needs receive prompt medical attention.

The elimination of these safeguards is a matter of particular concern, since existing policy, with its current safeguards, has been in effect during a time when many reported incidents of abuse in TYC facilities have occurred nonetheless.

V. The Experiences of Los Angeles County and Other Jurisdictions with OC Spray

Los Angeles County made OC spray available to all staff in its three juvenile detention facilities beginning in 1994-95. This widespread use of OC spray came about as a result of concerns similar to those of TYC administrators about injuries to staff in facilities. However, by 2000, the United States Department of Justice Civil Rights Division's Special Litigation Section (DOJ) was investigating conditions in the juvenile halls including use of OC spray. The Department's findings issued in 2003 should serve as a cautionary tale to TYC.³⁸ Despite the Los Angeles County Probation Department's efforts to train staff in the proper use of OC spray, DOJ findings included the following:

- Staff sprayed youth in situations in which such uses of force were not necessary, including situations that did not present serious threats of bodily

- harm, circumstances in which youth had already complied with staff's directives, and circumstances in which staff already had control of the youth.
- Staff sprayed youth for talking back or “disrespecting” staff, standing up when ordered to be seated, yelling or banging on doors, which DOJ found did not warrant this high level use of force.
 - Staff lacked the skills to de-escalate incidents in which youth failed to comply with orders, causing minor problems to become major confrontations that otherwise would not have required spray.
 - Staff sprayed a young man who was banging his head against a wall and threatening to kill himself after he failed to comply with an order to stop banging his head. The youth was cognitively impaired, psychotic and receiving psychotropic medications. In other cases, staff sprayed a young woman who had begun to cut herself with a plastic fork, and a young man who was trying to tie a shirt around his neck. In these examples it is likely that lower levels of force, coupled with mental health intervention, would have been more appropriate to intervene in the residents' harm to themselves.
 - Despite orders from physicians that youth not be sprayed due to health conditions, staff members were unaware of these restrictions for some youth and used spray on them.
 - Staff also failed to provide proper warning and opportunity to comply with an order before spray was used on them. For example, some staff gave a “blanket” warning intended to be in place for an entire shift or activity, warning all youth that if they acted out in any way they could be sprayed. Other staff would give the warning immediately before use without waiting for youth to respond. Such warning methods do not allow youth the opportunity to comply with staff members' requests.
 - Management failed to keep proper control of OC spray use, by allowing all staff to carry OC spray and simply request more when a canister ran out, rather than weighing canisters after each use. DOJ found that because use of spray inside locked units may cause pain to other residents who are not involved with harmful behavior, due care should be taken to restrict its use and the quantity of use to those situations in which it is necessary.

Los Angeles County and the Los Angeles County Office of Education entered a Memorandum of Agreement with the Department of Justice in 2004, and the Agreement has recently been extended while the County works to come into compliance with its terms.³⁹ In the course of its reform efforts, Los Angeles County has been able to reduce its uses of force while minimizing its use of OC spray at the same time. Between 2004 and 2006, annual uses of force for the three facilities, which house approximately 1600 youth, have dropped from 1741 to 1356.⁴⁰ While in 2001 staff used OC spray in approximately 1500 incidents, in 2006 staff in the juvenile halls used OC spray only 214 times.⁴¹ Serious youth injuries such as broken bones are now reportedly very rare.⁴²

Los Angeles County achieved its reduction in uses of force through a combination of reform of its use of force policies, intensive training in a crisis intervention system called Safe Crisis Management, reduction of the number of staff permitted to use OC

spray, increased review of all uses of force, reforms of mental health services and overall staffing levels, consistent application of an incentive-based behavior management system, and numerous other reforms.⁴³ The county's experience shows that large systems can improve behavior and reduce uses of force without the need for frequent use of painful OC spray.

Similarly, in Sacramento in the 1990s, then-Chief of Probation John Rhoads was able to reform policies and practices to minimize the use of OC spray without an increase in injuries to staff or youth.⁴⁴ In Connecticut, JKM Training, Inc. has been involved in training staff of the Connecticut Juvenile Training School in Safe Crisis Management. That facility has also seen steady drops in uses of force, youth injuries and other critical indicators.⁴⁵

VI. Reducing Injuries by Reducing Uses of Force

TYC administrators are right to be concerned about the numbers of staff and youth injured in use of force incidents. However, injuries from uses of force could also be reduced by comprehensive approaches to reducing the need for the application of use of force techniques.

Our observations from work, collaboration, and consultation with juvenile corrections professionals across the country are that juvenile facilities are best able to reduce their uses of force and concomitant injuries to youth and staff when the following occur:

- Agencies clarify staff understanding of their mission. Staff members who believe that their primary responsibility is to control youth are more likely to use force than staff who understand that their mission is to help youth develop skills to becoming productive citizens and lead more successful lives.
- Staff members have the opportunity for regular, frequent training and practice in use of de-escalation techniques and physical interventions so that they become accustomed to de-escalating situations without force and use force correctly when needed.
- Supervisors understand and reinforce agency expectations and regularly review and provide feedback to line staff to improve their responses to crisis situations.
- There is sufficient staffing for custodial staff to interact positively with youth.
- There is sufficient programming to keep youth occupied, and an incentive-based behavior management system is a part of the programming.
- Youth with mental illness receive sufficient treatment.

