Sixth Semi-Annual Report

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Sixth Semi-Annual Report

INTRODUCTION

This is the sixth semi-annual report of the Consultants Committee prepared pursuant to Section III F (5) of the Memorandum of Agreement between the United States Department of Justice and the State of Arizona concerning Adobe Mountain, Black Canyon, and Catalina Mountain Schools.

This report covers the time period commencing March 15, 2007 through September 15, 2007. This report will serve as the final report regarding compliance with the provisions listed within the MOA.

In this report each of the consultants will provide an overview of the monitoring to date. Those provisions, identified by their Unique File Numbers (UFN's), that have not been terminated due to continued substantial compliance will next be listed in each section with the consultant's narrative and rating of that provision included. Each section will also include a listing of all provisions in substantial compliance with the MOA. Many provisions in the MOA pertain to auditing activities that need to be performed by the ADJC as well as the newly formed Arizona Juvenile Corrections Advisory Commission. Dr. Megan McGlynn, the Director of the Quality Assurance division of the ADJC developed a grid that encompassed monitoring outlines submitted by the consultants. That grid is included in Appendix A and is intended to act as a guideline for the Juvenile Corrections Advisory Commission as it begins its work with the ADJC.

The Consultants Committee continues to acknowledge the cooperation of the staff of the Arizona Department of Juvenile Corrections. Director Michael Branham has provided to the Committee complete access to all facilities, youth, staff, files and data.

At the conclusion of each site visit de-briefings continue to be held with Director Branham and his leadership team. The team has continued to be receptive to recommendations of the Consultants Committee and in many cases instituted remedial measures prior to the termination of the visit.

2. DEFINITIONS

Compliance with the Agreement requires that ADJC demonstrate substantial compliance for each of the substantive remedial measures at all three facilities. In this report, the Consultants Committee describes the steps taken by ADJC to implement the remedial measures and the extent to which ADJC has complied with the requirements of the Agreement. In assessing compliance, the Committee utilizes the following terms, which have been agreed upon by the parties:

Substantial Compliance: Substantial compliance with all components of the rated provision. Non-Compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. At

the same time, temporary compliance during a period of sustained non-compliance shall not constitute substantial compliance. A rating of substantial compliance shall not be made unless such rating is applicable to all three facilities.

Partial Compliance: Compliance has been achieved on most of the key components of the Agreement provision at all three facilities, but substantial work remains. A rating of partial compliance shall also be made where one or more facilities are in substantial compliance with a provision, but the other(s) are not in substantial compliance.

Non-Compliance: Non-compliance with most or all of the components of the Agreement requirements at all three facilities.

Not Reviewed: This rating is given if the Consultant's Committee due to time constraints in the initial reporting period could not adequately review it.

The Consultants Committee has collaborated in developing this report but individual consultants have taken primary responsibility for sections of the report:

Lindsay Hayes	Suicide Prevention
Russ Van Vleet	Juvenile Justice
Peter Leone	Special Education
Louis Kraus	Medical Care, Mental Health Care

3. SUICIDE PREVENTION

Executive Summary:

Since the suicides of three youth at the Adobe Mountain School between April 2002 and March 2003, the Arizona Department of Juvenile Corrections (ADJC) has made tremendous progress to ensure that youth in their custody are as reasonably safe as possible from suicidal and other self-injurious behavior. The ADJC's Behavioral Health Services Division has revised policies and procedures, created training curricula, revised screening and assessment tools, and created measures to effectively communicate the management needs of suicidal youth. In addition, as the result of a substantial financial commitment by the state of Arizona, the Adobe Mountain School, Black Canyon School, and Catalina Mountain School are now physically safe environments for the housing of suicidal youth. Most importantly, as one long-term ADJC employee who has worked at the agency for many years confided to the Consultants Committee, the resulting suicides and CRIPA oversight have instilled and increased awareness and renewed sensitivity to the problem of juvenile suicide in confinement. This awareness and sensitivity is felt not only at ADJC central office, but in the housing units at each facility.

Beginning with our 1st Semi-Annual Report in September 2006, the agency has made steady progress to achieve substantial compliance in the 17 areas of the CRIPA Agreement related to suicide prevention. In some areas, particularly developing and maintaining a viable suicide prevention training program and identifying and screening suicidal youth, substantial compliance

has come with relative ease. Other areas, including receiving pertinent records from county juvenile courts and detention centers, as well as conducting comprehensive morbidity and mortality reviews, have been a work in progress with substantial compliance being achieved in the latter stages of the CRIPA Agreement. Unfortunately, the ADJC continues to struggle with one area (3.4.2), i.e., treatment planning for youth discharge from suicide precautions, that only recently resulted in a rating of substantial compliance for the first time during the three-year monitoring period.

Not surprisingly, this 6th Semi-Annual Report focuses upon areas that remain a concern to the Consultants Committee -- treatment planning, morbidity/mortality reviews through the Internal Review Committee process, and the sustainability of the sound suicide prevention practices through on-going quality assurance audits. With regard to treatment planning, there is no doubt that youth discharged from suicide precautions are being seen by mental health staff and are not potentially falling through the cracks as in years past. Continuous Case Plans (CCP) are created for all ADJC youth, and CCPs revised when the issue of self-injurious behavior is identified as a problem area. The concern of the Consultants Committee is that although the agency is beginning to achieve "paper" compliance with CCPs, the consistency of quality treatment planning for youth discharged from suicide precautions remains uneven. At such, there is spotty documentation to demonstrate the specific strategies utilized by mental health staff to decrease self-injurious behavior of youth on their caseload.

With continued oversight from the Consultants Committee, ADJC has made steady progress in conducting morbidity/mortality reviews through the Internal Review Committee process and sustainability of the sound suicide prevention practices through on-going quality assurance audits. As noted below in this report, more improvement is necessary to ensure that each process becomes institutionalized. Given the Consultants Committee's hands-on and aggressive oversight of these two areas, our only lingering concern is, without our continued presence in the future, will these two quality assurance processes continue to improve to ensure the maintenance of a viable suicide prevention program.

In conclusion, the ADJC is a far better agency and provides a much safer environment for youth then it was in 2002-2003. The agency and its staff should be highly commended for the great strides achieved to date and cautioned that sustainability of this comprehensive suicide prevention program will only come about through continued and aggressive quality assurance.

UFN 3.2 (Identification/Screening), 3.2.5. The State shall continue to ensure that mental health staff thoroughly review a youth's clinical and master files for documentation of any prior suicidal behavior.

Status: Substantial Compliance

Discussion: Although the Consultants Committee has continued to see improvement in this area, the results of the recent Quality Assurance Audit at AMS in May were disappointing. According to ADJC policy, file reviews should be completed by RAC staff within 8 hours of the youth's arrival. In addition, QMHP staff is required to review the mental health chart within 14 days of

the youth's arrival on the assigned housing unit. According to the "Quality Assurance Special Audit" of AMS conducted on May 2, 2007, the File Review Form was completed and located in only 7 or 12 charts (58%) by RAC staff. In addition, "File Review Forms were completed within 14 days of arrival by the PSA's at the receiving treatment units in 4 of 12 charts (33%) upon a youth's transfer to the new treatment unit. The File Review Form was either late or missing in eight MHCs. This item is not in compliance and will require a corrective action plan."

Although disappointing, a rating of Substantial Compliance is given because the problem of file review appeared limited to AMS, and the other facilities have shown steady improvement in this area.

In August 2007, the Consultants Committee was informed that corrective action was taken by automating the file review form in the YouthBase system, thus allowing for easier compliance with file review by QMHP staff.

Recommendation: None

Documentation: "Quality Assurance Special Audit, Behavioral Health Services, Adobe Mountain School, Conducted May 5th and 6th, 2007."

UFN 3.2 (Identification/Screening), 3.2.7. The State shall develop and implement policies and procedures to expeditiously obtain from the juvenile divisions of all Superior Courts in the state, as well as all county juvenile detention facilities and/or placement settings from which the youth is committed, all pertinent records with the youth upon commitment to ADJC within one week of the youth's arrival.

Status: Substantial Compliance

Discussion: ADJC entered into a Memorandum of Agreement (MOU) with the Administrative Office of the Courts concerning the timely transfer of pertinent information on youth committed to the agency from local juvenile courts throughout the state. Effective April 2005, the agreement requires that juvenile courts submit these pertinent records within seven (7) days of the youth's arrival to ADJC. A *Checklist for Juvenile Commitment to ADJC* was developed, and includes, but is not limited to, the requirement for juvenile courts to forward "incident reports generated during current detention period," "documentation of any suicidal behavior or ideation" and "psychological and psychiatric reports, including mental health treatment summaries." Although local court systems are allowed up to 7 days to submit this information, the records are ideally transferred with the youth upon their arrival at the ADJC's RAC unit.

Quality Assurance audits conducted in December 2005, January 2006, August 2006, and November 2006 indicated continued steady progress in this area. In fact, the most recent QA Audit at AMS found that all 12 reviewed cases had a *Checklist* (although 4 were misfiled in the field file). In addition, the most recent QA Audit at BCS high compliance rates (i.e., 9 of 10 reviewed files contained the *Checklist*).

The previous audits revealed that although the *Checklists* are not always filled out correctly,

county juvenile courts and detention facilities are doing a much better job in forwarding pertinent records. However, these jurisdictions are still inconsistent in providing "documentation of any suicidal behavior, ideation or self-injurious behavior, if applicable." The Consultants Committee continues to be concerned regarding the consistency of commitment shown by individual counties throughout the state, particularly related to the issue of prior suicidal behavior during detention. The Consultants Committee reviewed 7 mental health charts at CMS on March 22, 2007 and found that 4 lacked any detention records (despite the fact that each youth had extensive detention records).

Finally, in June 2007, the ADJC and AOC (Administrative Office of the Courts) extended their Memorandum of Agreement for 12 months until April 7, 2008. This action is very commendable.

Recommendations: Several recommendations are offered. First, it is strongly recommended that the Memorandum of Understanding continue to be extended by the parties on a continuing yearly basis. Second, consistent with Agreement's mission of sharing critical information, it is strongly recommended that ADJC develop a policy that requires the agency to forward pertinent medical and mental health information via a discharge summary form for youth transferred from one of its facilities and a county juvenile and adult detention center. Third, effective with this report, the ADJC has been in substantial compliance with this section of the agreement for 18 months. Termination from monitoring is recommended.

In August 2007, the Consultants Committee was informed that the ADJC Transfer/Discharge Summary form was revised to include distribution to adult county jails and outside providers/agencies (as recommended in Number 2 above).

Documentation: Renewed Memorandum of Agreement Between the Administrative Office of the Courts and the Arizona Department of Juvenile Corrections; sample case file reviews; "Quality Assurance Special Audit, Behavioral Health Services, Adobe Mountain School, Conducted May 5th and 6th, 2007," and "Quality Assurance Audit, Black Canyon School, June 9th through June 13, 2007."

UFN 3.4 (Supervision), 3.4.1. The State shall develop and implement a "step-down" level of observation whereby youth on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precaution.

Status: Substantial Compliance

Discussion: Overall, the Consultants Committee continues to find that current practices are consistent with this policy at each facility.

Recommendation: Effective September 2006, the ADJC has been in substantial compliance with this section of the agreement for 18 months. Termination from monitoring is recommended.

Documentation: ADJC Policy 4250.01; Daily Suicide Prevention Status Lists.

UFN 3.4 (Supervision), 3.4.2. The State shall ensure that all youth discharged from suicide precaution continue to receive mental health treatment in accordance with a treatment plan developed by a qualified mental health professional.

Status: Substantial Compliance

Discussion: Section 5 of ADJC's suicide prevention policy (4250.01) requires QMHP staff to "Note treatment follow-up and recommendations on the CIA form whenever juvenile is downgraded or is removed from precautionary status; Ensure treatment follow-up and recommendations are viewed and discussed at each weekly clinical meeting; and Ensure that the juvenile's case plan includes goals and objectives pertaining to suicide prevention and/or self-injurious behavior."

As discussed in detail in our March 2006, September 2006, and March 2007 reports, despite the requirement for QMHP staff to document a treatment plan and appropriate follow-up services on both the youth's CIA and Continuous Case Plan (CCP), the Consultants Committee found that such documentation continued to be inadequate.

For example, although the recent QA Audit at AMS found that suicide was identified as a problem area in 11 of 12 mental health charts of youth recently released from suicide precautions, "Contact Detail Reports were written for 5 of 12 youth who reached Standard SPS level and who were discussed at the Clinical Team Meeting," and "CIAs contained ineffective or generic treatment recommendations in 50% of the MHCs reviewed."

The Consultants Committee review of one CIA form (from CMS) symbolized the poor quality of real treatment planning. The QMHP had written the following treatment recommendations for Youth E.F. on the CIA form: "1) Youth placed on Standard Supervision; 2) Youth's CCP and CAPFA will reflect his C/O status,; and 3) Youth's CIA will be communicated to PA II Staff and Clinical Lead…" These are *not* treatment recommendations, they are requirements to fulfill ADJC policy!

In August 2007, the Consultants Committee returned to the three facilities to once again audit treatment planning. Specifically, we reviewed cases of youth who had recently been discharged from suicide precautions (after several days or weeks of observation) and should have had their CCPs revised accordingly. The focus was on revision of both CIAs and CCPs, as well as Progress Notes, to determine if treatment planning goals and objectives for reducing suicidal ideation as listed in the revised CCPs was adequately addressed in each Progress Note.

At AMS, 9 files were reviewed with only 3 deemed adequate. Problems in the other files included missing Progress Notes, the number of Progress Notes did not match the number of sessions recommended in the CCP, missing CCPs, and the quality of Progress Notes. On one case, the youth (M.L.) was on and off suicide precautions between April and July 2007, yet there were only four Progress Notes that addressed suicidal ideation.

At BCS, 5 files were reviewed with 3 deemed adequate. Problems in the other files included Progress Notes that did not address suicidal ideation or Progress Notes that addressed suicidal

ideation but were vague as to the specific interventions utilized by the clinician to reduce the youth's suicidal ideation.

At CMS, 9 files were reviewed with 7 deemed adequate. All CCPs were in place and most Progress Notes reflected suicidal ideation as targeted within the revised CCP. The ability to document the intervention provided by the clinician to decrease suicidal ideation varied by case, but the following demonstrates adequate treatment planning notations:

Youth G.E.

- Youth will begin to identify some ways that he can express being angry without tying sheet around his neck.
- Youth will identify how he can let staff know that he needs to be in a safe place with them and not alone – but also be allowed to be silent in their presence, at least for a while.
- Youth will begin to identify how he can work through being angry enough to be able to talk to staff about what he is thinking and feeling.
- Consult with staff re: past intervention for his anger and rage. He needs continued work in anger management, grief and needs intervention to stop the cycle of withdrawal.
- A formal sleep study should be completed over a 14-day period.
- Youth to work on identifying 5 or more triggers to include thinking errors that set him up for depression.

Youth A.C.

- I believe that someone has already called the CPS worker to clarify and will meet with youth to explain what she was telling him. I will check to be sure that this has been done. I will check with youth to be sure that he is clear and that his anxiety is alleviated. I will also meet with him to assess suicidality as a follow-up to his close observation.
- Work on relaxation techniques with youth.
- Ask Dr.____ to meet with youth to do interventions to diminish the effects of the abuse and trauma.
- Youth needs to develop various methods to distract when his frustration level is low.
- Training in anger management via relaxation methods may b helpful.
- I will see youth next week as a follow-up and to provide some skill training in relaxation.
- Youth will be seen for 4 sessions to follow-up and assess his mental status. Problem solving re: peer conflict will be explored.
- Youth commits to not use suicidal ideation as a manipulation of staff. Youth to write an inventory of everyone he is holding resentments toward to identify how his resentments lead to distrust and then to his outbursts.

In conclusion, although much more progress is needed in this area, given the recent efforts by both ADJC headquarters personnel, as well as QMHP staff at the facility level, a rating of substantial compliance is given for this monitoring period.

Recommendations: ADJC should again provide instruction during regular psychologists meetings, as well as during the up-coming mental health summit, regarding the necessity for

clinicians to document (in the Progress Notes) the specific intervention(s) utilized to decrease a youth's suicidal ideation.

Documentation: "Quality Assurance Special Audit, Behavioral Health Services, Adobe Mountain School, Conducted May 5th and 6th, 2007," "Quality Assurance Audit, Black Canyon School, June 9th through June 13, 2007," and sample case file reviews conducted at the three facilities on August 7 and August 8, 2007.

UFN 3.6 (Mortality Review), 3.6.1. The State shall continue to ensure that all completed suicides and serious suicide attempts are reviewed by the Internal Review Committee for policy and training implications.

Status: Substantial Compliance

Discussion: As discussed in previous reports, there are two layers of ADJC review following a completed or serious suicide attempt -- critical incident debriefing (1190.02) and internal review committee (4250.03).

The Critical Incident Debriefing is a multidisciplinary review at the facility level and involves: "1) a review of the circumstances surrounding the incident; 2) the effect of the incident on involved employees and juveniles; 3) the cause or potential causes of the incident; 4) identification of known or potential deficiencies in operational procedures and/or practices including circumstances leading up to the incident, response to the incident, and follow-up and notification after the incident; 5) need for immediate corrective action and steps taken; 6) specific employee training issues; 7) review of other options that were possibly available in resolving the incident; 8) identification of appropriate and/or extraordinary responses by employees or juveniles; and 9) assignments and delegation of report writing, including incident reports, and investigations, interviews, etc."

The Internal Review Committee is a multidisciplinary review at the central office level that is chaired by the Quality Assurance Administrator and includes critical review of: "1) the circumstances surrounding the incident; 2) the facility or community procedures relevant to the incident; 3) any Incident Debriefing Reports; 4) all relevant training received by involved employees; 5) all pertinent supervision and treatment plan reports; 6) all pertinent medical and mental health services/reports involving the victim; 7) pertinent family dynamics; and 8) recommendations for possible improvements in employee training, operational procedures, physical plant, and program services.

The Consultants Committee reviewed the following three IRCs reviews during this monitoring period:

Youth J.C at BCS on February 17, 2007
Youth N.P at BCS on March 5, 2007
Youth D.V. at EPS on March 30, 2007

Overall, we found the review processes were adequate and documented the positive and negative

issues related to each incident. In addition, both education and medical personnel were in attendance, correcting a previous problem. There were, however, varying problems related to the processes for each review. Both BCS reviews were brief and lacked some basic information. For example, although ADJC policy requires that the Internal Review Committee "review all pertinent supervision and treatment plan reports" and "review all pertinent medical and mental health services involving the victim," there was no indication in the BCS reviews that these documents were reviewed, or even if any of these youth were on suicide precautions at the time of the incidents. More importantly, many of the IRC recommendations for the J.C. case were troubling:

"Review level of service required by youth"
"Review medication levels and determine any possible impact on behaviors"
"Review youth history to determine any changes in February"

The above "recommendations" are tasks that should have been completed prior to, and presented at, the scheduled IRC meeting. Listing these tasks as recommendations is an indication that certain IRC members were ill-prepared for the meeting.

