

First Semi-Annual Report

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First Semi-Annual Report

1. INTRODUCTION

This is the first semi-annual report of the Consultants Committee in response to the Memorandum of Agreement Between the United States Department of Justice and the State of Arizona Concerning Adobe Mountain School, Black Canyon School, and Catalina Mountain Schools.

This report covers the time period commencing September 1, 2004 through March 1, 2005. The Committee will continue to issue a report every six months until conditions that precipitated this agreement are remedied or both parties agree to a termination of the action.

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

The first report attempts to build a foundation based on at least three site visits made jointly and individually by the Consultants. During those visits Consultants met with youth, direct care staff, advocates and administrative staff, in addition to reviewing information from hard files and the ADJC Youth Base data system, in order to develop a beginning understanding of the agency and its operations

At the conclusion of site visits, during the course of the first six months investigations, debriefings were held with Director Branham and his leadership team. The team was completely receptive to recommendations of the Consultants Committee and in many cases instituted remedial measures prior to the termination of the visit.

It is important to recognize that this first report attempts to cover the changes to the agency that have been instituted since Director Branham was hired April 20, 2004. The Consultants Committee acknowledges that the agency has made significant strides in remedying deficiencies identified in the CRIPA investigation that began in June 2002. It also acknowledges that a six month period is not sufficient time to thoroughly review all areas of the agreement and where time did not allow, at least a beginning review of the agency's response, a finding of not reviewed was provided in that section.

Arizona is developing a very solid base for not only responding to this settlement agreement but to providing an expectation of professionalism that will insure that incarcerated youth in the care of ADJC are not only safe from harm but recipients of strong rehabilitative programming within each of the ADJC facilities.

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 describe 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 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: The Committee does not have adequate information to rate the provision at this time.

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

3.1 Training

UFN 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.

Status: Partial Compliance

Discussion: The 8-hour suicide prevention training curriculum was most recently revised in October 2003. It was reviewed by the Consultants Committee according to topics 1 through 8 listed above. Although the curriculum contains instruction on the existing ADJC suicide prevention policy (No. 4250), as of the date of this compliance status report, it did not yet include the newly revised suicide prevention policy (3.1.1.1). The curriculum does make reference to “why facility environments may contribute to suicidal behavior” (3.1.1.2); “potential predisposing factors to suicide” (3.1.1.3); “high risk suicide periods” (3.1.1.4); and “warning signs and symptoms of suicidal behavior” (3.1.1.5). The curriculum, however, does not include “case studies of recent suicides and serious suicide attempts” (3.1.1.6). In addition, although the suicide prevention curriculum does not contain “mock demonstrations regarding the proper response to a suicide attempt” (3.1.1.7) or “the proper use of emergency equipment” (3.1.1.8), these topics will be more appropriately reviewed in section 3.5. below.

Recommendations: Overall, the existing curriculum is adequate for the material it contains, but in need of revision. For example, Section II (Youth at Risk for Suicide in Juvenile Corrections) should be the strongest section of the curriculum, yet it is the weakest for the following reasons.

First, this section does not contain *any* information on suicide risk in confinement.

Second, although four performance/learning objectives are offered in this section (i.e., 1) identify youth at risk for suicide to include population groups, environment conditions and events, 2) identify personal problems that may increase youth’s risk for suicide, 3) identify behaviors that youth may exhibit after making the decision to commit suicide, and 4) understand how self-injurious behaviors may increase risk of suicide), these four objectives are either inadequately addressed or not addressed at all in the section.

Third, some of the “high risk suicide periods” listed on page 8 of the lesson plan (also in slide 18) are incorrect. Juvenile suicides are not more likely to occur within the first 24 hours of confinement or at night. National data indicates that juvenile suicides in confinement are evenly distributed throughout the year, generally occur during the daytime, and under conditions of room confinement. In addition, all three AMS suicides occurred well after the first 24 hours of confinement, during the daytime, and under conditions of room confinement. Fourth, although youth at risk for suicide do have high rates of substance abuse (consistent with most youth in confinement), the literature does not support the notion on page 12 (slide 24) of the lesson plan that “usually suicide is the result of long-term substance abuse and addiction.”

It is strongly recommended that Section II of the curriculum be increased in time length and include the presentation of data on juvenile suicide in confinement [see Hayes, L. M. (2004), *Juvenile Suicide in Confinement: A National Study*, Washington, D.C.: U.S. Justice Department, Office of Juvenile Justice and Delinquency Prevention] and a better presentation of the four performance/learning objectives.

In addition, Section IV (Mental Disorders) should include data on mental disorders of youth confined within the ADJC.

Consistent with the requirements of 3.1.1.6, Section V (ADJC's Team Approach to Observing and Assessing Suicide Risk) of the curriculum should include a thorough discussion regarding the three AMS suicides (see *Report on Suicide Prevention Practices within the Arizona Department of Juvenile Corrections*, July 23, 2003, Lindsay M. Hayes, for discussion of those deaths and issues relating to observing and assessing suicidal youth).

Performance Objectives need to be listed on the face sheet and in the appropriate sections for Sections VII (Strategies for Managing Youth in Secure Care) and Section VIII (Suicide Prevention: Policy and Procedures). In fact, all performance objectives listed on the face sheet should be cross-checked in each section of the curriculum to ensure that they are adequately discussed.

The Consultants Committee acknowledges that ADJC will include the newly revised version of the suicide prevention policy (No. 4250) in Section VIII of the revised training curriculum.