Before concluding that staff must use an intervention as painful as OC spray rather than physical intervention, TYC administrators should examine whether staff are using the agency's crisis management system, Handle with Care, in the manner developed by the company. We would encourage administrators to study whether staff

are able to use the approved techniques in crisis situations, or whether they need more frequent opportunities for practice.

In addition, administrators should study the extent to which uses of force have occurred in situations where there was insufficient staffing and programming to engage youth in positive behavior. It may be possible to reduce incidents of youth violence by incorporating appropriate staffing levels and keeping youth busier with a variety of structured activities. It would also be important to examine whether any youth with orders from medical or mental health personnel not to be sprayed were exposed to OC spray anyway.

Furthermore, agency administrators should examine whether they are identifying all youth who have mental health needs, and whether those youth are receiving sufficient services to meet their needs. Staff sometimes use force because they misinterpret youths' behavior that is a product of a mental illness or developmental disability as acts of defiance or intentional disruption. Helping staff to better understand youth behavior that may be caused by these disabilities and giving staff the skills they need to respond more effectively may also lead to reductions in uses of force.

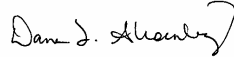
VIII. Conclusion

In view of the potential dangers of OC spray use with adolescents and the deficiencies in the proposed policy, we recommend that TYC not place OC spray ahead of physical restraint in its use of force continuum and not eliminate the requirements and safeguards on use of force in existing policy. It is a common experience in the juvenile justice field that, unless very carefully trained, staff will always resort to the highest level of force available to them when in a crisis situation. The vast majority of juvenile facilities around the country do not use pepper spray at all because it is generally believed that intentional infliction of the level of pain created by OC spray on youth is unacceptable.⁴⁶ If TYC uses OC spray at all, it should institute tighter controls rather than loosening them.

In addition, we have raised a number of specific concerns about the draft policy TYC has proposed. The draft policy allows use of force in circumstances where it is not warranted. Its loose use of language leaves room for staff to use force in circumstances where it may not have been intended in policy. Furthermore, the provision allowing staff to make up their own methods of force when they are more "practical" puts youth at risk of harm. The policy also removes significant protections including limitations on the length of time force may be used and other important protections.

We offer our assistance in resolving the challenges faced by TYC in developing effective use of force policies. Please contact us if you have questions or would like more information.

Sincerely,



Dana L. Shoenberg
Senior Staff Attorney



Mark Soler
Executive Director

¹ *Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982).

² The question whether the *Youngberg* 14th Amendment due process standard for institutional conditions or the 8th Amendment cruel and unusual punishment standard applies remains undecided in the 5th Circuit (where Texas is located). See *Morales v. Turman*, 562 F.2d 993 (5th Cir. 1977) (remanding for further evidentiary hearings and declining to decide the legal issues presented). Most courts that have decided the appropriate federal standard by which to judge state juvenile justice facility conditions have applied the Due Process Clause of the Fourteenth Amendment. *Gary H. v. Hegstrom*, 831 F.2d 1430, 1431-32 (9th Cir. 1987); *HC. Ex rel. Hewett v. Jarrard*, 786 F.2d 1080, 1084-85 (11th Cir. 1986); *Santana v. Collazo*, 714 F.2d 1172, 1179 (1st Cir. 1983), *cert. denied*, 466 U.S. 974 (1984); *Milonas v. Williams*, 691 F.2d 931, 942 & n.10 (10th Cir. 1982), *cert. denied*, 460 U.S. 1069 (1983). But see *Nelson ex rel. Nelson v. Heyne*, 491 F.2d 352, 355 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1974). Because the protections of the 14th Amendment go at least as far as the 8th Amendment, *Bell v. Wolfish*, 441 U.S. 520, 545 (1979), the 8th Amendment cases can provide some guidance as to the constitutional floor.

³ See *Hope v. Pelzer*, 536 U.S. 730, 737 (2002); *Hudson v. McMillian* 503 U.S. 1, 4 (1992); *Hewett*, 786 F.2d at 1089; *Morales v. Turman*, 364 F.Supp. 166, 173-74 (E.D. Texas 1973).

⁴ *Morales*, 364 F.Supp. at 173-74 (E.D. Tex. 1973); 383 F.Supp. 53, 77 (E.D. Tex. 1974), *rev'd on other grounds*, 535 F.2d 864 (5th Cir. 1976), *rev'd*, 430 U.S. 322 (1977); *remanded for rehearing*, 562 F.2d 993 (5th Cir. 1977).

⁵ *Alexander S. v. Boyd*, 876 F. Supp. 773, 786 (D.S.C. 1995), *aff'd in part and rev'd in part on other grounds*, 113 F.3d 1373 (4th Cir. 1997), *cert. denied*, 118 S. Ct. 880 (1998).