Prior to the IRC meeting for the D.V. case, the Consultants Committee discussed our critique of the J.C. and N.P. cases with the Quality Assurance Administrator. As a result of this meeting, the Quality Assurance Administrator appeared to have a much better understanding of the total scope and overall purpose of the IRC process. On May 3, 2007, the Consultants Committee participated in the IRC meeting regarding the D.V. case. The Quality Assurance Administrator did a terrific job in coordinating discussion at the meeting. With the assistance of the Consultants Committee, pointed questions were offered and extensive discussion was held regarding the case. The Consultants Committee sensed that IRC members believed that the review was very worthwhile in addressing certain individual personnel, as well as systemic, issues.

Overall, the written review subsequently produced by the Quality Assurance Administrator was thorough and much more detailed than previous reviews. However, there were several issues discussed during the review that were omitted from the written summary. For example, contrary to ADJC policy, the parents/guardians of D.V. were never notified when he was transported to the hospital. When D.V. was transported back to EPS following receipt of medical treatment at the hospital, he was placed on SPL 3 (not standard supervision as reported in the IRC review). This recommendation was made by the QMHP prior to the youth's transport to the hospital. The mental health representative at the IRC meeting agreed that the decision to place D.V. on SPL 3 upon release from the hospital was inappropriate. Although not specifically addressed in ADJC policy, common sense dictates that because youth are transferred to the hospital only when they have engaged in a serious and/or life-threatening self-injury, and the SPL 1 is reserved for serious and/or life-threatening self-injurious behavior, it should follow that the youth should be placed on SPL 1 upon their return from the hospital. This issue should be added to the recommendation section of the IRC summary, and all recommendations should have a deadline established for corrective action.

Finally, the Consultants Committee observed a comprehensive audit of suicide prevention practices at AMS by the Quality Assurance Team on May 2, 2007. Following initial confusion between ADJC central office officials and the subject matter experts regarding the scope of the

audit, the process commenced after a short delay. Overall, the Consultants Committee was very impressed with the quality and thoroughness of the review. The process also allowed the QA Team and Consultants Committee to review the "Comprehensive Review Checklist" form utilized during the audit and offer revisions to the form. They are offered below. The Consultants Committee also reviewed the two-page abbreviated "Comprehensive Review Checklist" form utilized in the recent April 2007 audit at CMS. Unfortunately, there were several critical questions omitted from the abbreviated form regarding suicide prevention that effected the thoroughness of the CMS audit.

In conclusion, our March 2007 report gave a rating of partial compliance to this section because ADJC had taken a step backwards in conducting proper CID, IRC, and 60-day suicide prevention audits. However, although continued improvement is still necessary, given the overall progress in these areas that was aided by the Consultants Committee, a rating of substantial compliance is given during this monitoring period.

Recommendations: First, to ensure consistency in QA audits, the Quality Assurance Team must utilize the same "Comprehensive Review Checklist" form during each audit. Second, the following areas of inquiry should be added to the "Comprehensive Review Checklist" form: 1) page 4, add "The weekly clinical team meeting includes representatives of PSA, YPO, medical, and education," 2) page 7, add "The QA team member attended at least one suicide prevention training workshop and found it to be of high quality," 3) page 8, add "within 7 days" to question 20, 4) page 9, add "In review of three Housing Units, all emergency response equipment was found in assigned area"; and 5) add "In review of the Separation Unit and three Housing Units, no youth in their rooms had blankets covering their heads."

Documentation: "Comprehensive Review Checklist" form; IRC reviews of J.C., N.P. and D.V. cases; participation in IRC review on May 3, 2007; "Quality Assurance Special Audit, Behavioral Health Services, Adobe Mountain School, Conducted May 5th and 6th, 2007."

Discussion: Pursuant to Section III H.5 of the Memorandum of Agreement (MOA) the following Sections of the MOA are terminated from the agreement and no longer subject to monitoring, based upon a finding of "Substantial Compliance" for at least 18 months.

UFN 3.1 (Training), 3.1.1. The DOJ acknowledges that ADJC has designed and implemented a suicide-prevention training curriculum. ADJC shall continue to conduct suicide prevention training for youth contact staff. Within six months of the effective date of this Agreement, the State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics:

(1) (3.1.1.1) the ADJC suicide prevention policy as revised consistent with this Agreement;
(2) (3.1.1.2) why facility environments may contribute to suicidal behavior;
(3) (3.1.1.3) potential predisposing factors to suicide;
(4) (3.1.1.4) high risk suicide periods;
(5) (3.1.1.5) warning signs and symptoms of suicidal behavior;
(6) (3.1.1.6) case studies of recent suicides and serious suicide attempts;

(7) (3.1.1.7) mock demonstrations regarding the proper response to a suicide attempt; and
(8) (3.1.1.8) the proper use of emergency equipment.

UFN 3.1 (Training), 3.1.2. Within six months of the effective date of this Agreement, the State shall ensure that all existing and newly hired direct care, medical, and mental health staff, receive an initial eight-hour training on suicide prevention curriculum described in paragraph (1) above. Following completion of the initial training, the State shall ensure that two hours of refresher training on the curriculum are completed by all direct care, medical, and mental health staff each year.

UFN 3.2 (Identification/Screening), 3.2.1. The DOJ acknowledges that the State has extensively revised its suicide prevention policies and procedures. Within six months of the effective date of this Agreement, the State shall revise its suicide prevention policy to reflect that any staff member who observes and/or identifies a youth as potentially suicidal shall immediately place the youth on suicide precautions and refer them to a qualified mental health professional for assessment.

UFN 3.2 (Identification/Screening), 3.2.2. The State shall continue to ensure that any staff member who places a youth on suicide precaution shall document the initiation of the precautions level of observation, housing location, and conditions of the precautions.

UFN 3.2 (Identification/Screening), 3.2.3. The State shall continue to develop and implement policies and procedures to ensure that the documentation described in paragraph (b) above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of a youth on suicide precaution.

UFN 3.2 (Identification/Screening), 3.2.4. The State shall continue to ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions.

UFN 3.2 (Identification/Screening), 3.2.6. The State shall continue to ensure that newly arrived residents are placed under close observation until they can be assessed by mental health staff.

UFN 3.2 (Identification/Screening), 3.2.8. The State shall develop and implement policies and procedures to ensure that ADJC creates an integrated medical and mental health record system for each youth. The State shall promulgate a policy requiring that all ADJC mental health staff shall be required to utilize progress notes to document each interaction and/or assessment of suicidal youth.

UFN 3.2 (Identification/Screening), 3.2.9. The State shall continue to develop, implement, and comply with policies and procedures for communicating the management needs of suicidal youth among direct care, medical, and mental health personnel.

Discussion: Although this section has been terminated from the agreement due to a finding of substantial compliance, the Consultants Committee would note that we attended AMS clinical team meetings on March 22 and May 2, 2007. With one noted exception, we found that the sessions were well attended (by QMHP, housing unit, and administrative personnel) and included

the necessary discussion of youth on suicide precautions, as well as those scheduled for release from precautions. The one noted exception was the continued long-standing absence of any medical personnel in attendance at these meetings. In fact, the March meeting included discussion of a medical issue that could not be resolved because there were no medical personnel in attendance. Medical personnel consistently attend both CMS and BCS clinical team meetings. The absence of any AMS medical representation is inexcusable and should be immediately corrected.

In August 2007, the Consultants Committee was informed that an AMS nurse has consistently attended the four (4) previous weekly clinical team meetings.

Documentation: March 22 and May 2, 2007 AMS clinical team meetings.

UFN 3.3 (Safe Housing of Suicidal Youth), 3.3.1. The DOJ acknowledges that the State has taken significant steps to remedy physical plant hazards to suicidal youth. The State shall continue its remedial plans to ensure that all youth placed on suicide precaution are housed in suicide-resistant rooms (i.e., rooms without protrusions that would enable youth to hang themselves).

UFN 3.3 (Safe Housing of Suicidal Youth), 3.3.2. The State now requires that all direct care staff carry packs on their person containing extraction tools and CPR microshields. The State shall continue to ensure that direct care staff has immediate access to appropriate equipment to intervene in the event of an attempted suicide.

UFN 3.5 (Intervention), 3.5.1. The State has revised ADJC's suicide prevention policy to specify the proper role of staff in responding to a suicide attempt by youth and shall continue to ensure that staff are trained in appropriate response techniques and the use of emergency equipment on an annual basis.

4. JUVENILE JUSTICE

Executive Summary:

During the course of the monitoring of this agreement the ADJC has developed an administrative infrastructure that will allow the agency to provide services to youth while protecting them from harm. The development of this infrastructure, over the last 3 years, has been very impressive and is a major accomplishment for Director Michael Branham, his leadership team and all staff throughout the agency.

Staff have been recruited and trained. Staffing ratios consistent with best practice are met the vast majority of the time. A functional grievance system is in place, which includes a Youth Ombuds at each facility who represents the youth in that process. The Inspections and Investigations Division (I&I) is a professional law enforcement office that insists on enforcing the Zero Tolerance programming (no abuse) adopted by ADJC. This office has been successful in the termination of

employees that are unable to perform work consistent with ADJC and national standards of care. A well-organized quality assurance process is operational that includes Institutional Coordinators at each facility who oversee the implementation of audit recommendations. A Governor's Juvenile Corrections Advisory Commission, recommended by the Committee of Consultants, agreed to by Governor Napolitano and the ADJC will soon be formed. This Council will provide oversight, primarily though it's participation in the auditing process, to the ADJC and assist it with retaining its mission of rehabilitation for troubled youth of Arizona. To assist with this process a QA grid outlined by the Committee of Consultants and organized by Dr. McGlynn is included in Appendix A of this report.

In addition to the development of the Juvenile Corrections Advisory Commission and its inclusion in the Quality Assurance process the Committee of Consultants wishes to emphasize that the ADJC should retain the administrative structure embodied in the settlement agreement. The Quality Assurance Office, while contained within the ADJC structure, must be able to function without hindrance from other entities within the agency. The director of that office should report directly to the ADJC Director. It is anticipated that the QA Director will also provide reports to the Juvenile Corrections Advisory Commission at each of its meetings.

A new director of QA has been hired to replace Dr.Megan McGlynn who is leaving the agency. The new director has an impressive auditing background but lacks direct care experience within the juvenile justice system; however he has supervised the ADJC pre-service academy for two years. The ADJC is currently in a stage of reform and development that requires such an expertise if that Division is to successfully complete audits and provide the recommendations crucial to sustaining reform. The inclusion of juvenile justice expertise within the auditing process will be critical for continued system improvement.

During this time frame the ADJC has successfully reduced the use of exclusion in living modules (absent self-referrals) and provided significant oversight to the use of separation. Exclusion and Separation were focuses of the original CRIPA investigation and the change in the agency culture required by the settlement agreement is evidenced by this decreased usage. Agency personnel oversee separation units in each facility. Exclusion is monitored for appropriate usage based on new standards developed during this monitoring period. This has resulted in a much safer institutional environment for youth and staff and introduced programming concepts that clearly provide the structure both programmatically and administratively that was lacking and which led to the intrusion of the U.S. Department of Justice in its operation

What is currently lacking in the ADJC is a philosophy of treatment that is embraced by all segments of the agency and which will result in a culture change necessary to successful reformation. The New Freedom cottage management system is being installed and it holds promise but it lacks commitment to it from youth and staff. With continued work that will come with time. What is needed for the ADJC to move forward is embodied in principles of program endurance. People, Commitment and Legacy. A dilemma with reform is that it results in an unstable organization. People who resist change either leave or are terminated. New staff are hired and trained but lack the experience to implement programming. Many senior staff continue to resist the change resulting in organizational turmoil that has to be overcome. One of the former monitors of the *Johnson v. Upchurch* Consent Decree, Allen Breed, described reform as a period

of intense activity, followed by a period of apathy, followed by a return to the status quo. Unfortunately, that has been true of many reform efforts.

Staff (people) that are currently being hired and trained need to be retained (commitment & legacy). New Freedom (legacy) needs to be successfully installed and the organizational structure embodied in the Settlement Agreement needs to be retained.

The ADJC is much safer now than when this process began. This is due to the outstanding effort of Director Branham and his staff to come into compliance with the MOA provisions and the institutional culture change created by the monitoring of the settlement agreement. The most difficult part of this process is just beginning. To sustain the reform the ADJC will have to allow the transparency that came with the Settlement Agreement monitoring. The infrastructure that has been installed allows for that to occur. As long as it does the ADJC will provide rehabilitation opportunities for committed youth not formerly available to the youth of Arizona.

4.2 Protection from Harm

This section is divided into two. 4.2.1 The reporting and investigation of allegations of abuse and 4.2.1A Protection from Harm.

UFN 4.2.1 The reporting and investigation of allegations of abuse. The DOJ acknowledges that the State has made significant efforts to improve the policies, procedures, and practices for the reporting and investigation of allegations of abuse of a youth made by any person, including youth. Effective immediately upon the effective date of this Agreement, the State shall continue to make all reasonable efforts to ensure that all youth are protected from harm and that all allegations of abuse, including but not limited to physical and sexual abuse, are investigated in a timely and thorough manner by ADJC's Investigations and Inspections Unit, or other appropriately trained investigative personnel, as designated by the ADJC Director.

Status: Substantial Compliance

Discussion: Reporting and investigations of allegations of abuse: The I&I Division continues its work as outlined in previous reports. See Appendix B for a full summary of its activities from the beginning of the settlement agreement through July. During a period of reformation it is expected that investigative activity will be enhanced. As can be seen by the summary the total number of incidents is the second highest since the beginning of the monitoring. Those assigned to criminal is the highest number. Inspections are also the highest which probably accounts for the other numbers since additional oversight would allow for more identification of problems. There are no national figures that allow comparisons with other facilities. The National Performance Based Standards (PbS) is attempting to provide that comparison and hopefully will be able to in the very near future. What is known is that Arizona has a highly sophisticated management information system. Arizona is collecting data that many jurisdictions do not collect. A decision was made at the beginning of this process to include the data in the report. Monitoring will continue through audits and through the Governors Juvenile Corrections Advisory Commission. As the agency continues to become more stable and programming more

developed these numbers will decrease and should be used to monitor the culture of the agency continuously.
Recommendation: None.
Documentation: Discussion with John Dempsey at CMS during August site visit and with Kellie Warren at AMS during the August site visit.
4.2.1 A Protection from Harm
Status: Substantial Compliance
Discussion: Appendix C contains the summary of the CRIPA reporting through July 2007. As can be seen the total # of calls responded to by security is the highest of any period during the 3 year monitoring period. All other categories remained approximately the same but the total number of uses of force declined. The same explanation as provided in 4.2.1 applies to this provision. It is the opinion of all of the monitors and of senior staff interviewed over the last year of this agreement that the facilities are all much safer now than at the beginning of the monitoring of the Settlement Agreement. The numbers will need to continue to be reviewed for administrative and programmatic improvement so that they begin to show steady and continual declines.
Recommendation: Continue to track through auditing.
Documentation: Data provided by ADJC.
UFN 4.2.3 In collaboration with the local office of Child Protective Services and with local law enforcement, the facilities shall develop and implement policies and procedures regarding steps that must be taken immediately upon the reporting of an allegation of abuse in order to preserve evidence and to protect youths pending an investigation of the abuse.
Status: Substantial Compliance
Discussion: During the last reporting period and at meeting with the Governor's Task Force on April 26, 2007, the Governor's Office indicated its intent to form the ADJC Advisory Council comprised of members appointed by the Governor. Members of the existing juvenile justice task force were asked of their interest and advised to make that known to the Governor if they wished consideration for appointment to the advisory council. This council will have as it main responsibility the oversight function so necessary to maintain the monitoring function of the settlement agreement. The chairman of the Committee of Consultants, Russell K. Van Vleet, was requested to develop an auditing process that would be sufficient in detail so that this new advisory council might have direction in how to assist the ADJC in its continued review of its policy & procedures as well as practices so that reforms developed during the monitoring of the settlement agreement will not be lost in the future. By policy ADJC will include subject matter expertise in all areas being audited. The process developed by the Consultant's Committee is included in Appendix A of this report.

Recommendation: None.

Documentation: Meeting with Governor's Task Force on April 26, 2007.

UFN 4.2.8 The State shall evaluate regularly the training and the trained techniques through quality assurance data (including data correlating use of force incidents and abuse allegations with data measuring the efficacy, occurrence of, and staff participation in training programs), Performance based standards data, evaluations from training program participants, Incident Review Team reviews of use of force incidents, abuse investigation reports, interviews with staff and youths, and other means evidencing the efficacy of the trained techniques in managing behaviors and crisis interventions at the facilities. As warranted, the facilities shall adjust the training curriculum based on such evaluations.

Status: Substantial Compliance

Discussion: There were two changes in training in response to data collected on use of force investigations. Handle With Care curriculum was changed (2007) to include more scenario based skills practice and additional moves (Ikkyo and Kotegashi.) The basic (16) hour course is being taught this year on an In-service basis in addition to the Academy class. All direct contact staff, not just YCOs (kitchen, education, maintenance, etc.) are required to demonstrate the skills of HWC, all others (non-direct) are to attend for knowledge base only. In addition, training is conducted monthly on HWC and TCI at the facilities.

Recommendation: None.

Documentation: Memo from Megan McGlynn to Lou Goodman to Committee of Consultants dated 6/27/07.

4.3 Staffing

UFN 4.3.1 The DOJ acknowledges that the State has embarked on a plan to add necessary additional direct care staff positions. The State shall ensure that there are sufficient numbers of adequately trained direct care and supervisory staff to safely supervise youth and protect youth from harm.

Status: Substantial Compliance

Discussion: It is the intent of the ADJC to meet staff ratios outlined in the first report. No ratios were contained in the Settlement Agreement. It was agreed during the first reporting period, however, that best practice would provide staffing ratios of 2-3-2 for a 24 bed cottage which would be 1:12, 1:8 and 1:12. For a 32 bed the staffing would be 3-4-2 or ratios of 1:11, 1:8 and 1:16. ADJC is in compliance with these ratios, a great majority of the time on all but the 3rd shift.

Over the last six months (from January through July 2007) ADJC's total average rate of non-compliance in staff-to-youth ratios, for first and second shift, was only .008. During this time period there were 4,229 1st shifts with only 7 not meeting minimum ratios. There were 4,229

second shifts with only 53 not meeting ratios. When out of compliance it was when new youth would enter the facility during a shift and ratios would, for the remainder of a shift, sometimes go up to 1:9, 1:10, or 1:13 or 1:14. For 1st and 2nd shifts then, January through July 2007 there were 8,958 total shifts between 1st and 2nd shifts with only 60 of those shifts not meeting best practice ratios.

Effective August 3, 2007 ADJC has begun to post security officers in housing units, on a rotating basis. The security officers will spend up to one hour on each unit and will be expected to document their arrival and departure times in the unit log book. In addition, ADJC will add one staff person to 32 bed cottages allowing for a minimum of 3-4-2 and 4-4-2 on weekends. 24 bed cottages will also be increased to 3-3-2 on weekends.

Ratios have not always been 100% met due to staff vacancies. Over the course of the 3 year settlement agreement wages have been increased by 1/3 which has decreased the number of staff who finish the Academy but do not remain with the agency. In addition the Academy is graduating a much larger number of new staff. In 2006 there were 119 YCO's that came out of the academy. In FY 2007 the Academy graduated 191. Lastly, the ADJC hired a retention officer that will assist in retaining staff.

Overtime: Overtime continues to be used to cover for staff vacancies, training, Level I Suicide Watches on youth, etc. For the first 2 pay periods, reviewed, staff vacancies were more prevalent. As the fiscal year progressed, new staff have been placed in housing units to fill those vacancies while security has been allocated less. Security overtime has continued to drop from the level of the first 2 pay periods. For the housing units, shift coverage has been supplemented in some cases by Youth Program Officer III's (Case Managers) working a small number of shifts per pay period.

Overtime usage continues to be reduced. Staff cannot work more than the 16 hours per pay period allowed by policy.

The card swipe system mentioned in the last report has not, to this point, provided additional verification of staff attendance. That system is still being developed.

Manzanita cottage: In the 5th report there was mention of 19 shifts not meeting ratios in the Manzanita cottage of CMS. A request was made for clarification of that number. In a memo sent On 6/26/07 it indicates that the summary provided for the 5th report was in error There really was not an error, different ratios were used to determine compliance.

During the August site visit this issue was clarified. Policy 4002.5D does allow for ratios to exceed the ratios stated in this report. It states that a ratio of 1:13 can be maintained on 1st shift, worst case scenario and 1:9 on the 2nd shift, worst case scenario. An explanation of these ratios indicates that given staff shortages cottages can go to the increased ratios without increasing staffing. However, the agency cannot exceed the worst case scenarios. Once the ratios get beyond the 1:13 and 1:9 it must bring in additional staff.

Substantial Compliance was given in the last report and is continued in this report because it is recognized that the agency has done everything it can do to recruit, train and retain staff. All

projections indicate that the agency will be able to maintain best practice ratios in the very near future and currently it is not exceeding worst case scenarios contained in policy.
Recommendation: Conduct auditing work using best practice ratios for purposes of compliance. Use worst case scenarios to determine minimum compliance.
Documentation: Met with Patti Cordova who had assumed responsibility for this material during the January site visit. She provided the numbers shown in the report. Excel spread sheet provided by Patti Cordova, electronic mail, February 27, 2007. Report from Grady Daniels on March 5, 2007. Report from Peter Lusaczak to committee of consultants date 6/27/07. ADJC I&I report from Jack Martin dated 6/26/07. Memo from Peter Luszczak, 6/28/07. Clarification of issues in August site visit consultation with Jack Martin and Grady Daniels at CMS. Discussion with Judy Dyess at CMS during August site visit. Discussion with leadership team during de-briefing of August site visit. Electronic mail from Kellie Warren of August 7, 2007 quoted in discussion. Telephone with Judy Dyess on August 7, 2007.
4.4 ADJC's Investigations and Inspections Unit and Quality Assurance Team
UFN 4.4.3.4 assuring the implementation and adequacy of the educational, medical, and mental health quality assurance programs required by this Agreement; and
UFN 4.4.3.5 coordinating quality assurance activities performed by various Division offices to prevent unnecessary duplication of efforts.
UFN 4.4.4 The Quality Assurance Team, in collaboration with the Inspections and Investigations Unit, shall create and implement a written quality assurance program, as defined in the Definitions Section of this Agreement, as supplemented below:
UFN 4.4.4.1 The comprehensive audits as specified in the Definitions Section shall include:
UFN 4.4.4.1.1 inspection of institutional, medical and educational records, unit logs, incident reports, use of force reports, major disciplinary reports, documentation of room checks by line staff, etc.
UFN 4.4.4.1.2 Interviews with staff, administrators, and youth at each facility;
UFN 4.4.4.1.3 where appropriate, interviews with the parents or other care givers of youth confined in the facilities;
UFN 4.4.4.1.4 inspection of the physical plant;
UFN 4.4.4.1.5 determination of compliance with the facilities' policies, including those relating to: suicide prevention, staffing levels and youth supervision, use of force, disciplinary practices, positive behavior management programs, grievance procedures, sanitation, youth-on-youth violence, conditions in security units, adequacy of counseling and rehabilitative services, and the adequacy of all facility documentation; and

UFN 4.4.4.1.6 A written report recording the findings of the audit.
UFN 4.4.4.2 Unannounced periodic site visits will occur at each facility. Investigations and Inspections Unit staff and the Quality Assurance Team shall have complete and unimpeded access to the facilities, their records, staff, and residents. Staff at the facilities shall be informed of their obligations to cooperate in all Investigations and Inspections Unit and Quality Assurance Team operations.
Status: Substantial Compliance
Discussion: The QA sections are all identified above. During the last reporting period all of the consultants have participated in audits. The QA process is operational, effective and extremely important to the maintenance of the reform effort and compliance with the provisions of this agreement. Megan McGlynn, QA Administrator, has taken monitoring outlines developed by the consultants and used those, coupled with the ADJC monitoring process to create a QA grid that is contained in Appendix A. That grid represents a process for continued monitoring of the ADJC system by the QA division as well as the Governor's Advisory Council that will assist with that effort beginning as soon as the Council is appointed by the Governor and trained to the process. It is expected that both of those actions will occur in the next two months.
Recommendation: Appoint Advisory Council members, complete the training and initiate their activity with the ADJC.
Documentation: Participation in audits at all 3 facilities during the last reporting period. Review of audits provided by the QA division.
UFN 4.4.4.4 Review of all incidents of use of force and the use of separation in excess of 24 hours shall be conducted. The Investigations and inspections Unit shall be sent copies of every use of force report. The Administrator of the Investigations and Inspections Unit shall establish criteria under which such incidents shall be independently investigated for compliance with the facilities' policies. Such criteria shall include review of all incidents of use of force resulting in serious injury or hospitalization.
Status: Substantial Compliance
Discussion: During the April site visit use of force was reviewed along with the audit team at Catalina Mountain School. Between 4-9-07 and 4-13-07 there were 17 uses of force. Information was taken from the youth base information system. Incident reports were read to determine that criteria for use of force were met. In each instance the criteria were met.
Recommendation: None
Documentation: Participation in CMS audit and discussion with Jeff Turney staff member developing oversight of use of separation. Reviewed the use of separation with Jeff Turney at CMS in the April, June and August site visits.

UFN 4.4.4.6 When, through audits, investigations or other quality assurance activities, there are findings of substantial non-compliance with the requirements of the facilities' policies or this Agreement, a plan of correction shall be developed.
Status: Substantial Compliance
Discussion: The use of cameras was discussed during the last two site visits. Their use in supervision is being explored more thoroughly by the administration.
Recommendation: None.
Documentation: Discussion with administration during the April, June and August site visits.
4.5 Disciplinary Confinement/Due Process
UFN 4.5.1 The DOJ acknowledges that the State has enacted policies and procedures regarding the use of exclusion, in-room confinement, lock down, large group, or other such restrictions to ensure usage when strictly appropriate consistent with facility security. The State shall continue to implement those policies and procedures, and shall monitor those policies and procedures for compliance, as described in 4 (c) and 4 (d) above.
Status: Substantial Compliance
Discussion: During the site visit to CMS in April an audit was conducted by QA and a review of the use of exclusion was included in that audit. The audit staff reviewed logs to match entries and to determine the use of exclusion as well as to verify that P&P was followed when exclusion was utilized. In addition records are being kept that determines whether exclusion is staff or youth initiated, the issues that led to the exclusion if it was staff initiated, time in, checks completed and youth prohibited from exclusion included in the log book. The audit team had a formal outline that it followed when conducting this review. The form required that the audit staff document the following: Date Time on Time off LSI (completed or not) Quality of LSI Exclusion initiated Comments The audit staff is to conduct a comprehensive audit of exclusion in each cottage in each facility. Every use of exclusion should be reviewed. This is not a randomized check and should not be in the future.
Exclusion: In the last report there was an agency response to the use of exclusion and a violence reduction plan. The Agency Response included program initiatives that would be undertaken. This Violence Reduction Plan is included in Appendix D.

The successful implementation of these initiatives will reduce the use of exclusion. See Appendix E for summary of the use of exclusion.

The Arizona Department of Juvenile Corrections (ADJC) defines exclusion as "the brief removal of a juvenile from regular programming and contact with other juveniles." Exclusion is intended to provide a juvenile with time and space in which to practice appropriate problem solving or a brief cool down period prior to processing

As can be seen in Appendix E the use of exclusion is the highest of any reporting period. This is explained by self-referrals to exclusion. Previous reporting did not include this because it was not allowed. Current programming does allow for youth to self-exclude, (except during school hours) but only with staff permission. This is recognizing that youth do need some privacy and it is allowed for youth who are meeting levels.

Exclusion is now broken out by staff initiated, youth initiated and multi disciplinary team (MDT) initiated.

For the months of April, May, and June, 2007 at each of the 3 facilities youth initiated exclusion is significantly higher than staff initiated exclusion, 831 to 566. MDT initiated exclusion is utilized as a reward for good behavior (not to exceed 60 minutes). It is part of a rewards and incentives program being initiated at ADJC. 52% of exclusion is youth initiated, staff initiated 40% and MDT 8%. Time spent in exclusion shows that MDT-initiated exclusion types spent the most time in exclusion (52 minutes), followed by youth initiated exclusion types (47 minutes) and staff initiated (44 minutes). If youth initiated exclusions were removed then the use of exclusion does not show increases that would be of any concern.

Separation

Separation is used by the agency to manage the segregation of juveniles. Placement in separation is seen as a serious and extreme measure and should only be used when all reasonable alternative measures have failed. Juveniles, however, do have an option to self-refer.

The use of separation is now managed by several people within ADJC. There is one person responsible for the daily operation at each unit. There is an institutional coordinator at each facility who should be reviewing the use of separation daily. There is also a position, system-wide whose sole purpose is to see that the use of separation conforms to the policy & procedure developed for its use during the course of this Memorandum of Agreement. Separation usage was low during the days of site visits except in August when 20 youth were in Separation at AMS. During the last several site visits all separation units have been visited and during each visit its use, system-wide has been consistent with P&P. There should be no problem in following best practice with the administrative detail now in place to monitor separation usage. A list is now kept in each cottage of youth who cannot be excluded.

To assist in this process Jeff Turney, the staff member with the responsibility to monitor separation is tracking youth who are multiple users of separation, "frequent fliers". As can be seen by the chart and graphs (Appendix F) the use of separation is higher than it has been during past

reports. It continues to be monitored very well at each facility but its increased usage is of some concern. One attempt to explain this was to take a look at unduplicated counts. That is, how many youth, the so-called "frequent fliers" were utilizing separation? In discussions with Jeff Turney during the June site visit it was clear that much of the use of separation could be explained by a relatively small number of youth using separation a great deal of the time. Examples of this are as follows:
AMS: From January-July 007 had a monthly average of only 14 juveniles who accounted for 50% of the separations. (7% of the AMS population accounted for half of the separation referrals.) One juvenile had 34 referrals in one month.
BCS: From January to July 2007, a monthly average of only 5 juveniles accounted for 50 % of the BCS separations. (8% of the BCS population accounted for half of the separation referrals.) One particular juvenile had 48 referrals in one month.
CMS: From January to July 2007 a monthly average of only 11 juveniles accounted for 50% of the CMS separations (11% of the CMS population accounted for half of the separation referrals) One particular juvenile had 33 referrals in one month.

This, of course, raises questions about the proper tracking of these youth and responses to their need for placement in separation as described by Dr. Kraus in previous reports. During the August site visit each facility was visited and it was confirmed that a process is in place that identifies the "frequent fliers", sees to it that they are properly referred. In addition to the referral these youth are staffed in clinical meetings.

Recommendation: Continue to monitor the use of exclusion and separation. With respect to exclusion special emphasis should be placed on the location of increased usage. During the early monitoring of this exclusion was high is some cottages. It would be wise to determine to what extent the rise in exclusion, including self-exclusion is in these same cottages and utilized by some of the same staff.

Documentation: Participation in CMS audit of April 07. Discussion with Jeff Turney at April and June site visits. Review of exclusion and separation at all facilities during the August site visit. Material provided by Dr. John Vivian outlining the use of separation. Electronic mail of August 7, 2007.

Discussion: Pursuant to Section III H.5 of the Memorandum of Agreement (MOA) the following Sections of the MOA are terminated from the agreement and no longer subject to monitoring, based upon a finding of "Substantial Compliance" for at least 18 months.

4.1 Grievance System

UFN 4.1.1 Upon the effective date of this Agreement, the State shall provide youths with an effective, reliable process to raise grievances without exposing them to retribution from staff. The State shall:

UFN 4.1.1.1 Ensure that at the time of orientation, newly arrived youths receive a clear explanation of the grievance process, and that youths' understanding of the process is at least verbally verified.

UFN 4.1.1.2 Ensure that, without any staff involvement, youths can easily obtain grievance forms and submit grievances directly.
UFN 4.1.1.3 Ensure that there are no formal or informal preconditions to the completion and submission of a grievance.
UFN 4.1.1.4 Ensure that grievances are examined and investigated by persons other than staff and the direct supervisors of those staff, who supervise the youth making the grievance. This provision shall not be interpreted to exclude the possible use of mediation in accordance with ADJC policy and procedure to resolve grievances.
UFN 4.1.1.5 Ensure that a youth who files a grievance is informed in writing of the results of the grievance process.
UFN 4.2.2 Each youth entering the facility shall be given an orientation that shall include simple directions for reporting abuse and assuring youth of their right to be protected from retaliation for reporting allegations of abuse.
UFN 4.2.4 Each youth who reports to the Health Unit with an injury shall be questioned by a nurse or other health care provider outside the hearing of other staff or youths, regarding the cause of the injury. If, in the course of the youth's infirmary visit, a health care provider suspects abuse, that health care provider shall immediately:
UFN 4.2.4.1 Take all appropriate steps to preserve evidence of the injury (e.g. photograph the injury and any other physical evidence);
UFN 4.2.4.2 report the suspected abuse to the investigations and Inspections Unit, which shall in turn report it to the local Child Protective Services office;
UFN 4.2.4.3 document adequately the matter in the youth's medical record; and
UFN 4.2.4.4 Complete an incident report.
UFN 4.2.5 Within six months of the effective date of this Agreement, the State shall develop and implement policies directing how, when, and to whom (including to Child Protective Services, law enforcement officials, and/or facility administrators) allegations of abuse shall be referred and investigated. A referral to Child Protective Services shall be made in accordance with Arizona state law, and an abuse investigation shall be warranted, whenever;
UFN 4.2.5.1 a health care provider, staff or youth reports suspected abuse; or
UFN 4.2.5.2 an incident report, use of force report, injury report, grievance or other source of information provides a credible basis for concluding that abuse may have occurred.
UFN 4.2.6 Effective six months from the effective date of this Agreement, the facilities shall provide appropriate behavior management/crisis intervention training to staff before staff may

work in direct contact with youths.
UFN 4.2.7 All staff shall continue to complete successfully competency based training in behavior management/crisis intervention before working directly with youths.
UFN 4.3.2 The State shall continue to ensure that there are adequate staff to provide adequate security for the facilities; permit youth to use the bathroom facilities in a timely manner and provide a sufficient level of supervision to allow youth reasonable access to medical and mental health services, education, and adequate time spent in out-of-room activities.
UFN 4.4.1 ADJC has created the Investigations and Inspections Unit within ADJC to consolidate and supplement quality assurance activities already undertaken by ADJC in accordance with this Agreement. ADJC has hired, from outside ADJC, an Administrator for the Investigations and Inspections Unit, who reports directly to the Director of ADJC. ADJC shall continue to provide the administrator with sufficient staff and resources to perform the tasks required by this Agreement.
UFN 4.4.2 ADJC shall create a Quality Assurance Team, the Administrator of which shall report directly to the Director of ADJC. The Quality Assurance Team shall work in conjunction with the Investigations and Inspections Unit.
UFN 4.4.3 The Investigations and Inspections Unit and the Quality Assurance Team, in Coordination, shall be responsible for the following tasks:
UFN 4.4.3.1 monitoring compliance with Department policies and procedures in the facilities, with emphasis on policies and procedures relating to issues addressed in this Agreement;
UFN 4.4.3.2 conducting audits and other quality assurance activities as described in 4 (d) below;
UFN 4.4.3.3 reviewing and, where appropriate, investigating allegations, of child abuse;
UFN 4.4.4.3 Investigation of significant incidents (as defined by the Administrator of the Investigations and Inspections Unit) shall include: Deaths; serious injuries or hospitalizations; suicides and serious suicide attempts; escapes or other serious breaches of security; and medical emergencies. The investigation shall result in a written report to the Director of ADJC and shall include findings and recommendations. The Director of the Investigations and Inspections Unit shall issue protocols for coordination of such investigations with other law enforcement, administrative disciplinary, or other quality assurance investigations.
UFN 4.4.4.5 Review of grievances raising significant issues (as defined by the Administrator of the Investigations and Inspections Unit) shall be conducted.
UFN 4.4.5 ADJC shall hire sufficient numbers of qualified investigators for the Investigations and Inspections Unit to permit prompt and thorough investigations of all allegations of abuse, including incidents of violence, use of force, serious injury or sexual misconduct. ADJC shall also ensure the investigators are provided initial and on-going training, and review and ensure the quality of all Investigations and Inspections Unit investigations.

UFN 4.4.6 ADJC shall develop and implement policies and procedures specifying that abuse investigations may be initiated by Investigations and Inspections Unit staff's review of grievances, incident reports, use of force reports, and injury reports when it appears that abuse may have occurred but was not reported. Abuse investigations also may be initiated by Investigations and Inspections Unit staff as a result of staff tours of facilities and interviews with youth, parents, or staff.
UFN 4.4.7 The Administrator of the Investigations and Inspections Unit shall issue policies and procedures regarding steps that must be taken upon the reporting of an allegation of abuse in order to preserve evidence and protect youth pending an Investigations and Inspections Unit investigation.
UFN 4.4.8 The Administrator of the Investigations and Inspections Unit shall develop and implement an Investigations Manual and training program for abuse investigations. The Training shall include specific instruction by qualified individuals on the conduct of abuse investigations relating to youth, and investigations within a correctional setting, and shall include an annual in-service training requirement.
UFN 4.4.9 The Administrator of the Investigations and Inspections Unit shall ensure that the Investigations Manual contains guidance and information regarding the following requirements:
UFN 4.4.9.1 An interview with the alleged victim and perpetrator:
UFN 4.4.9.2 Identification and interview of all possible witnesses, including other youth and staff in the building or unit at the time of the incident;
UFN 4.4.9.3 Examination of the youth and staff member's institutional and personnel records, including any prior allegations of abuse against the staff person whether substantiated or not;
UFN 4.4.9.4 Examination of any potentially relevant medical records; and
UFN 4.4.9.5 Determination whether any facility staff knew of but did not report the alleged abuse, or provided false information during the investigation.
UFN 4.4.10 The Administrator of the Investigations and Inspections Unit shall continue to ensure that a written report of each investigation of an allegation of abuse is produced. The report shall describe steps taken during the investigation, the information obtained, and the factual conclusions reached by the investigators finding the allegation substantiated, not resolved or unfounded. The Investigations and Inspections Unit shall continue to keep records of all of its investigations, and any disciplinary action taken in response to the investigation, including investigations that do not substantiate abuse.
UFN 4.4.11 The Director of ADJC, upon receipt of an investigative report for allegations of abuse, shall approve or disapprove the report's conclusion that the allegation was substantiated, not resolved or unfounded, or shall order further investigation. Only the Director of ADJC shall have the authority to disapprove a report's conclusion that the allegation of abuse was

substantiated. In such cases, the Director must explain the reason for such a decision in writing for personnel reasons. ADJC shall ensure that prompt and appropriate personnel actions are taken in response to substantiated findings.