⁶ *Id.*

⁷ Institute of Judicial Administration/American Bar Association, *Juvenile Justice Standards: Standards Relating to Corrections Administration* § 7.8 and Commentary at 145 (1980).

⁸ *Id.* at 146.

⁹ 3-JTS-3A-28.

¹⁰ 3-JTS-3A-16, Commentary.

¹¹ 3-JTS-3A-31.

¹² These standards are available from the Annie E. Casey Foundation or online at <http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={EE63D15F-5ECC-4581-A1EB-D223973F4820}>.

¹³ §VI(A)(2) through (4).

¹⁴ 42 C.F.R. § 483.356(a)(3).

¹⁵ 42 C.F.R. § 483.358(e). Under this standard, each order for restrain or seclusion must be limited to the duration of the emergency safety situation and must not exceed 4 hours for residents ages 18 to 21, or 2 hours for residents ages 9 to 17.

¹⁶ E.g., Marita Broadstock, “What is the safety of ‘pepper spray’ use by law enforcement or mental health service staff?” New Zealand Health Technology Assessment Tech Brief Series, September 2002, Vol. 1 No. 2; C. Gregory Smith, MD, MPH and Woodhall Stopford, MD, MSPH, “Health Hazards of Pepper Spray,” North Carolina Medical Journal, 1999; 60:268-74.

¹⁷ Broadstock, p. 12.

¹⁸ Id. at 15.

¹⁹ Id.

²⁰ Hon. Charles M. Greinsky et al., Report of the Pepper Spray Committee, New York Civilian Complaint Review Board (October 2000), pp. 9-10.

²¹ Michael Cohen, “The health effects of pepper spray: a review of the literature and commentary,” Journal of Correctional Health Care 1997;4:73-89.

²² Broadstock, p. 15.

²³ C. Gregory Smith, MD, MPH and Woodhall Stopford, MD, MSPH, “Health Hazards of Pepper Spray,” North Carolina Medical Journal, 1999; 60:268-74.

²⁴ Id.

²⁵ Id.

²⁶ Id.

²⁷ Id.

²⁸ Theodore Chan, et al, “Pepper Spray’s Effects on a Suspect’s Ability to Breathe,” National Institute of Justice Research in Brief, December 2001, pp.1-6.

²⁹ Id. at 4.

³⁰ American Civil Liberties Union of Southern California, *Pepper spray update: more fatalities, more questions*. (1995).

³¹ J. Granfield et al., “Pepper spray and in-custody deaths.” RCMP Gazette, Vol. 56, pp. 12-17.

³² Smith and Stopford.

³³ Id.

³⁴ See, e.g., H.C. by Hewett v Jarrard, 786 F.2d 1080, 1089 (11th cir. 1986)(superintendent of juvenile facility liable for punitive damages for excessive use of force).

³⁵ City of Canton v. Harris, 489 U.S. 378, 380 (1989).

³⁶ Hudson v. McMillian, 503 U.S. 1, 10 (1992).

³⁷ Telephone conversation with Lindsay Hayes, Program Director, Jail Suicide Prevention and Liability Reduction Program, National Center on Institutions and Alternatives, September 12, 2007.

³⁸ The DOJ findings letter may be found at http://www.usdoj.gov/crt/split/documents/la_county_juvenile_findlet.pdf. The OC spray findings are at pp. 20-23.

³⁹ The 2004 MOA may be found at http://www.usdoj.gov/crt/split/documents/split_setagree_lajuvhall_8-12-04.pdf. The 2007 Amendment to the MOA may be found at http://www.usdoj.gov/crt/split/documents/la_juv_8-01-07.pdf.

⁴⁰ Michael Graham, et al., *Fifth Semi-Annual Monitoring Report for the Memorandum of Agreement between the United States, Los Angeles County and the Los Angeles County office of Education*, May 25, 2007, Paragraphs 28 and 29.

⁴¹ Telephone conversation with Ron Barrett, Detention Services Bureau, Los Angeles County Probation Department, September 12, 2007.

⁴² Id.

⁴³ See MOA and monitor’s report, above, n.34-35.

⁴⁴ Telephone with John P. Rhoads, JPR Consulting, September 11, 2007.

⁴⁵ Telephone and e-mail consultation with Steven Laidacker, Ed.D, Senior Training Associate, JKM Training, September 11-13, 2007.

⁴⁶ For example, in 1999 Virginia prohibited the use of pepper spray as part of an aversive therapy plan or as a means of controlling violent behavior in a secure custody facility because OC spray “permits the destruction of any sort of therapeutic environment in a secure custody facility by permitting staff to cause discomfort, pain, or possibly death to a child in their care.” Virginia Regulatory Town Hall Agency

Background Document Final Regulation, Nov. 1999, p. 50-51;
<http://www.townhall.state.va.us/L/GetFile.cfm?File=E:%5Ctownhall%5Cdocroot%5C44%5C189%5C614%5C6vac35-50%20final%20repeal.pdf>.