UFN 4.4.12 ADJC shall develop and implement policies and procedures to address management problems that are uncovered during the course of an Investigations and Inspections unit investigation (e.g., inadequate staffing, location of abuse or fights, etc.). Corrective action plans will be developed to address these problems in an effort to prevent them from reoccurring,

UFN 4.5.2 The State shall continue to ensure that youths confined in Separation for more than 24 hours receive a due process hearing by an impartial official to determine whether cause exists for continued confinement.

5. SPECIAL EDUCATION

Executive Summary:

This section of the report discusses the status of the education and special education program within ADJC with a particular focus on the sustainability of the changes that have occurred during the past three years. The Fifth Semi-annual Report issued by the consultants on March 15, 2007 reported that all education provisions were in substantial compliance and several were being passively monitored. In preparing this final section of the report on education, the Consultants examined internal ADJC education program audits and ADJC quality assurance reviews that have been conducted during the past 6 months and briefly reviewed the special education sections of prior reports.

The administrative structure supporting the education program is sound. Policies and procedures that have been developed enable direct service staff – principals, teachers, para-professionals, psychologists, and others – to provide appropriate services to children and adolescents committed to ADJC. The education program has developed a regular system of staff development activities and actively recruits to fill vacant positions. The classrooms are adequately equipped and teachers and other staff have sufficient instructional materials and assessment tools. Dr. Jeske, the Superintendent for Education, was hired during the last reporting period, has continued the work of his predecessor.

The ADJC education program has developed and maintained a system to promptly request and receive prior school records for all students. This enables staff to adequately screen and assess students, review and update IEPs, and ensure that students who need special education services receive them. While many students eligible for special education services have been identified prior to their commitment to ADJC, new referrals for special education assessments are made by teaching and support staff. Periodically students with Section 504 eligibility receive appropriate accommodations and support at each facility. Staff at each school maintains contact with parents or guardians. Parents or surrogates participate in the majority of students' IEP meetings, occasionally by phone.

During the past year, the special education program, consistent with directives for all school districts in Arizona, has embraced an inclusion model of special education service delivery. While a few students may be pulled out of the regular classroom for intensive work with a special education teacher, most special education students receive services from their special education teacher in a co-taught general education classroom. Students receive services as specified on their IEPs. Therapists and other support staff maintain logs for services they provide as part of students' IEPs and teachers travel to separation units to provide direct services to students who are temporarily housed there. Youth aged 16 and older have transition services identified on their IEPs; older students at each of their schools have opportunity to participate in vocational education courses.

In addition to the periodic monitoring from the ADJC Office of Quality Assurance, the education program is monitored at each facility through an internal database maintained by the education staff. Finally, the ADJC education program has an on-going relationship with the Arizona Department of Education (ADE) and participates in ADE sponsored conferences and staff development activities. Every three years at a minimum, ADE conducts an extensive review of special education services at each facility.

UFN 5.1 The State shall at all times, provide all youth confined at the facilities with special education services as required by IDEA, 20 USC sec 1400 et seq., and regulations promulgated thereunder, Section 504 of the Rehabilitation Act of 1973, 29 USC sec 794, and regulations promulgated thereunder, and this agreement.

Status: Substantial Compliance

Discussion: A review of internal monitoring documents as well as ADJC quality assurance documents indicate that ADJC education programs at AMS, BCS, and CMS continue to provide special education services consistent with the requirements of IDEA.

Recommendation: No recommendation.

Documentation: Review of audit report. Discussion with Drs. Jeske and Jacobs.

UFN 5.2 The State shall retain a Superintendent of Education who shall meet the minimum standards as specified by the State. The State shall provide the Superintendent with sufficient staff and resources to perform the tasks required by this Agreement, [including…]

Status: Substantial Compliance

Discussion: Dr. Jeske continues in his role as Superintendent of Education.

Recommendation: No recommendation.

Documentation: Discussion with Dr. Jeske.

UFN 5.2.1 Oversight of the special education programming in the facilities, including development and implementation of policies and training programs.
Status: Substantial Compliance
Discussion: Oversight is appropriate and active.
Recommendation: No recommendation.
Documentation: Review of internal and external audits, discussion with Dr. Jacobs.
UFN 5.2.2 Monitoring whether special education staffing and resources are sufficient to provide adequate special education services to youth … and to ensure compliance with this agreement;
Status: Substantial Compliance
Discussion: Staffing and resources continue to be adequate.
Recommendation: Sustaining compliance in this area requires on-going vigilance by central office administrators as well as school principals. ADJC education staff has demonstrated good attention to this provision of the Settlement Agreement.
Documentation: Review of audit documents, discussion with diagnostician at BCS, interviews with principals at BCS and AMS indicate that staffing and resources are sufficient to provide appropriate services to youth.
UFN 5.2.3 Development and implementation of a quality assurance program for special education services.
Status: Substantial Compliance
Discussion: The internal tracking system "Special Ed at a Glance" continues to serve as an early warning system to ensure that students' needs are promptly addressed.
Recommendation: No recommendation.
Documentation: Review of internal and external audits.
UFN 5.3 The Superintendent shall provide prompt and adequate screening of youth for special education needs and shall identify youth who are receiving special education in their home school districts or who may be eligible to receive special education services but have not been so identified in the past. Such procedures shall include:
Status: Substantial Compliance

Discussion: Diagnosticians and administrative assistants at each site monitor student files. Annual staff development activities devote attention to screening and assessment of youth for special education services.
Recommendation: No recommendation.
Documentation: Review of internal audits.
UFN 5.3.1 Guidelines for interviewing youth to determine past receipt of special education services.
Status: Substantial Compliance
Discussion: Intake interviews continue as part of the intake process at RAC.
Recommendation: No recommendation.
Documentation: Discussion with Dr. Jacobs and review of internal and external audits.
UFN 5.3.2 Protocols developed in conjunction with local school districts and the State Department of Education for expedited reporting of special education status of students entering the facilities, conducting adequate testing of youths' substantive educational knowledge, and performing necessary vision and hearing tests;
Status: Substantial Compliance
Discussion: ADJC education staff continues to work with the Arizona Department of Education and local school districts.
Recommendation: No recommendations.
Documentation: Discussion with Dr. Jacobs.
UFN 5.3.3 Procedures identifying criteria under which staff or teachers must refer a student for evaluation for special education eligibility, including identifying criteria under which youth whose behavior has led to repeated exclusion from class must be referred for evaluation;
Status: Substantial Compliance
Discussion: Procedures and criteria for referral have been developed and continue to be used.
Recommendation: No recommendation.
Documentation: Review of internal and external audits.
UFN 5.3.4 Policies describing the required activities of Student Support Team pre-referral and

support team functions;
Status: Substantial Compliance
Discussion: Policies have been developed and are used by staff.
Recommendation: No recommendation.
Documentation: Discussion with Dr. Jacobs and review of internal audits.
UFN 5.3.5 Policies describing the requirements for comprehensive evaluation procedures to determine eligibility for special education services;
Status: Substantial Compliance
Discussion: ADJC education staff follows evaluation and eligibility guidelines established by the Arizona Department of Education.
Recommendation: No recommendation.
Documentation: Review of internal audits.
UFN 5.3.6 Policies describing the criteria for multidisciplinary team decision-making regarding eligibility for special education.
Status: Substantial Compliance
Discussion: ADJC education staff follows guidelines established by the Arizona Department of Education.
Recommendation: No recommendation.
Documentation: Review of internal and external audits.
UFN 5.5 The State shall continue its collaboration with the Arizona Department of Education to ensure appropriate parent guardian or surrogate parent involvement in evaluations, eligibility determinations, placement and provision of special education services.
Status: Substantial Compliance
Discussion: Parents and surrogates continue to regularly participate in IEP meetings, evaluations, and eligibility determinations.
Recommendation: No recommendation.
Documentation: Review of internal and external audits.

UFN 5.6 ADJC shall continue to ensure that if a youth is discharged from the facilities before the completion of the educational evaluation required above is complete, ADJC will forward to the superintendent of the youth's receiving school district all information regarding screening and evaluations completed to date, noting what evaluations are yet to be performed.
Status: Substantial Compliance
Discussion: ADJC education staff maintain contact with receiving school districts and forward information for youth in the process of being evaluated or re-evaluated.
Recommendation: No recommendation.
Documentation: Internal and external reviews of special education services.
UFN 5.7.1 ADJC shall, in a reasonable time period, create and/or implement an IEP, as defined in 34 C.F.R. § 300 300.340, for each youth who qualifies for an IEP. As part of satisfying this requirement, ADJC shall conduct required evaluations of IEPs, adequately document special education services, and comply with the IDEA regarding parent, surrogate, and student participation in the IEP process. ADJC shall hold team meetings once per week, if necessary, to develop IEPs for qualified special education students in accordance with federal regulations.
Status: Substantial Compliance
Discussion: Students' IEPs are developed in a timely manner and meet ADE and federal requirements for special education services as specified in 20 U.S.C. 1401 et seq. and 34 C.F.R. § 300 300.340
Recommendation: No recommendation.
Documentation: Review of internal audits.
UFN 5.7.2 In developing or modifying the IEP, ADJC shall ensure that the IEP reflects the individualized education needs of the youth. When the nature or severity of a youth's disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily, ADJC shall provide an appropriate alternate educational setting. ADJC shall ensure that each developed or modified IEP include documentation of the team's consideration of the youth's need for related services and transition planning. ADJC shall employ or contract with appropriate professionals to ensure the timely availability of related services to youths in the facilities.
Status: Substantial Compliance
Discussion: IEPs are appropriate to students' needs.
Recommendation: No recommendation.

Documentation: Review of internal and external audits.
UFN 5.7.3 The Superintendent shall continue to develop and implement a system to promote parent, guardian, and surrogate involvement in IEP development and placement meetings. This shall include such meetings through telecommunications technology or during times reasonably calculated to accommodate the schedules of parents, guardians, or surrogate parents. ADJC shall post notices in each facility stating the rights of students, parents or guardians regarding education services, including special education services.
Status: Substantial Compliance
Discussion: Review of internal and external audits.
Recommendation: No recommendation.
Documentation: Review internal and external audits.
UFN 5.7.4 The Superintendent of Education shall develop and implement an education staffing plan to ensure adequate staff to comply with the terms of this agreement. The plan shall provide for…
Status: Substantial Compliance
Discussion: During the monitoring of this settlement agreement, staff attrition has decreased. Performance incentives, staff development activities, and a school calendar that meets students' and teachers' needs have helped retain teachers and other staff.
Recommendation: No recommendation.
Documentation: Discussion with principals at AMS and BCS and Special Education Director Jacobs.
UFN 5.7.4.1 Sufficient numbers of certified special education teachers and staff to provide all youths with the opportunity to attend school full-time and to obtain adequate educational services, and to provide teachers with sufficient time to plan lessons, grade assignments, and participate in special education meetings;
Status: Substantial Compliance
Discussion: Sufficient number of qualified staff with adequate time to plan lessons and related activities are on staff at each of the three facilities.
Recommendation: No recommendation.
Documentation: Discussion with principals at AMS and BCS and Dr. Jacobs.
UFN 5.7.4.2 Sufficient psychological services to provide psychologist participation in the IEPs, administration of psycho-educational assessments, consultation with teachers and staff, and individual counseling related specifically to issues in youths' IEPs and educational plans.

Status: Substantial Compliance
Discussion: The ADJC education program has sufficient number of school psychologists to provide services to youth. Contract school psychologists are used as needed.
Recommendation: No recommendation.
Documentation: Review of internal audits.
UFN 5.7.5 ADJC will continue to designate an individual at each facility who is responsible for ensuring compliance with all provisions in this Agreement related to special education services.
Status: Substantial Compliance
Discussion: At each facility principal continues to be the designated staff member responsible for ensuring compliance.
Recommendation: No recommendation.
Documentation: Discussion with Dr. Jacobs and principals at AMS and BCS.
UFN 5.9.2 The Superintendent of Education shall be charged with quality assurance of all special education services at all of the facilities. The Superintendent of Special Education shall, in coordination with the ADJC Quality Assurance Team, develop and implement a written quality assurance program. This program shall include a system of on-going review of at least a representative sample of IEPs developed or modified in the facilities to monitor quality and assure compliance with the requirements of the ADJC policy and the IDEA.
Status: Substantial Compliance
Discussion: Procedures for internal and external monitoring are in place and being used by the education administrative staff and ADJC administration to ensure that appropriate services are being delivered.
Recommendation: None.
Documentation: Review of internal and external audits. Discussions with Dr. Jeske, Dr. Jacobs, and Dr. McGlynn.

Discussion: Pursuant to Section III H.5 of the Memorandum of Agreement (MOA) the following Sections of the MOA are terminated from the agreement and no longer subject to monitoring, based upon a finding of "Substantial Compliance" for at least 18 months.
UFN 5.4 The State shall continue to ensure that qualified professionals participate in the process for determining special education eligibility as required by federal regulations.

UFN 5.8.1 The State shall ensure that appropriate Section 504 plans are developed for all eligible youth. The State shall employ two Section 504 coordinators/guidance counselors at Adobe Mountain and one such position at each of the other facilities to develop and implement ADJC's Section 504 program and provide additional educational counseling services to youth.
UFN 5.9.1 The Superintendent of Education shall continue to design and implement annual inservice training requirements for special education staff of not less than four times per year, to enhance their ability to implement their duties under the provisions of this agreement.

6. MEDICAL CARE

Executive Summary:

Administrative:
Policies, fiscal support, training and adequate facilities have all been in place. The Adobe Mountain School has a new medical cottage and there is ongoing assessment of the facilities at both Catalina and Black Canyon Schools.

There has been some concern regarding nursing staff ratios. The plan is that this will be assessed by an outside evaluator. The primary issue has to do with the budget of 280 hours per week of nursing time at Black Canyon and the Catalina Schools versus what the current supervisory nurses feel is necessary which is 360 hours per week. Until the past month or so, facilities for the past year have been running on the 360 hours of nursing time per week.

In response to this request ADJC increased nursing coverage at BCS & CMS on June 28, 2007. An additional nurse was added to the day shift at those facilities.

All other areas of medical work appear to be running smoothly.

Program Services/Service Delivery:
After interviewing a multitude of staff, reviewing pertinent files, reviewing policies and procedures, there has been wonderful growth and stability regarding medical service and service delivery. There are some staffing concerns which continue to be addressed in a consistent matter.

Medical:
There continues to be adequate, appropriate and timely medical care. The emergency equipment continues to be consistently maintained. Although at the present time, there is not a full compliment of either physician assistants, advanced practice nurses or MD's for the children on a full time basis, the medical service has been able to use staff from Black Canyon to consistently meet the medical needs of the youth at all three facilities.

The Department has hired a new medical director, Dr. Ron Williams, a board certified pediatrician, who has begun work.

It will be very important that there continues to be a permanent medical director, preferably a pediatrician or family practice physician. I would also strongly recommend having an additional part-time physician on staff so that if there is a resignation of the medical director there is reasonable coverage until there is replacement. This would also allow for reasonable coverage for vacation or illness.

Nursing:
There is 24 hour, 7 days a week nursing coverage at all three facilities. There continues to be adequate nursing coverage. A question continues to be raised by the nurses regarding what is a safe and appropriate staffing ratio for nurses. As the nursing budget is currently in deficit, related to the current staffing, this issue needs to be addressed. As agreed upon, there will be an outside consultant to further address the staffing ratio. There continues to be adequate nursing care. The devotion of the nursing staff to the youth in the facility is consistently impressive. For the most part, there has been adequate supervision of youth by the YCO's, while receiving medical care. There is at times, some inconsistency with this. For the safety of all, this should be closely followed in the future. The emergency nursing equipment continues to be adequately maintained.

Dental:
There continues to be adequate dental coverage at each of facilities. The minimum requirements are consistent with ADA recommendations appear to be followed.
Not only is there a full compliment of dentists at all three facilities, but there has also been additional dental equipment, such as the Panamax machine. It will be important to maintain a full compliment of dentists at all three facilities.

Pharmacy:
Communicating between the pharmacists and the doctors appears to be adequate. A formulary has recently been developed. The P&T committee has been consistent and ongoing.

When a physician or psychiatrist deems it necessary to use medications not on formulary there is a non-formulary request sheet which can be filled out. Although there have been some conflict regarding this initially, the process appears to be working well. It will be important to watch that the formulary does not become more restrictive and the P&T Committee continues.

Monitoring:
There continues to be several levels of monitoring, including an internal division review, the ADJC Quality Assurance continues with consistent implementation. Most recently, the Governor's Advisory Board is being formed. I would recommend considering medical representation from the department of pediatrics and from the section of child and adolescent psychiatry from the University of Arizona to assist with ongoing monitoring.

UFN 6.1 The state shall ensure that youth in these facilities receive adequate, appropriate and timely (a) Medical, (b) Dental, and (c) Nursing care to meet the individual needs of the youth.

UFN 6.1 (a) Medical
Status (a): Substantial Compliance for Medical Care
Discussion (a): Pursuant to the agreement between Arizona and the Department of Justice, the Consultants Committee is reviewing data relevant to this requirement only to the extent that there is an indication that substantial compliance is not being maintained.
UFN 6.1 (b) Dental
Status (b): Substantial Compliance
Discussion (b): Pursuant to the agreement between Arizona and the Department of Justice, the Consultants Committee is reviewing data relevant to this requirement only to the extent that there is an indication that substantial compliance is not being maintained.
UFN 6.1 (c): Nursing Care
Status (c): Substantial Compliance
Discussion (c): Pursuant to the agreement between Arizona and the Department of Justice, the Consultants Committee is reviewing data relevant to this requirement only to the extent that there is an indication that substantial compliance is not being maintained

Discussion: Pursuant to Section III H.5 of the Memorandum of Agreement (MOA) the following Sections of the MOA are terminated from the agreement and no longer subject to monitoring, based upon a finding of "Substantial Compliance" for at least 18 months.
UFN 6.4 The state shall develop and implement a formal system for the pharmacist to document alerts to the physicians regarding information regarding any youth's medication issues.

7. MENTAL HEALTH CARE

Executive Summary: Administrative: After interviewing a multitude of staff, reviewing pertinent files, reviewing updated policies and procedures; there has been a tremendous level of improvement in overall mental health services. The facilities are set up appropriately so there is adequate working space and a reasonable working environment for the staff. Program Services/Service Delivery:

There continues to be adequate mental health care and treatment services. Staffing is near complete, although they are still down 10 hours of psychiatric services in the Adobe Mountain School and 10 hours of psychiatric services at the Catalina Mountain School and are down several psych associate positions.

Service delivery overall has been adequate. Intake screening and assessment has been consistent. Consistent referrals to mental health and education has occurred. There is still an ongoing process in developing the New Freedom Program and implementation. However, there has been a tremendous level of growth regarding implementation of mental health services. There is a plan to begin a universal behavioral management program which will reportedly begin soon. Generally speaking, psychiatric services have been relatively consistent.

There have been changes in staff and new staff has been hired. The process of obtaining informed consent has shown has shown some improvement. However, this is progressing in a positive fashion. Beyond this, in my opinion there has been adequate psychiatric care in all three facilities. There has been monitoring regarding efficacy and side effects to psychotropic medication. Adequate lab work has been obtained.

Monitoring:
Monitoring has been a consistent process of development. There has been tremendous growth, including such areas as the internal division review, the P&T Committee for pharmacy, and the ADJC Quality Assurance, which has continued to develop a quality QA program. Most recently, the Governor's Advisory Board is in the process of being formed, which will add yet another level of oversight for mental health.

In summary, there has been quite a bit of turnover of mental health staff, including psychiatry. It will be important to stay focused on keeping a full complement of staff. Followup with a comprehensive behavioral management plan and ongoing implementation of the New Freedom Plan will be important. The follow-through with appropriate mental health use of restraint and physician assessment of youth in restraint should be ongoing, follow-through with issues of cultural competency will be important with appropriate informed consent, psychiatric involvement in the MDT meetings and appropriate transitions when youth are being released from the facility regarding mental health followup, should all be part of an ongoing process.

UFN 7.1 The state shall ensure that adequate mental health care and treatment services are provided to youth in the facilities.

Status: Substantial Compliance

Discussion: A mental health outline has been developed. The discussion within these outlines will be referred to in the remaining components of Section 7.

I. Initial Intake Screening:

A. Timely medical care to meet the individuals needs. The majority of intake screening is done through the RAC unit at the Adobe Mountain School. The initial screening is done in a timely fashion (within one hour) of the youth arriving to the facility. They are given several

initial intake screenings, including the Criminogenic and Protective Factors Assessment (CAPFA). One hundred percent of youth coming into the institution are given this assessment. In addition, they are given the MAYSI, SASI (for substance issues). The TABE will be given to children at the initial assessment. If indicated, additional testing will be performed shortly after returning to the unit. Additional testing can include the WASI or the K-BIT. At the present time, all positions within the RAC unit are filled. The Consultants Committee discussed issues of RAC with Dr. Seymour, the acting head of RAC and Dr. Warren. Dr. Seymour reported hiring a new head of RAC, Dr. Anderson. Overall, all appeared to be quite appropriate in regards to policies and procedures and the assessment protocols that were occurring.

The Consultants Committee is seeing all of the components of the RAC intake being completed in a timely and consistent way.

Tom Seymour, PhD continues to do an exceptional job in his role as Director of the Mental Health Services. He has continued to follow through with any areas of subtle deficit and continued to work hard in finding consistent competent staff. He also helps out clinically when needed.

There are two psych associates assisting with the evaluation in the RAC program, Paul Bosse and Kenneth McNichols and a supervising psychologist. One is from the Enterprise Dorm and the other from the Challenger Dorm. Mr. Bosse and Mr. McNichols reported that the interview process takes about four hours. The Intake unit will now have a separate cottage for additional protection of youth while they go through this diagnostic process.

B. Screening Tools and Processes

- **Identification of Suicidal youth** – Initial identification of suicidal youth will continue to be through an initial interview which will include giving of the CAPFA and MAYSI assessments.
- **Identification of Youth with Substance Abuse Problems** – most youth entering Arizona Department of Juvenile Corrections have a history of substance abuse or use. As such, basically all the children are considered to have substance abuse problems. Nonetheless, as part of the initial intake, the children are given the SASSI. This is a validated assessment tool to further address potential substance abuse issues. AMS has two cottages and each other facility has only one cottage that focuses on substance abuse and even within these facilities there have been prior mental health staffing shortages. As such, although many of the youth have been identified with a history of substance abuse, interventions have not been consistently been put into place.
- There have been a variety of additional new staff hired that have substance abuse treatment background. Now each psych associate in charge of special treatment units, are all LISAC certified, except one who is a licensed clinical social worker with a significant amount of prior substance abuse treatment history. In addition, a supervisor for all substance abuse programs for the Arizona Department of Juvenile Corrections has been hired. In addition to the specialized treatment programs, the New Freedom Program will encompass a significant component of substance abuse education.
- There are now appropriate policies and procedures regarding identification of children with

varying levels of mental illness and the corresponding need for levels of treatment. Consistent implementation of these policies and procedures are occurring.

- **Identification of Youth with Cognitive and Learning Disorders** – The Consultants Committee was initially informed by Dianne Gadow that the plan on the initial assessment within the RAC unit will be to have a representative from education give all youth the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) to assess cognition.
- At present, the plan will be to implement the WASI for youth who have not had intelligence testing over the past year, to further assess achievement (mathematics, reading and written expression). Youth will be given the Woodcock Johnson test of achievement. At the present time different testing instruments are being used. These materials take less time and are less ideal, but sufficient.

- **Identification of Youth Taking Psychotropic Medication or Otherwise Needing Referral to Psychiatry** - The behavioral health domain of the CAPFA is signed off by the psychologist. A decision regarding referral recommendations is reportedly made at that time. In speaking with the psychiatrist at Adobe, as well as the treating psychiatrist at the Black Canyon School, follow-up on referrals occur in a timely fashion, essentially seeing the youth the next time they are in the facility. Additional mental health screening to assist with the referrals include the MAYSI and SASSI. There is a mental health referral policy, both to psychologists and psychiatrists for those youth that are exhibiting mental health problems, but do not yet have current mental health diagnoses or are not yet on medications. Those youth who are currently taking psychotropic medications are referred in a timely manner to psychiatry. Policies include 3100.01, 14203.04, Mental Health Referral Form 4203.00, Behavioral Health Screening and Assessment, 4203.02, 4321.02, 4321.01 referrals were reviewed.

- **Identification of Youth with Other Behavioral, Educational, and Mental Health Needs** – Initial identification will occur at the RAC screening in association with a clinical interview with implementation of the CAPFA, MAYSI and SASSI assessment. There are four psych associates and one psychologist within the RAC unit. They now have a full complement of staff.

C. Staffing and Training/Qualifications of Staff Conducting Screening:
There have been significant amounts of training. Staff has had CAPFA classroom training with clear identification of those individuals who have had the four-hour CAPFA follow-up training. There has now been significant training regarding the new comprehensive treatment program, New Freedom.

II. Timely Referrals for Mental Health and Psychiatric Assessment Post-Intake UFN 7.33, 7.331, 7.332, 7.333, 7.3.3.4: The revised mental health referral policy for those youth on psychotropic medication ensures that juveniles on psychotropic medication receive adequate psychiatric follow-up. Specific policies regarding timely referrals and the process of these timely referrals regarding communication between a qualified mental health professional and the psychiatrist or an initial evaluator and either mental health or psychiatrist is in place. In assessing mental health charts, youth are consistently seen in a timely manner.

There are now appropriate policies and procedures regarding identification of children with varying levels of mental illness and the corresponding need for levels of treatment.

III. Assessments:

A. **Psychiatric:** Psychiatric assessments are occurring in a timely manner. There are procedures regarding the timeframe when a youth initially comes to the institution on psychotropic medications and when they are seen by the psychiatrist. It is important to maintain protocols. Overall, psychiatric assessment at all three facilities has been consistent and comprehensive. There is a need for better attempts and follow through with collateral contacts. Dr. Karumanchi has replaced Dr. Hellman at Catalina Mountain School. Dr. Karumanchi currently works 20 hours per week and is adjusting well to the institution.

B. **Psychological/Psych Associate:** The psychologist and psych associates who are completing initial assessments on youth need to use the information available through CAPFA, the MAYSI, and SASSI assessments for their initial assessments. They need to review available collateral information and conduct a comprehensive clinical evaluation with a defined mental status exam, preliminary diagnoses, and recommendation for treatment, referrals, and treatment goals.

C. **Substance Abuse:** Initial substance abuse assessments is completed through the RAC. This is initially completed through implementation of the MAYSI and SASSI assessments. At the present time, the Consultants Committee has been informed that most of the youth at the Arizona Department of Juvenile Corrections have a history of substance use and are in need of treatment on some level. Procedures are now in place for assessing both mental health and substance abuse treatment needs. Dr. Seymour reported that there are three key reasons for referrals of youth to the special treatment substance abuse programs (RSAT). This can include: 1) via court order, 2) a clear identification of an alcohol or substance abuse dependency versus abuse, and 3) any child who comes in that has a history of med amphetamine or other potentially acute life-threatening abuse. In addition, Dr. Seymour and Dr. Warren previously reported that the New Freedom Program will comprehensively address substance abuse issues, including the use of a treatment focused workbook and the use of process groups. There is ongoing development for implementation of substance abuse education and treatment.

D. **Cognitive:** As was described in our prior meetings with Ms. Gadow and others, cognitive assessment will occur at the RAC through education with the TABE, a brief cognitive assessment tool. This will include all youth who have not had testing in the past year, being given cognitive and an achievement test to assess educational achievement. This will be a tremendous accomplishment when consistently achieved.

E. **Suicide Risk Assessments:** Initial suicide risk assessments through the RAC will be accomplished through clinical interview and assessment of the CAPFA, MAYSI and the suicide probability scale. Newly hired direct care medical and mental health staff will receive additional training on suicide prevention to assist with effective intervention and identification of youth who are suicidal.

F. Emergency Mental Health Assessments (e.g., sexual assault, acute loss, suicidal threat, etc.) Regarding issues of physical or sexual assault there will be an obvious medical assessment as per ADJC policy, such as Policy No. 3100.18 (alleged sexual assault within a secure facility). This includes a facility psychologist being available to evaluate the juvenile for a mental status examination. 1) At the present time, based on the information reviewed and discussion with staff, there is no consistent clear mental health assessment in place, although all would be seen by a psych associate. 2) Other than the psychologists or their designee seeing an acute sexual assault victim, there are no additional descriptions regarding the role of the evaluation. In the Consultants Committee opinion, psychiatry should also be involved with that assessment. 3) Policy, No. 4025.01, addresses emergent use of medication at times such as a psychiatric emergency.

A comprehensive procedure regarding the examination and documentation to the extent of physical injury by the pediatrician and a clear determination whether or not a referral to a medical facility is indicated. With the victim's consent, the examination includes the collection of evidence from the victim, using a kit approved by the local legal authority. Prophylactic equipment, including emergency contraception consistent with the state law, the regulations of the jurisdiction of follow-up care for sexually transmitted or other communicable diseases are offered to all victims as appropriate. A report is made to the correctional authorities to effect a separation of the victim from his/her assailant in the housing assignments. Assessment of the adolescent victim for potential for suicide and/or anxiety disorders or other mental health problems by a qualified mental health professional and psychiatrist is necessary. Treatment plans must also take into understanding the cultural competency and language issues.

IV. Comprehensive Treatment Planning:

A – B: Interdisciplinary Plan Content (Specific content requirements identified in UFN 7.3.6.1; 7.3.6.1-9.). **C) Cultural competency and language considerations. D) Transition to the community.** (Psychiatry, psychology/psych associates, medical, education, social work). Treatment plans have specific content which need to include: the treatment plan to be individualized (7.3.6.1), the identification of the mental and/or behavioral health issues to be addressed, a description of any medication or medical course of action to be pursued (7.3.6.2, including the initiation of psychotropic medication (7.3.6.3), a description of planned activities (interventions to monitor the efficacy of any medication or the possibility of side effects) (7.3.6.4), a description of any medical behavior plan or strategies to be undertaken (7.3.6.5), a description of any counseling or psychotherapy to be provided (7.3.6.6), a determination of whether the type of level of treatment needed can be provided in the youth's current placement (7.3.6.7), a plan for monitoring the course of treatment (7.3.6.8). and development of a transition plan for when the youth leaves the care of the state, which shall include providing the youth and his/her parents/guardian with information regarding mental health resources available in the youth's home community; making referrals to such services when appropriate; and providing assistance in making initial appointments with service providers (7.3.6.9).

Policies regarding multidisciplinary treatment planning have been put into place starting 4-25-05. The newest Policy 4200 and procedure 4200.07, effective 11/29/06 were reviewed.

According to Dr. Seymour, case plans are now being implemented at near 100% based on report. They are being reassessed on 30, 60, and 90 day intervals. The Consultants Committee reviewed treatment plans from all three facilities. The complexities of everything that has gone into these treatment plans are quite impressive. The Consultants Committee reviewed sign in sheets which show a variety but not consistent attendees. However, attendance by all staff is variable. Dr. Helmann previously was the only psychiatrist who has been writing treatment plans. However, he did not attend meetings. Dr. Seymour had written a memo and met with the psychiatrists to request that they all submit psychiatric input in advance of meetings. I am unsure if this has consistently occurred. The treatment plans are quite complex and at present, a great beginning. As time progresses, using the information at hand to develop well-structured plans regarding education, mental health, behavioral interventions and transitions to the community should be an ultimate goal. The current plans are clearly going in that direction.

There are now additional attempts at cultural competency, including Spanish speaking therapists to assist with Spanish speaking groups and a liaison, Frances Gonzalez, to assist with native cultural competency for native Americans and transitions back to reservations.

There are interpreters available for Spanish speaking families and youth in each of the facilities. There is a relative paucity of culturally competent and bilingual therapists. There is now a Spanish speaking licensed therapist at the Catalina Mountain School.

Mental Health Treatment

A. Counseling/Therapy services:

At the time of this report, most psych associate positions were filled. The psychology position at Catalina has been filled. I met with Dr. Peter Smith, the new Catalina psychologist, who appeared competent, experienced and motivated. He was hired to work 20 hours per week. The Consultants Committee met wit the new RAC psychologist at Adobe. He is in the process of learning the RAC program. Until all positions are filled, mental health interventions will have some level of compromise. This decreases the likelihood of youth being seen consistently who are in need of therapeutic treatment. New forms to assess how many youth are being seen by individual psych associates have been developed. There is a nearly full complement of psych associates and psychologists at the facilities seeing youth relatively consistently. At the present time, the facilities have changed over to the New Freedom plan, the process of how youth are treated will change. For example, youth will not be treated cottage by cottage, but rather by need.

Goals and measurements of success need to continue to be implemented regarding target symptoms and assessment of these symptoms following set periods of time. There are now 30, 60, and 90-day assessments.

B. Substance abuse treatment services: Each facility has one substance abuse treatment unit. These units are now staffed with at least one psych associate who has certification in substance abuse treatment. The Consultants Committee was informed that the substance abuse treatment units now have LISAC certified psych associates in Catalina and Black Canyon. At Adobe, they have an LSCW with a substance abuse treatment background.

The development of the New Freedom Program will hopefully better address the significant

alcohol and substance abuse and dependency issues.

C. Behavioral intervention staffing and training/qualifications of staff providing counseling/therapy services: There is now less of a blurring between mental health interventions and non-mental health interventions. The great majority of mental health interventions are by trained and licensed mental health professionals. There are some exceptions where some bachelor level YPO-3's are assisting or directly involved with mental health treatment, but this is minimal and typically with YPO-3 who are well trained. Procedure 4200.00 implemented 11-20-06 was reviewed. The proposal for a behavioral management system is in place. Sample cases were reviewed. Full implementation has not yet occurred, but based on report from Dr. Seymour and Mr. Branham, is in process.

Mental health interventions regarding behavioral management will include more complicated behavioral interventions with the youth, often in association with dynamic and other cognitive approaches. Therapeutic groups are now run by a qualified mental health professional such as a psych associate, psychologist or a psychiatrist. If one had advanced practice nurses they would also be included in that group. It is important to clearly demarcate the role or mental health and the role of non-mental health staff. Non-mental health staff should not be responsible in either solely leading therapeutic groups or direct mental health interventions.

VI. Psychotropic medication management:

A. Appropriateness of prescribed medications and dosages: Numerous charts were reviewed from the prescribing psychiatrists. In the Consultants Committees opinion, prescribed medication and dosages were appropriate for the symptoms being treated. A formulary was developed which appeared reasonable there is also a non-formulary request form for use when psychiatrists have a non-formulary medication which, in their opinion is clinically indicated.

B. Monitoring of medications being administered:

a. Lab work protocols: There are procedures regarding lab work protocols. These are in the process of being followed by all of the treating psychiatrists. Overall, I saw no deficits regarding lab works being ordered for the medications which youth were on. This will be reassessed. Lipid profiles and glucose levels should be obtained every six months for those youth on neuroleptics.

b. Side effect monitoring (e.g., AIMS): Side effect monitoring has primarily been focused on clinical assessment of side effects for example assessing whether there are extrapyramidal side effect or signs of tardive dyskenesia. Overall, it is the opinion of the Consultants Committee that there has been appropriate assessment of these. However, the Consultants Committee suggests that this could be more clearly documented. In addition, using standardized assessments such as the AIMS would be of assistance with this.

C. Documentation/charting: The Consultants Committee reviewed charting from all current psychiatrists within the Arizona Department of Juvenile Corrections. Overall, charting was readable and consistent; signatures were legible. When collateral information was used this was substantiated in the chart. There was inconsistency regarding the initial psychiatric assessment and its placement in the charts. For some, they were handwritten and for others they had been typed by the psychiatrist, or they had access to a transcriber. The Consultants Committee would recommend that the initial assessment be typed and comprehensive as has

previously been described in this outline.

D. **Informed consent:** The Consultants Committee reviewed charts from the current psychiatrists. The psychiatrists reported that they make attempts to reach parents or guardians regarding informed consent and then document this. There was documentation that more consistent attempts were made. There are now structured side effect sheets that can be sent out to the parents and can be reviewed with the youth. These are comprehensive side effect sheets that are published through the American Psychiatric Association Press. These have just begun to be used. Almost all of the youth currently on psychotropic medication have reviewed the side effect sheet and signed off. Most of the charts at the Catalina School had consents signed off by the parents. More often than not when an informed consent couldn't be obtained by the physician it was given to the nurse to obtain the informed consent. Nurses interviewed at the three facilities could review specific goals and side effects of psychotropic medications using side effect sheets now available to them. If there are specific questions which guardians have the nurse can then refer them back to the parents. All of the nurses had specific updated child and adolescent psychopharmacology reference books to assist them with this process. The facilities now have a spiral bound book on psychotropic consents entitled "A Resource Book of Medication Information Handouts". The process of informed consent was still being reviewed with the Adobe and Black Canyon schools.

There is still a concern that many of the guardians will not be able to be reached for a variety of different reasons. Procedure 4200.05 Consent for Psychiatric Services effective 11-20-06, addresses this. This is just in the process of being implemented.

This procedure reported "when the parent or legal guardian cannot be located, the Clinical Services Administer, in consultation with the treating psychiatrists shall: a) contact the Assistant Director, Legal Services Division and request whether a new court order is needed for a new or continued treatment. b) Authorize an ADJC employee to sign the consent for treatment for in place of the parents/legal guardian in accordance with Rule 6.C.I.ii.

At the present time, there are still numerous youth who do not have signed consents from their parents. Although understood by the staff at the ADJC, the implementation of Item 7 Procedure 4200.05 has not yet occurred. Lou Goodman, Assistant Director reported that this had begun. On a very positive note, there has been a more stringent and consistent attempt in obtaining informed consent and procedure addressing this issue.

Clear informed consent needs to be given both to the youth and his guardian. The specific information given and what was reviewed should be documented. If a particular handout were given, documentation regarding what handout was given and how it was explained should be recorded.

E. **Staffing and training/qualifications of psychiatric staff:**

Previously when the Consultants Committee was interviewing, the goal was to increase psychiatric services at the Catalina program from .5 to 1.0 FTE. It was now decided that it would remain a .5 FTE and a 1.0 FTE psychiatric physician at the Black Canyon. Dr.

Brockway, an adult trained psychiatrist was hired. The Adobe Mountain School still needs a .25 FTE psychiatrist position to replace the .5 FTE psychiatry position which was vacated in their special treatment unit.

Minimally, psychiatrists should be board certified in general psychiatry with significant experience in treating adolescents. The Consultants Committee would recommend that within ADJC that there is at least one board certified child and adolescent psychiatrist. At the present time, there is one child and adolescent psychiatrist, Dr. Broadway who is board certified in adolescent but not child psychiatry.

I reviewed the medication log for Adobe on August 3, 2007. At that time, they had 72 youth on medication out of a total census of 299. That amounts to 24% of youth on medication. It is interesting that there is a special treatment unit at Adobe and that the more acutely mentally ill youth are sent to Adobe, yet there is a higher percentage of youth (more consistent with research norms) at Catalina (38%) compared to the 24% at Adobe. In my opinion this is most likely related to the paucity of psychiatric services at Adobe as compared to Catalina. At Catalina they have 92 children. They have a 20-hour psychiatrist who is busy and doing what he needs to do. At Adobe they have 299 youth, over three times the number at Catalina, yet they have one 40-hour per week psychiatrist who is covering all of this, including a special treatment unit which should have their own psychiatrist.

When reviewing the youth which have had 3 or more placements in Separation, Catalina and Black Canyon have 12-14 per month. However, Adobe has approximately 60 per month. In my opinion this added need for separation is related to the relative deficit of psychiatric services at Adobe Mountain School. I would recommend that there be one additional FTE adolescent psychiatrist at Adobe Mountain School, so that consistent treatment can occur.

VII. Crisis Management:

A. Use of restraints: At present, Procedure 4058.01 under security describes the use of force continuum. Additional documentation defines the different types of restraint which are used. The use of "therapeutic restraint" still falls under security. The potential concern is that a child could be put into security restraints for some type of behavioral reason and there could then be a blurring of boundaries when this issue becomes a mental health problem, dependent on the time or any potential morbidity that can occur. There is a procedure under mental health dealing with therapeutic restraints. Nursing coverage provide 24 hour/7 days per week coverage. As such, nursing should be assessing vitals and assessing the youth once they have been placed in restraints every 15 minutes for any morbidity.

It is extremely important that the restraint policy and procedures be reviewed. The purpose of mental health restraints is therapeutic. There is a clearly defined difference between the use of security restraints and mental health restraints. This needs to be identified and implemented.

It is best when the psychiatrist can be contacted prior to the youth being placed in restraint. When they are placed in restraint it would be the Consultants Committee's recommendations that the psychiatrist is contacted within one hour, not three hours, and a physician will assess the child within two hours if they are still in restraints. Specific national protocols continue to

be variable. Many hospital settings and states still require a one-hour rule (where a physician has to evaluate a child in restraint within one hour). Due to the difficulty of independent hospitals being able to follow through with this and the cost for on call psychiatrists, many hospitals use their emergency room physician or other physicians who may be on call for that initial assessment. Any MD can initially assess the child. Ideally it should be a psychiatrist. At present, the Consultants Committee has been informed that each facility has at least one psychiatrist on call and has been given a state phone for that purpose. This should be in the therapeutic restraint procedure.

Restraints should never be used for behavioral control. In the rare instance when a juvenile would be restrained beyond one hour, exercising each limb for at least 10 minutes every 2 hours is recommended to prevent blood clots.

There must be performance measures which include no new injuries, comparison of the previous year, expressed number of occurrences, trends in these occurrences, and ultimate outcomes. The National Commission of Correctional Health Care recommends that every 15 minutes a health trained personnel health service staff check any patient placed in clinically ordered restraints and that the checks are documented. Fifteen minute checks have not occurred consistently. Clear assessment of restraint and development of appropriate mental health policy must occur. There are new draft flow sheets under procedure 4058.2 which were sent for review.

If a restrained juvenile has any medical or mental health condition a physician must be contacted ASAP.

B. **Separation/Exclusion:** The NCCHC definition of a segregated juvenile is those isolated from the general population and who receive services and activities apart from other juveniles. Youth, whether in separation or exclusion fall into this category. The Consultant's Committee has concern that if youth who are placed on separation or exclusion on multiple occasions will have a higher likelihood of having underlying mental health issues and be at higher risk for a suicide attempt. The use of segregation as a cottage management tool is termed exclusion. During the process of this assessment, there is no clear documentation of youth who have been repeatedly placed on exclusion, although attempts to obtain this material were made during the evaluation process. The Consultants Committee concerns were that if youth on exclusion were to have concerning or potentially suicidal behavior, there was no procedure for when staff should contact mental health. The Consultants Committee would recommend that a list of basic concerning/suicidal-type behaviors should be part of the dorm staff list which is used to assess the youth on exclusion and if any of these items are identified, mental health should be contacted.

If for any reason, out of control behavior lasts for more than 24-hours the youth must be evaluated by a psych associate, psychologist or psychiatrist.

There were inconsistencies regarding youths placed on separation. The Consultants Committee understood why this was needed due to potential staffing and risk issues in the evening. The Consultants Committee would recommend that there be clarification and

potential policy/procedure regarding when a youth who is potentially on a level II crisis, or other youth on crisis, may spend the day in the cottage but the evenings in separation. In addition, clarification of mental health procedures which would result in the closing of the whole separation unit should be established, as the Catalina unit was completely shut down on the June, 2007monitoring visit.

The Consultants Committee also expressed some level of concern regarding youth who are in the separation unit. In particular when there are acute or concerning mental health issues, at what point does staff call for psychological and/or psychiatric assessments.

Policy No. 4064 regarding security exclusion describes issues of removal and exclusion and concern over issues such as suicide prevention.

C. Psychiatric Assessment of Youth:

a. Timeliness:
b. Assessment:
c. Follow-up care

The terminology, psychiatric hospitalization, implies that a psychiatrist needs to be involved with this process. Psychiatric hospitalization should occur in a timely fashion. When a youth is identified as needing hospitalization every attempt should be made within a 24-hour period. At the present time, there are still delays in hospitalization, but it has typically occurred between 24 and 72 hours. At present youth are typically hospitalized at a private hospital and then transferred to a public hospital. For some youth, hospitalization has taken up to a week if not longer. This is not efficient or safe. When one thinks about the issue of safety it is not just regarding suicide risk, but also morbidity such as cutting, head banging, etc.

The assessment for hospitalization is completed by a qualified mental health professional and a psychiatrist. The initial assessment and assistance regarding hospitalization should be completed through psychology/psych associates in as timely a fashion as possible, a follow-up psychiatric assessment and when indicated, assistance from psychiatry, such as "doc-to-doc." Conversation with the hospital should also occur. Procedure 4203.04 was reviewed.

Transitions from the hospital are quite important. The ADJC has done a very good job in transitioning youth back from hospitalizations. Often transition meetings over the phone are held. These meetings are extensive reviewing what has occurred in the hospital and post hospital recommendations. Youth are seen in a timely fashion when they return from the hospital, both from the psychiatrist and their psych associate or psychologist.

At the present time, ADJC is still working with the state hospital to develop timely hospitalization. At the present time, for the most part, hospitalization occurs within 72 hours. ADJC has developed a sufficient process for heightened monitoring and mental health intervention pending transfer to a hospital.

There have been some changes in the staff at the state hospital which has put somewhat of a

crimp into this. However, staff at ADJC continue to work consistently and diligently with the state hospital system to ensure that hospitalization can occur in as timely a way as possible.

UFN 7.1 Documentation: Articles reviewed include the Fifth Semiannual Report dated March 15, 2007, the Fourth Semiannual Report dated September 15, 2006, the Third Semiannual Report dated March 15. 2006, the Second Semiannual Report dated September 15, 2005, and the Quality Assurance Review form. A variety of medical records, notes, separation log reports, the petition for hospitalization of a youth, a variety of emails, UFN projection status for Section 7, CRIPA UFN action plan transmittal forms for UFN 7.31, 7.32, 7.33, 7.3.3.1, 7.3.3.2, 7.3.3.3, 7.3.3.4, 7.3.3.5, 7.3.3.6, 7.3.3.1 through 7.3.6.9, 7.3.7, 3.1.1.8, 3.1.1.7, 3.1.2, 3.2.6, 3.2.3, 3.2.4, 3.2.5, 7.2.1.3, 4.2.4.4, 7.3.3.2, the training calendar for behavioral health services for ADJC, Procedural Guidelines for administering mental health and substance use screening and assessment instruments dated January 10, 2005, a fax from Traci Wherry to Kellie Warren dated 5-20-05, Policy 4250 Counseling Suicide Prevention effective 4-6-05, Memorandum dated June 21, 2005 regarding 24-hour nursing schedules, CMS close observation assignment, incident report tracking log for CMS from 6-1-05 to 6-21-05, Assault Injury Report from May of 2005, scheduling description for the different health units and what posts are needed to be filled, Procedure 1120.07, Policy 1052,1052.01, 1052.02, 1053.03, 3025.01 and the psychiatric medication informed consent, examples of the Quality Assurance Review, review of Maintenance of Mental Health Records, emails from Mary Ann Picardo, MD. Interviews with Dr. Warren, Dr. Seymour, Dr. Picardo, Dr. Randall, Dr. Smith, Dr. Brockway, supervising nurses from all three facilities, including nurse Wuce and Dr. Hellman. Personnel lists were reviewed. QA Policy 1052 was reviewed. Procedures 1052.01 and QA reports were reviewed.

A series of new policies and procedures effective 11/20/06 were reviewed, including policy 4200 Rule Scope of Behavioral Health Treatment Services. Policy 4058, Procedure 405.802 Chapter Security Rule Therapeutic Restraint draft, Procedures 4200.02 Criminogenic and Protective Factors Assessment, Procedure 4200.04, Mental Health Classification, Procedure 4200.00 Behavioral Health Screening and Assessment, Administrative Memorandum No. 110-.06 regarding Individualized Behavior Plans (IBP), Procedure 4200.05, Consent for Psychiatric Services. The ADJD Medication Formulary dated 3-13-2007 and the Formulary Request Form was reviewed, as well as a draft mental health restraint procedure.

UFN 7.2

a. The state shall ensure a deputy director who shall meet minimum standards as specified by the state, to oversee the mental health care and rehabilitative care of youth at the facilities.
b. The state shall provide the deputy director with sufficient staff and resources to perform the tasks required by this agreement, including:

Status: a) Substantial Compliance; b) Substantial Compliance

Discussion: Consistent with the third semiannual report, Diane Gadow, Kellie Warren and Tom Seymour continue to oversee mental health care and rehabilitative care of youth at the facilities. Please refer to UFN 7.1 regarding the substantial compliance status in part b. Most significantly, there has been significant staff hiring, in medical and mental health.

Recommendation: 1. Particular effort needs to continue to be focused on hiring approved staff. 2. Effort needs to continue in maintaining approved staff.
UFN 7.2.1 Oversight of mental health care in the facilities, including monitoring the performance of psychologists and private psychiatric contractors, and the development and implementations of policies and training.
Status: Substantial Compliance
Discussion: The Consultants Committee spoke with Dr. Kellie Warren, Dr. Thomas Seymour and Megan McGlynn, Ph.D. QA procedures are being implemented. Oversight and monitoring has been consistent.
Recommendation: a. Clear expectations of psychology and psychiatry need to be established.
7.2.2 Monitoring whether staff for resources are sufficient to provide knowledgeable mental health care and rehabilitative treatment services to the facility youth and to ensure compliance with this agreement.
Status: Substantial Compliance
Discussion: An organizational chart with clear reporting lines has been put into place. Thomas Seymour, Ph.D. is in charge of mental health services and oversees psychiatry. See UFN 7.1. Policies and protocols have been implemented and the reporting supervisory lines have been made clear.
Recommendation: 1. Follow through with the lines of communication that have been established on the policy. 2. Psychiatry needs to also report to the medical director. 3. Documentation: **See UFN 7.1 Documentation Section.**
UFN 7.2.3 Development and implementation of a Quality Assurance Program for mental health care in coordination with the quality assurance team.
Status: Substantial Compliance

Discussion: See UFN 7.1 Section on Quality Assurance

Recommendation:
1. Clear procedures regarding mental health and psychiatric quality assurance need to be followed.
2. Implementation of quality assurance for mental health and psychiatry needs to be consistently implemented.

UFN 7.3 Intake Screening and Assessment:

UFN 7.3.3 The Deputy Director shall develop and implement policies and procedures for referral of youth for mental health evaluations based on the results of a mental health and suicide risk screening or a mental health needs assessment, other referrals from staff or the conduct of the youth during the course of confinement at the facility. These procedures shall require referrals when: 7.3.3.1 A youth's mental health poses a risk of physical harm to him/herself or others if the youth has been diagnosed as mentally ill.

Status: Substantial Compliance

UFN 7.3.3.2 The youth exhibits mental health problems but does not have a current mental health diagnosis from a psychologist or psychiatrist.

Status: Substantial Compliance

UFN 7.3.3.3 The youth is determined to be taking psychotropic medication, or has taken them in the past.

Status: Substantial Compliance

UFN 7.3.3.4 The youth requires a change of medication prescribed as a result of any mental health condition.

Status: Substantial Compliance

Discussion 7.3.3.1; 7.3.3.2; 7.3.3.3; 7.3.3.4 Please refer to 7.1 Section 2, Section 3.

Recommendation:
The procedures for referrals to psychiatry and mental health are formalized. The process of implementation will be assessed on the sixth semiannual report.

Documentation: Please refer to UFN 7.1 Documentation Section

UFN 7.3.5 Each youth receiving psychotropic medication or otherwise in need of mental health treatment shall have a treatment plan in accordance with professional standards of practice. The treatment plan shall be developed by a treatment team pursuant to policies developed by the deputy director, which shall include the identification of the required members of the treatment

team.

Status: Substantial Compliance

Discussion: See UFN 7.1 Section 4

Recommendation:

1. MDT procedures have been revised and approved and signed by the director on 5-6-2005. There should be consistent implementation.
2. Family interventions and cultural competency with a particular focus on transition to the community will continue to be an important part of this process and will be looked at closely when assessing implementation.

Documentation: Please refer to UFN 7.1 Documentation Section

UFN 7.3.6 The Deputy Director shall develop and implement policies and procedures for the required content of treatment plans which shall include:

7.3.6.1 That the treatment plan be individualized;
7.3.6.2 A description of any behavioral management plan or strategies to be undertaken;
7.3.6.3 A description of any counseling or psychotherapy to be provided;
7.3.6.4 A determination of whether the type or level of treatment needed can be provided in the youth's current placement;
7.3.6.5 A description of any behavioral plan or strategies to be undertaken.
7.3.6.6 Clear informed consent needs to be given both to the youth and his guardian. The specific information given and what was reviewed should be documented. If a particular handout were given, documentation regarding what handout was given and how it was explained should be recorded.
7.3.6.7 A transition plan for when the youth leaves the care of the State, which shall include providing the youth and his or her parents or guardian with information regarding mental health resources available in the youth's home community; making referrals to such services when appropriate; and providing assistance in making initial appointments with service providers.
7.3.6.8 A plan for monitoring the course of treatment and a transition plan for youth leaving the center should be implemented.
7.3.6.9 However, nothing in this Agreement shall make ADJC responsible for providing mental health services to youth no longer in the custody of the State.

Status: 7.3.6.1 Substantial Compliance; 7.3.6.2 Substantial Compliance; 7.3.6.3 Substantial Compliance; 7.3.6.4 Substantial Compliance; 7.3.6.5 Substantial Compliance; 7.3.6.6 Substantial Compliance; 7.3.6.7 Substantial Compliance; 7.3.6.8 Substantial; 7.3.6.9 Substantial Compliance

Discussion: Refer to UFN 7.1 Section 4, Section 6, Sections a and b and Section 8

Recommendation:

1. There should be ongoing development and monitoring of treatment plans.
2. Appointments must be set up before the 10-day supply of medication is gone.
3. If the psychiatrist cannot make the meetings, his recommendations need to be submitted in writing. A clear protocol regarding this should be developed.
4. Consistency with all attending MTD meetings should continue. Consistent policies, procedures and implementation of behavioral plan need to be clinically implemented.

Documentation: See UFN 7.1 Documentation Section

UFN 7.3.7 The Deputy Director shall issue and implement policies and procedures for the admission of appropriate tests (including for example, blood tests, EKG's, and abnormal and involuntary movement scale test) to monitor the efficacy and any side effects of psychotropic medications in accordance with professional standards.

Status: Substantial Compliance

Discussion: See UFN 7.1 Section 6, Section A and B

Recommendation:

1. When starting a child on a psychotropic medication, particularly if their symptomatology is significant, a follow-up within one week and some level of communication with the psych associate during that time is recommended.
2. Clear informed consent needs to be given both to the youth and his guardian. The specific information given and what was reviewed should be documented. If a particular handout was given, documentation regarding what handout was given and how it was explained should be recorded.

Documentation: UFN 7.1 Documentation Section

Discussion: Pursuant to Section III H.5 of the Memorandum of Agreement (MOA) the following Sections of the MOA are terminated from the agreement and no longer subject to monitoring, based upon a finding of "Substantial Compliance" for at least 18 months.

UFN 7.3.1 The Deputy Director shall continue to develop and utilize policies and screening instruments for qualified mental health professionals to conduct proper intake screenings at each facility as soon as practicable upon the youth's admission. When no such professional is on site to conduct the screening, it shall be conducted by another staff member who has received specific training in conducting such assessments. The staff member shall, as soon as is practicable, then contact a qualified mental health professional and confer. A psychiatrist or psychologist shall review and sign the mental health needs assessment.

UFN 7.3.2 The Deputy Director shall issue policies and procedures to assure appropriate action when an intake screening indicates that a youth is taking or prior to admission may have been prescribed, psychotropic medications. This shall include appropriate steps to contact the prescribing psychiatrists when necessary and referral to the facility psychiatrist for evaluation.
UFN 7.3.4 The deputy director shall if a need for mental health treatment is indicated ensure the youth receive the treatment indicated.

APPENDIX A
Quality Assurance Grid

UFN	Quality Assurance Process	
	JUVENILE JUSTICE	
4.4.3	UFN title only	
4.4.3.1	Monitor compliance with Department policies and procedures in the facilities, with emphasis on p/p relating to issues addressed in this agreement	Comprehensive audits and follow-up audits-QA
4.4.3.2	Conducting audits and other QA activities as described in 4 (d) below	Comprehensive audits and follow-up audits-QA
4.4.3.3	Reviewing and, where appropriate, investigating allegations of child abuse	Investigations data base of cases-I&I
4.4.3.4	Assuring the implementation and adequacy of the educational, medical, and mental health quality assurance programs required by this agreement	Comprehensive audits and follow-up audits address specific areas to educational, medical and mental health programming-QA
4.4.3.5	Coordinating quality assurance activities performed by various division offices to prevent unnecessary duplication of efforts	Internal QA programs-QA and Division Documentation in QA office
4.4.4	QA team along with I/I create written plan	Comprehensive audits, follow-up audits and action plans-QA QA Policies and procedures-Youthbase
4.4.4.1	Title-audits shall include…..	
4.4.4.1.1	Inspection of institutional, medical and educational records, unit logs, incident reports, use of force reports, major disciplinary reports, documentation of room checks by line staff, etc.	Comprehensive audits, follow-up audits and action plans-QA
4.4.4.1.2	Interviews with staff, administrators and youth at each facility	Comprehensive audits, follow-up audits and action plans-QA
4.4.4.1.3	Where appropriate interviews with the parents or other caregivers of youth confined in the facilities	Parent surveys results from Peggy Eggemeyer and R&D
4.4.4.1.4	Inspection of physical plant	Comprehensive audits, follow-up audits and action plans-QA
4.4.4.1.6	Determination of compliance with the facilities policies, including those related to: suicide prevention, staffing levels and youth supervision, use of force, disciplinary practices, positive behavior management programs, grievance procedures, sanitation, youth on youth violence, conditions in security units, adequacy of counseling and rehabilitative services, and the adequacy of all facility documentation	Compliance with policy addressed in comprehensive audits, follow-up audits and action plans-QA Re-writing and revision of policy and subsequent implementation data collected in audits and follow-up addressing action plan compliance-QA Implementation of changes in policy addressed in IRC also (ie criteria for critical incident debrief for suicidal behavior in IRC 2007-05004)

4.4.4.2	Unannounced periodic site visits will occur at each facility. I/I and QA shall have complete and unimpeded access to the facilities, their records, staff and residents. Staff at facilities shall be informed of their obligations to cooperate in all I/I and QA operations	Unannounced site visit write up-QA IC weekly activities memo-QA
4.4.4.6	When through audits, investigations or other QA activities, there are findings of substantial non-compliance with the requirements of the facilities policies or the Agreement a plan of corrective action shall be developed	Action plans in response to audits-QA Follow-up audits address compliance to action plan dates, etc.-QA Training also included on distribution list for Internal Review, which includes recommendations for changes to training
	SUICIDE PREVENTION	
3.1 3.1.1 -8 3.1.2	Training	All QA staff attend suicide prevention on annual basis. Will give feedback to training department as staff attend during regular schedule.
	Review data including files	Comprehensive audit review-QA Follow-up audits-QA Institutional Coordinator Duties-QA 60 day suicide prevention-Behavior Health
3.2 3.2.3	Examine youth folders for proper contact	Comprehensive audit (check red folders and SME on annual & follow-up audits)-QA Internal 60day suicide prevention audit
3.2 3.2.4	Randomly select files to check assessment	Comprehensive audit-QA Follow-up audit-QA Internal 60 suicide prevention audits-Behavioral Health
3.2 3.2.6	Interview RAC staff emphasis on suicide prevention	Facility debrief of SIR
3.2 3.2.5 3.2 3.2.7	Review files on recently admitted youth IRs from county Psych reports Any other documentation in correct place	Psych Associate required by policy 4250 to review.
3.2 3.2.8	Randomly review files for content	Comprehensive audit-QA Follow-up audit-QA Internal 60 suicide prevention audits-Behavioral Health
3.2 3.2.9	Attend treatment team meeting for attendance	Comprehensive audit-QA Follow-up audit-QA Institutional Coordinator weekly reports-QA
3.4 3.4.1 3.4 3.4.2	Note that youth on suicide precaution are properly monitored and documented	Comprehensive audit-QA Follow-up audit-QA Institutional Coordinator weekly reports-QA
3.3	Tour each housing unit and identify issues logs,	Comprehensive review-QA

3.3.1	suicidal youth care 15 minutes	Follow-up audit-QA Institutional Coordinator weekly reports-QA
3.3 3.3.1	Observe staff properly observe youth	Comprehensive review-QA Follow-up audit-QA Institutional Coordinators weekly-QA
3.4 3.4.1 3.4 3.4.2	Review suicide precaution list for LOS step down	Comprehensive review-QA Follow-up audit-QA
3.4 3.4.2	Monitor suicide precaution list 30 to 90 days	Suicide prevention 60 day audit-Behavioral Health
3.4 3.4.2	Review MH files of youth no longer on suicide precaution ensure recommendations are followed	Comprehensive audit with SME-QA Follow-up audit-QA Internal 60 suicide prevention audits-Behavioral Health
3.4 3.4.2	Review daily contact report to ensure proper treatment	Comprehensive audit-QA Follow-up audit-QA Bi-annually only
3.4 3.4.2	Interview QMHP	Comprehensive audit-QA Follow-up audit-QA
3.1 3.1.1-8 3.1.2	Review training curriculum	QA personnel attend training and will give formal feedback to training department
3.1 3.1.2	Quarterly review suicide compliance report	60 day suicide prevention audit-Behavioral Health
	Periodically interview staff to determine level of compliance	Comprehensive audit-QA Follow-up audit-QA
3.6 3.6.1	Review all SIRs involving suicide attempts	Facility debriefs of incident QA reports for serious and life threatening
3.6 3.6.1	Interview staff involved in SIR	Facility debriefs of incident
3.6 3.6.1	Examine quality & participation in incident debriefing	IRC would address this-QA
3.6 3.6.1	Determine recommendations follow-up corrective action	Audit action plan follow-ups-QA IRC follow-up recommendations-QA
	SPECIAL ED	
5.2 5.2.2	File review Review sample of student files	QA comprehensive audit-QA Follow-up audit-QA Internal review-Education QA comprehensive audit-QA Follow-up audit-QA

		Internal review-Education
5.2.2	Observe classes	QA comprehensive audits-QA
5.7.4.1	Interview teachers and administrators	Education administration does this
5.2 5.2.1	Review any policy changes Caseloads Vacancies	Education administration does this
5.3 5.3.1	Review screening forms	QA comprehensive audit-QA Follow-up audits-QA
5.3.3	Discuss with teachers frequency with which youth are in spec ed	QA comprehensive audit observations-QA
5.3.4 5.3.5 5.3.6	Review policies related to special support team " eligibility " IEP/MET meetings	Education administration does this
5.4	Determine qualified professionals are determining eligibility for sped	Education administration does this
5.5	Review files for parent involvement surrogate	QA comprehensive audit-QA Follow-up audits-QA Internal QA program-Education Dept
5.7.1	Review internal monitoring documents	QA office reviews
5.6	Determine if receiving school districts are notified of student need	Not currently in QA process but will be added
5.7.2	Interview Diagnostician regarding: Student accountability in system Timeliness of evaluation Documentation of parent contact	QA comprehensive audit-QA Follow-up audit-QA Internal QA program-Education Department
5.7.2 5.7.3	Interview students IEPs general	QA comprehensive audit Follow-up audit-QA
5.8.1	Review 504 plans	Education administration does this
5.2	Determine that school is properly started and # of days appropriate	Education Superintendent would have calendar
5.7.2	Review content at class session referring to sped	Comprehensive Audit-QA Follow-up audit-QA

APPENDIX B
Incidents and Inspections Activity

	2005				2006				2007	
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd
Total Incidents Reviewed	**812**	**983**	**875**	**707**	**725**	**643**	**681**	**610**	**786**	**867**
Assigned to Criminal	**118**	**118**	**119**	**130**	**111**	**114**	**114**	**97**	**173**	**221**
Submitted to County Attorney	54	32	41	83	23	25	57	16	96	110
Cleared by Arrest	12	6	1	10	1	3	5	1	3	8
Unfounded	14	4	10	10	5	10	4	0	1	11
Cleared Exceptional	27	23	23	50	39	44	30	31	61	52
Information Only			4	6	6	15	4	7	14	17
Assigned to PSU	**53**	**62**	**50**	**60**	**42**	**53**	**69**	**31**	**66**	**102**
Sustained	15	21	12	22	18	19	15	9	19	21
Partially Sustained		2	2	5	1	0	0	0		
Not Sustained	13	16	7	18	7	9	9	8	1	12
Unfounded	18	10	13	18	5	2	5	17	7	7
Inspections										
Random Inspections	34	18	15	37	7	9	19	13	199	233
Unannounced Visit									3	10
Audits	1	2	1	1	2	0	1	1	3	1
Follow-Up Audits		1						1	3	1

APPENDIX C
CRIPA Summary

Table 1: Security totals and rates* by time period

CRIPA Summary (AMS, BCS, & CMS)	9/04 - 2/05 CRIPA Rpt #1		3/05 to 8/05 CRIPA Rpt #2		9/05 to 2/06 CRIPA Rpt #3		3/06 to 8/06 CRIPA Rpt #4		9/06 to 12/06 CRIPA Rpt #5		1/07 to 8/07 CRIPA Rpt #6	
	Total	Rate	Total	Rate	Total	Rate	Rate	Total	Rate	Total	Total	Rate
Total # calls responded to by Security	2933	5.08	5726	6.68	5977	5.86	7.21	5386	6.49	3309	8238	8.20
Total # Youth Injured (all sources)	1099	1.26	1334	1.56	11.26	0.93	1.36	832	1.00	528	1126	1.02
Total # Youth Assaulted by Youth	192	0.22	199	0.23	196	0.20	0.24	225	0.27	111	274	0.29
Total # Youth Injured in Assaults by Youth	112	0.13	122	0.14	119	0.11	0.14	136	0.16	61	115	0.10
Total # of Staff Assaulted by Youth	123	0.14	173	0.20	178	0.12	0.21	156	0.19	70	191	0.09
Total # Staff Assaulted by Youth resulting in Injury	18	0.02	20	0.02	33	0.01	0.04	24	0.03	4	22	0.01
Total # Incidents of Mutual Fights	355	0.41	530	0.62	570	0.59	0.69	460	0.55	331	571	0.44
Total # Mutual Fight with Injury	128	0.15	148	0.17	175	0.14	0.21	110	0.13	78	144	0.10
Total # of Uses of Force	470	0.54	760	0.89	801	0.82	0.97	839	1.01	462	1057	1.04
Total Mechanical Restraint Usage	307	0.35	638	0.74	604	0.65	0.73	661	0.80	367	1010	1.02
Average Daily Population	483		466		458			451		463	453	

* The rate is calculated by dividing the number of youth on youth incidents for a specific time period by the respective average daily population x days in the respective time period. The resulting number is then multiplied by 100 to arrive at the rate.

Explanation of rates: "The rates represent occurrences per 100 youth days. For example, 0.14 assaults with injury per 100 youth days means that the average youth would be involved in an assault resulting in injury every 714 days. Given ADJC's 212 day average length of stay, an average youth would have to stay approximately 3.4 times longer than the average length of stay to be injured in an assault." (Provided by Jim Hillyard.)

Table 2: Security averages and rates by time period

CRIPA Summary (AMS, BCS, & CMS)	9/04 - 2/05 CRIPA Rpt #1		3/05 to 8/05 CRIPA Rpt #2		9/05 to 2/06 CRIPA Rpt #3		3/06 to 8/06 CRIPA Rpt #4		9/06 to 12/06 CRIPA Rpt #5		1/07 to 8/07 CRIPA Rpt #6	
	6MO Avg	Rate	6MO Avg	Rate	6MO Avg	Rate	Rate	6MO Avg	Rate	4MO Avg	7MO Avg	Rate
Total # calls responded to by Security	733	5.06	954	6.68	996	5.86	7.21	898	6.49	827	1177	8.20
Total # Youth Injured (all sources)	183	1.26	222	1.56	188	0.93	1.36	139	1.00	132	161	1.02
Total # Youth Assaulted by Youth	16	0.22	33	0.23	33	0.20	0.24	38	0.27	28	39	0.29
Total # Youth Injured in Assaults by Youth	9	0.13	20	0.14	20	0.11	0.14	23	0.16	15	16	0.10
Total # of Staff Assaulted by youth	10	0.14	29	0.20	30	0.12	0.21	26	0.19	18	27	0.09
Total # Staff Assaulted by Youth resulting in Injury	2	0.02	3	0.02	6	0.01	0.04	4	0.03	1	3	0.01
Total # Incidents of Mutual Fights	30	0.41	88	0.62	95	0.59	0.69	77	0.55	83	82	0.44
Total # Mutual Fight with Injury	11	0.15	25	0.17	29	0.14	0.21	18	0.13	20	21	0.10
Total # of Uses of Force	39	0.54	127	0.89	134	0.82	0.97	140	1.01	116	151	1.04
Total Mechanical Restraint Usage	26	0.35	106	0.74	101	0.65	0.73	110	0.80	92	144	1.02

Table 3: Security totals and rates for January 1 to July 31, 2007 by facility

	AMS		BCS		CMS		Combined	
	Total	Rate	Total	Rate	Total	Rate	Total	Rate
Total # calls responded to by Security	4082	7.41	1766	10.23	2390	9.51	8238	8.20
Total # Youth Injured (all sources)	725	0.97	240	1.84	161	0.70	1126	1.02
Total # Youth Assaulted by Youth	197	0.35	22	0.11	55	0.20	274	0.29
Total # Youth Injured in Assaults by Youth	93	0.13	5	0.06	17	0.03	115	0.10
Total # of Staff Assaulted by youth	71	0.09	68	0.00	52	0.13	191	0.09
Total # Staff Assaulted by Youth resulting in Injury	10	0.00	6	0.00	6	0.03	22	0.01
Total # Incidents of Mutual Fights	383	0.42	43	0.22	145	0.63	571	0.44
Total # Mutual Fight with Injury	105	0.07	1	0.00	38	0.23	144	0.10
Total # of Uses of Force	450	0.78	349	1.72	258	1.50	1057	1.04
Total Mechanical Restraint Usage	344	0.49	312	1.39	354	2.53	1010	1.02
Average Daily Population	289		66		98		453	

Table 4: Security averages and rates for January 1, 2007 through July 31, 2007 by facility

	AMS		BCS		CMS		107 to 8/07	
	7Mo Avg	Rate	7Mo Avg	Rate	7Mo Avg	Rate	7Mo Avg	Rate
Total # calls responded to by Security	583	7.41	252	10.23	341	9.51	1177	8.20
Total # Youth Injured (all sources)	104	0.97	34	1.84	23	0.70	161	1.02
Total # Youth Assaulted by Youth	28	0.35	3	0.11	8	0.20	39	0.29
Total # Youth Injured in Assaults by Youth	13	0.13	1	0.06	2	0.03	16	0.10
Total # of Staff Assaulted by youth	10	0.09	10	0.00	7	0.13	27	0.09
Total # Staff Assaulted by Youth resulting in Injury	1	0.00	1	0.00	1	0.03	3	0.01
Total # Incidents of Mutual Fights	55	0.42	6	0.22	21	0.63	82	0.44
Total # Mutual Fight with Injury	15	0.07	0	0.00	5	0.23	21	0.10
Total # of Uses of Force	64	0.78	50	1.72	37	1.50	151	1.04
Total Mechanical Restraint Usage	49	0.49	45	1.39	51	2.53	144	1.02

APPENDIX D
Violence Reduction Plans

	FACILITY: Adobe Mountain School DATE: July 25, 2006
Topic:	**Violence Reduction**
Milestones:	**Inclusion of the RAC Administrator at Classification staffings to ensure timely placement of youth and consistent communication between facilities (Supported Norms: Positive Communication, Safe Environment) *Completed December, 2005 Provide Strategies for Juvenile Supervision refresher training for clinical and leadership personnel (Supported Norms: Positive Communication, Safe Environment) *Completed February, 2006 Education Operations Committee formed to identify problem areas within the education environment and develop a facility Superintendent's Management Order (SMO) (Supported Norms: Positive Communication, Safe Environment, Responsibility) *Completed July, 2006 Introduction and tracking of Individual Behavior Plans on ADJC network hard drives (Supported Norms: Positive Communication, Safe Environment, Responsibility) *Completed May, 2006 Develop guiding principles and mission statement of the AMS Sting Quality Assurance and Communication team (Supported Norms: Positive Communication, Responsibility) *Completed July, 2006 Incorporate violence and incident reports at management debriefings (Supported Norms: Positive Communication, Safe Environment) *Completed January, 2006 Introduce ADJC ACAB Cultural Norms and develop and implement Norms Kick-off event (Supported Norms: Respect, Responsibility, Safe Environment, Positive Communication) *Completed May, 2006 Incorporate ACAB within the Employee-of-the-Month selection process (Supported Norms: Respect, Positive Communication) *Completed July, 2006 Train Clinical and MDT staff in areas of New Freedom (Group Dynamics) and Multi-Disciplinary Team Policy (Supported Norms: Safe Environment, Positive Communication, Responsibility) *Completed May, 2005**

Current Violence Reduction Plan activities	On all of these, refinements have continued on an ongoing process. 1. Develop and implement housing unit after-school and weekend recreation plan centered around social development and rewards **(Supported Norms: Respect, Safe Environment)** Responsible parties Recreation Staff, Unit Manager, Principal, Assistant Superintendents Initial plan due by August 31, 2006. Completed. Phase 2 to be developed due to new school. Schedule, and staff Scheduling Software.
	2. Clarify security roles and expectations in conjunction with the education Superintendent's Management Order **(Supported Norms: Responsibility, Positive Communication, Safe Environment)** Responsible parties – Assistant Superintendent, Captain, Lieutenant, Superintendent Due by August 18, 2006 Completed.
	3. Improve communication with housing unit leadership and staff: • Assistant Superintendent Monthly MDT meetings • Weekly Unit Manager meetings • Unit Manager daily check in/out with administration • Debriefings and IR follow-ups • All pertinent communication items distributed to housing unit staff and returned with written acknowledgement **(Supported Norms: Positive Communication, Responsibility, Safe Environment)** Responsible Parties – Assistant Superintendent, Unit Manager Communication Plan due by September 1, 2006 Completed.
	4. Review RAC and AMS Administrator roles to ensure consistency in classifying and disseminating information regarding youth's history, victims, and potential accomplices and threats **(Supported Norms: Responsibility, Positive Communication, Safe**

	Environment) Responsible parties – Case Management Administrator, RAC Administrator, Assistant Superintendent, Superintendent Initial review on August 7, 2006 Completed.
	5. Develop radio etiquette training and monitoring plan: Summary: Utilize Security leadership at monthly MDTs to reinforce positive/proper radio etiquette, discuss scenarios and obtain feedback. Assistant Superintendents will reinforce radio etiquette through their own observation and practice. **(Supported Norms: Positive Communication, Safe Environment, Responsibility)** Responsible parties – Security Captain, Assistant Superintendents Due by December 31, 2006 Not Completed. To be re-established.
	6. Assign Remote Desktop Connection to all Housing Unit Mangers for the monitoring of staff practices and youth issues **(Supported Norms: Safe Environment)** Responsible parties – Assistant Superintendents, Unit Mangers, MIS Due by September 31, 2006 Partial.
	7. Develop Unit Manager quality assurance expectations: • Monthly one-on-one with staff • Monthly meetings on unit • Regularly scheduled meeting with unit youth to discuss ACAB Norms and violence reduction plan for the unit • Staff acknowledgement of the Employee Misconduct Policy • Use of radio earpiece while on shift to minimize noise and behavioral issues • MIS and reporting utilities • Employee misconduct automated system by October 1, 2006 **(Supported Norms: Positive Communication, Safe Environment, Responsibility)** Responsible parties – Superintendent, Assistant Superintendents, Unit Managers

	Review formally on a monthly basis Completed.
	8. Train YCO series and education staff in appropriate youth interventions through Handle with Care and Therapeutic Crisis Intervention curriculum **(Supported Norms: Safe Environment, Positive Communication)** Responsible Parties – Superintendent, Staff Development Target Completion Date: December 31, 2006 Completed, and ongoing with move of the month.
Expected outcomes in measurable terms	25 percent reduction in reported violence by October 2006 Additional 25 percent reduction in reported violence by April 2007 Outcome not achieved. Re-tooling of the VRP has been occurring since August 2006 in response, including use of COMPSTAT Trend information, etc.
Notes	

	FACILITY: **BLACK CANYON SCHOOL** DATE: Thursday, August 10, 2006 (updated)
Topic Success Measure	**Violence Reduction**
Summary of activities	1. Review of the continuum of intervention with unit staff at MDTs within each unit and remaining facility staff at department staff meetings (Completed). 2. Review of basic juvenile supervision strategies with all unit staff at MDT and remaining facility staff at department staff meetings (Completed). 3. Provide Unit Managers access to cameras for review of daily IRs and routine unit practices/procedures. YPS will be responsible for ensuring that basic safe operating procedures are followed by their unit staff. YPS will coach and train staff who are not following ADJC's supervision procedures. YPS and or Superintendents will positively recognize via Cabby awards, two staff per month who are effectively supervising youth (Ongoing). 4. Camera review of all IRs involving violence by Superintendent, Assistant Superintendent, and Captain on a daily basis if necessary. Share with all involved staff giving either positive reinforcement or constructive feedback for improving appropriate intervention (Ongoing). 5. Youth who engage in acts of violence will have a case plan goal and objectives developed in the CCP addressing violence prevention with specific programming, including New Freedom assignments targeting violence prevention (Ongoing). 6. YPSs will direct unit staff to share pertinent information between all shifts regarding daily observations of youth behavior, both verbally and in unit log book. Unit YCOs will then develop daily plans anticipating potential problems and solve them before they occur. The YCO III/Shift leader will summarize the plan in the unit logbook. YPSs will follow-up with the YCO and report

	progress of daily shift plans at weekly Managers meeting (Ongoing). 7. Individual behavior plans (IBPs) will be developed for all high profile youth. These plans will be maintained in a new work folder to facilitate communication to all staff and will be reviewed weekly at the clinical team meeting and MDT (Ongoing). 8. BCS Superintendent and Administrative staff will work with the QA BCS BACE team to develop a specific classification plan for the housing of female youth at BCS that addresses programmatic need and risk (In progress through Classification Office due 10/07). 9. Gang Coordinator Sgt. Flores will identify youth who have a history or are actively participating in gang activity. These identified youth will meet with Sgt. Flores and the Superintendent. Sgt. Flores will explain correlation between gang activity and violence. Girls will be given expectations and an explanation of consequences of violence including additional charges, delay in release, and loss of privileges (In progress). 10. Portable air conditioning units will be installed in Units Success and Venture (Completed). Now full installation. 11. Implementation of a Superintendent Management Order (SMO) to correct problems recurring during education. This has clarified staff, security, and teacher roles in developing a safe educational environment (Completed). 12. Implementation of a weekly behavior party as a reward for girls who display actions representing the four norms (Ongoing). 13. Monthly review of TCI techniques and interventions during staff meetings. Enroll staff in a training class if they are in need of extra assistance and guidance (In progress).
Expected outcomes in measurable terms	Reduce violent acts by 25% as evidenced in IRs by October, 2006. Outcome met.

Timeline of anticipated implementation	All plans still in progress will be completed by October, 2006.
Person responsible (from each area)	1. YPS and all Department Heads 2. YPS and all Department Heads 3. Super. MIS and all YPSs 4. Super., Asst. Sup. and Captain 5. YPSs and YPO IIIs and PSAs 6. YPS and YCO III 7. YPS and Psych. Associate 8. Superintendent, Management team, BCS BACE Team 9. BCS Gang Coordinator, Superintendent 10. Mike Machamer 11. Super., Asst. Sup., Captain, Principal 12. Asst. Sup. 13. YPS, Training Officer
Timeline for QA submission	October, 2006
Date	August 10, 2006

	FACILITY: **CATALINA MOUNTAIN SCHOOL** DATE: **Friday, August 04, 2006– (updated)**	
Topic: Success Measure	**Violence Reduction** **AREA: *Housing Units***	**Updates**
Summary of activities	**Housing Units:** 1. Creation of consistent Individual Behavior Plans.	Completed / Ongoing
	2. All staff assaults to be debriefed by Asst. Superintendents and YPSs (@ MDTs).	Completed / Ongoing
	3. Implement ACAB training & groups (beginning with Unit Chiricahua May 2006). Further refinements after Chiricahua pilot. Full Training re-established July 2007.	Completed / Ongoing in Unit Chricahua Completed / Ongoing
	4. Creation of Line movement procedures that limit ability to throw gang signs or other forms of inappropriate contact.	Completed / Ongoing
	5. Conduct ACAB positive norms kick off and hold quarterly assemblies to reinforce/support the norms.	Completed / Ongoing
	6. All arriving youth are to be toured and introduced (by YPS or YPOIII) to all of CMS Administration and introductory community group held with youth (as soon as able) on day of arrival.	Completed / Ongoing
	7. CMS Administration utilizes Catalina Youth (Student) Council (CYC) as pro-social outlet, role models, and mentors for arriving youth.	
	8. If any violent incidents occur, CMS Administration will hold and document an immediate one-on-one	Completed / Ongoing

	with Unit Manager to discuss response and follow-up needed. Notes will be forwarded to the Superintendent for record. 9. Creation of 'Superpass' program that allows CMS Administrators to automatically reward behaviors in support of ACAB positive norms. 10. Automatic violent incident debriefs sent to ADJC Leadership by 1200 hrs. the following day for notification and immediate follow-up. 11. Automatic phone notifications to CMS Administrators by OIC and/or Late night ODAs of violent incidents for feedback and immediate response suggestions. 12. Positive rewards will be issued to youth who have no negative incidents – Off site rewards may include participation in intramural activities with other institutions, pool transports to AMS, furloughs, and other rewards as deemed appropriate.	 Completed / Ongoing Completed / Ongoing Completed / Ongoing In progress 7/4/06 / Ongoing
	13. Staff with several grievances will meet with CMS Administration to give feedback as necessary. 14. Creation of Control room video feed monitor (to act as 'set of eyes' for unit staff and to correct potential problems). 15. CMS Administration will recognize three staff members per month for acting proactively or handling crises well.	In progress 6/1/06 / Ongoing In progress 5/1/06 / Ongoing In progress / Ongoing 5/31/06 Not established as yet.
	16. All direct contact staff will be scheduled for updated TCI training as well as new 'Boundaries' training.	Completed

	17. Youth with three separation referrals will be staffed by the PSAII for possible creation of behavior plan in conjunction with MDT.	Completed
	18. Creation of 'step down' program for youth in separation that appropriately transitions youth back into the unit after an incident.	In progress-7/31/06
	19. Installation of air conditioning systems in all units, decreasing discomfort and deescalating potential crises.	Completed.
Topic: Success Measure	**Violence Reduction** **AREA: *Education***	**Updates**
Summary of activities	**Education:**	
	20. Conduct formal training/discussion with teachers and unit staff on Thursday 4/27/06 to discuss updated AE procedure and I.R. writing/TCI techniques.	Completed 4/27/06
	21. Increase presence of support staff and administrators during education movements. Conduct random audits to ensure support staff are reporting to duty post upon calling. Support staff will also act as crisis counselors and will assist with supervision of movement throughout the day.	Completed/Ongoing
	22. Utilize ACAB positive norms in communicating concerns and in addressing issues.	Completed/Ongoing
	23. Create educational movement procedures that institute structure and decrease opportunity for violent incidents.	Completed/Ongoing
	24. Implement midday intramural program to expend youth energy and	Completed/Ongoing

	allow for recreation prior to 2nd half of school/New Freedom hours. 25. Create and post high priority classroom list for Security and unit staff for appropriate coverage in potential areas of concern.	 Completed/Ongoing
	26. Distribute radio ear pieces and ensure all staff members wear their ear pieces during programming. 27. Institute a 'three code' practice in which all support staff are called out to the education areas if more than three significant codes are called. 28. Establish and implement Student of the Month program through student council sponsors. 29. Create and implement new AE post orders that tie education into housing unit MDTs more effectively.	Completed/Ongoing Completed/Ongoing Completed/Ongoing Completed/In progress 8/1/06

	FACILITY: **CATALINA MOUNTAIN SCHOOL(cont.)** DATE: **Friday, August 04, 2006– (updated)**
Expected outcomes in measurable terms	**REDUCE VIOLENT ACTS BY 25% AT CMS BY OCTOBER 2006.** (Review of IR information collected over the course of months)
Timeline of anticipated implementation	With the exception of TCI/boundaries Training completion and air conditioning installation (expected completion for both by December 2006), CMS plans to have all other in progress action items completed by October 2006.
Person responsible (from each area)	**Housing Units:** 1. CMS Administration (Supt, Asst Supt., Psych, Lt.) 2. Asst. Supt Steve Ramirez & Asst. Supt Richard I. Robinson 3. Principal Margarito Uranga, Asst. Supt Steve Ramirez & Asst. Supt Richard I. Robinson, Joyce Morgan 4. YPS' Martin, Lynch, Jabczenski, Simon, Maier 5. CMS Maintenance – Bill McPheron 6. Anthony Parrish **Education:** 1. Elmar Cobos, Supt., Principal Margarito Uranga, Asst. Supt.

	Steve Ramirez, Asst. Supt. Richard I. Robinson, Joyce Morgan 2. YPSs Martin, Lynch, Jabczenski, Simon, Maier 3. All CMS CEPTs
Date:	**Friday, August 04, 2006**

APPENDIX E
Exclusions

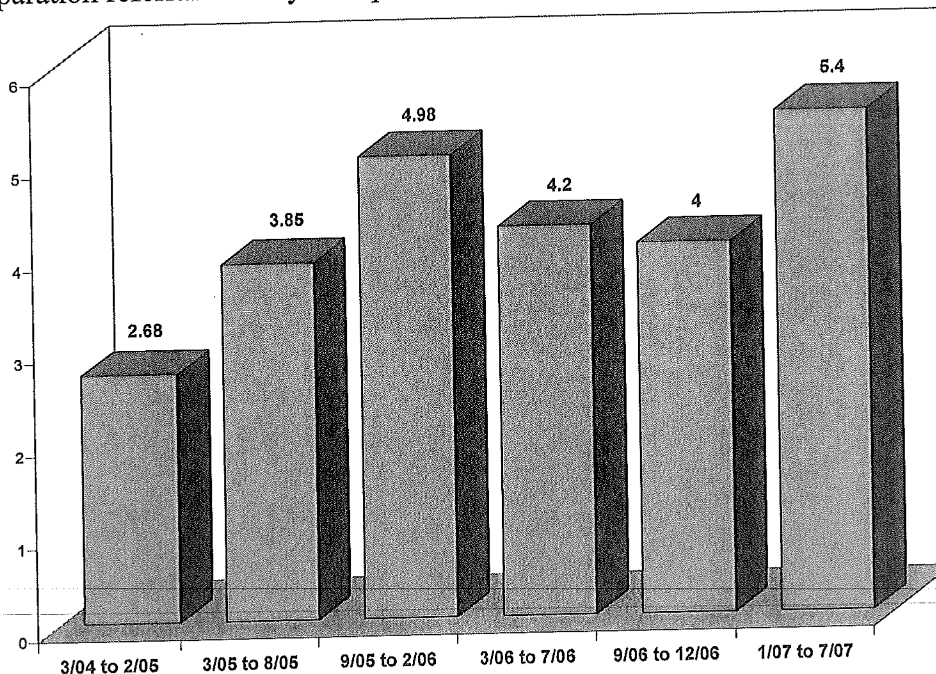
ADJC* Use of Exclusion, March 2006 through June of 2007				
All Exclusions Lasting More than 15 Minutes				
Month	**# of Exclusions**	**Rate**	**Total Length**	**Average Length**
March	390	2.8	17,764	46
April	297	2.2	13,186	44
May	365	3.1	10,860	31
June	465	3.3	20,641	46
July	374	2.1	17,651	47
August	218	1.6	10,241	47
September	274	2	12,698	46
October	192	1.4	9,078	47
November	260	1.9	7,207	28
December	282	2.2	13,965	50
January	298	2.2	13,872	47
February	391	3.2	17,992	46
March	460	3.2	21,949	48
April	399	2.9	18,722	47
May	557	4	25,477	46
June	565	4.1	26,506	47
* Excludes Eagle Point School				

APPENDIX F
Separations

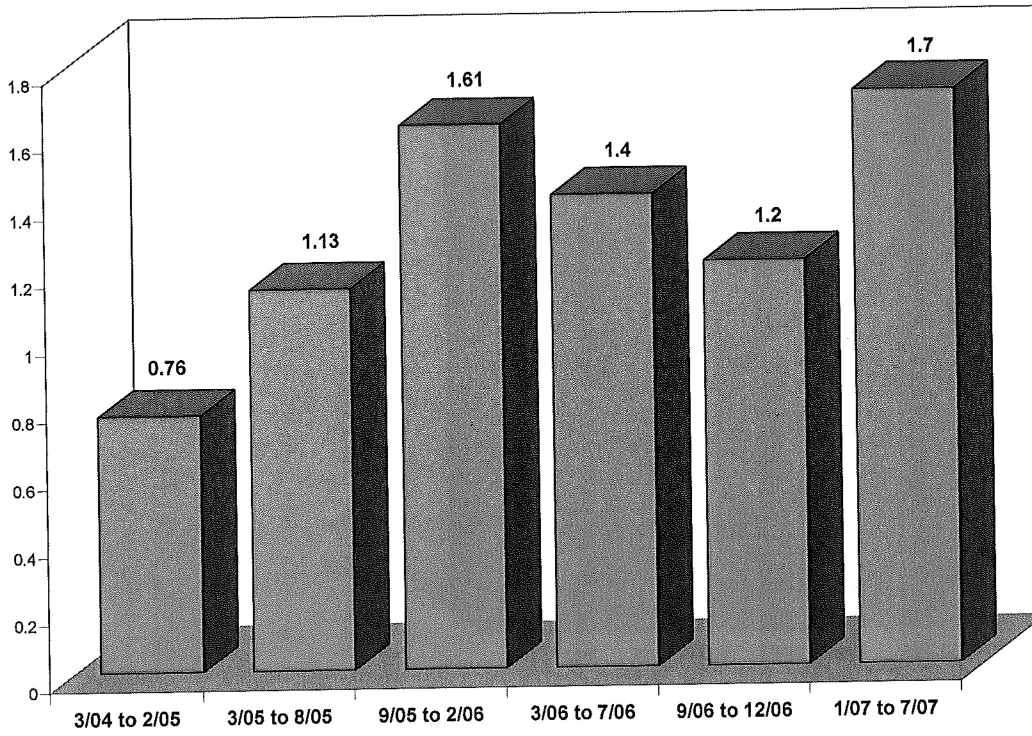
ADJC Separation, March 2004 – June 2007												
	3/04 to 2/05		3/05 to 8/05		9/05 to 2/06		3/06 to 7/06		8/06 to 12/06		1/07 to 6/07	
	Avg	Rate	Avg	Rate	Avg	Rate	Avg	Rate	Avg	Rate	Avg	Rate
Total # of Separation Referrals	523	2.68	741	3.85	800	4.98	782	4.2	736	4.0	999	5.4
Total # of Self-Referrals to Separation	149	0.76	217	1.13	264	1.61	254	1.4	221	1.2	311	1.7
Total # Danger to Self Referrals to Separation	59	0.30	110	0.57	83	0.52	73	0.4	74	0.4	104	0.6
Total # Danger to Others Referrals to Separation	162	0.83	199	1.03	207	1.29	205	1.1	198	1.1	227	1.3
Average Separation Length of Stay (hours)	12		10		9		9		7.4		7	
Median Separation Length of Stay (minutes)	105		110		102		150		165		170	
Average Daily Population	643		626		564		608		600		588	

The formula for calculating the rate is the total number of separations for the period divided by the product of the average daily population and the number of days in the time period. The resulting number is then multiplied by 100.

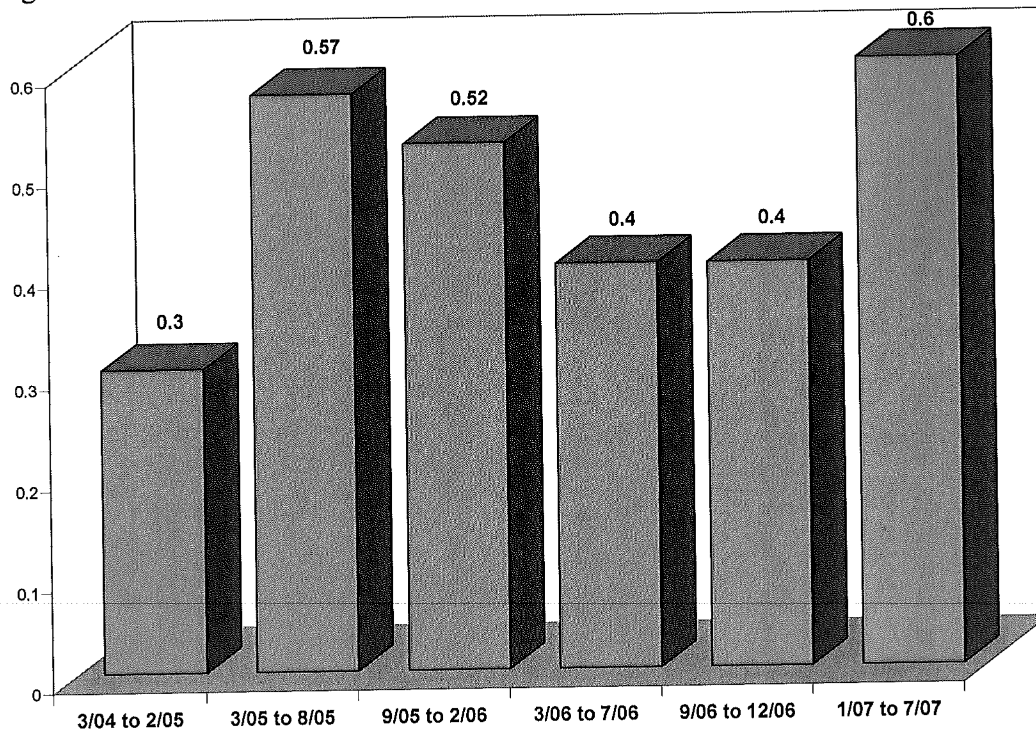
Separation referral rates by time period



Self referral rates to separation by time period



Danger to self referral rates to separation by time period



Danger to others referral rates to separation by time period