Further, the 2-hour suicide prevention *update* training curriculum was most recently revised in May 2004. It is devoted to ADJC's existing suicide prevention policies and procedures, and will also need to be revised to incorporate the newly revised policy. It is strongly recommended that this curriculum also include discussion on completed suicides and/or serious suicide attempts within the previous year.

Finally, national data indicates that over 50 percent of all juvenile suicides in confinement occur under conditions of room confinement (see, e.g., the three AMS deaths). As such, *it is strongly recommended that a continued and recurring theme within both the 8-hour and 2-hour suicide prevention training curricula should be that room confinement under any name within ADJC (e.g., exclusion, separation, large group, marathon, freeze, suspension, conflict resolution, lockdown, etc.) is strongly associated with suicidal behavior and that any youth confined to their rooms under these circumstances is immediately at a higher risk for suicide.*

UFN 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.

Status: Partial Compliance

Discussion: Beginning in February 2003, the ADJC began offering an 8-hour suicide prevention training curriculum to all agency employees, including direct care, medical, mental health, and education staff. As of January 26, 2005, 96% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 8-hour suicide prevention workshop, including 98% of direct care (including mental health) personnel, 85% of medical staff, and 84% of education staff. It is noteworthy to report that *only* 10 of 636 direct care staff at these facilities did not complete the workshop. The high compliance rate for direct care staff is very impressive.

Beginning in October 2003, ADJC began offering a 2-hour suicide prevention *update* training curriculum to all agency employees, including direct care, medical, mental health, and education staff. As of January 26, 2005, 89% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 2-hour suicide prevention workshop, including 91% of direct care (including mental health) personnel, 67% of medical staff, and 88% of education staff. It is noteworthy to report that a partial explanation for the lower compliance rate in the update training is that new employees (including cadets) hired during the past year would be required to complete the 8-hour, not the 2-hour, suicide prevention training.

In the near future, ADJC plans to revise and expand the suicide prevention *update* training to a 4-hour workshop. Entitled *Suicide Prevention Refresher*, the curriculum will be scenario-based, and include revised suicide prevention policies and procedures, as well as behavior management techniques.

Although the ADJC has achieved very high rates of compliance for suicide prevention training of its agency staff that might normally result in a rating of “substantial” compliance, a rating of “partial” is given because agency staff have not yet been trained in the newly revised suicide prevention policies and procedures, nor trained utilizing the revised training curriculum as recommended above in 3.1.1.

Recommendations: It is strongly recommended that compliance rates be increased for both medical and education personnel.

3.2 Identification/Screening

UFN 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.

Status: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report.

Notwithstanding the newly revised policy, the Consultants Committee found that existing practices indicate that ADJC staff consistently notify either the unit manager or officer-in-charge when they observe and/or identify a potentially suicidal youth. The youth is then placed on suicide precautions and referred to QMHP staff. The newly revised policy will reflect this practice. A rating of partial compliance is given because the newly revised policy was not approved and implemented as of the date of this compliance status report.

It should also be noted that the Consultants Committee heard complaints from several direct care and QMHP staff regarding an August 3, 2004 memorandum from the ADJC Deputy Director concerning levels of observation assigned to potentially suicidal youth by non-QMHP staff. The memorandum essentially requires that any non-QMHP staff that observes and/or identifies a youth demonstrating potentially suicidal behavior should immediately place the youth on Level 1: Constant Observation pending an assessment by QMHP staff. The concern expressed by both direct care and QMHP staff is the possibility that non-QMHP staff might be reluctant to place a youth displaying only mild suicidal ideation/behavior (e.g., scratching of the arm, joking about self-harm, etc.) on the level of observation reserved for the most acutely suicidal youth (i.e., Level 1: Constant Observation) and, therefore, not impose *any* level of observation. The Consultants Committee views this issue as a legitimate concern.

Recommendations: It is strongly recommend that the revised suicide prevention policy be further revised to simply require the initiation of suicide precautions by non-QMHP staff at a level of observation that is commensurate with the youth's behavior (i.e., at Level 1, Level 2, or Level 3.)

UFN 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.

Status: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. Notwithstanding the newly revised policy, the Consultants Committee found that existing practices indicate that, following the placement of a youth on suicide precautions, a Suicide Prevention Time Sheet is initiated and includes the youth's name, "K" number, time and date, level of observation, special instructions, and document time intervals of observation. Within 24 hours of placement on suicide precautions, the youth's name will be appear on the facility's Daily Suicide Prevention Daily Status List. This document, initiated by the facility psychologist, includes the youth's name, assigned housing unit, "K" number, level of observation, reason and start date for suicide precautions. The newly revised policy will reflect this practice. A rating of partial compliance is given because the newly revised policy was not approved and implemented as of the date of this compliance status report.

Recommendations: None at this time.

UFN 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.

Status: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. Notwithstanding the newly revised policy, the Consultants Committee found that existing practices indicate that the documentation described in paragraph (b) above is provided to QMHP staff and that the appropriate QMHP staff member is notified of the youth's placement on suicide precautions. The newly revised policy will reflect this practice. A rating of partial compliance is given because the newly revised policy was not approved and implemented as of the date of this compliance status report.

Recommendations: None at this time.

UFN 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.

Status: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. ADJC currently utilizes several suicide risk assessment instruments at two points during a youth's confinement: 1) upon entry into the ADJC's Reception and Classification (RAC) units, and 2) upon observation and/or identification of suicidal behavior. Almost immediately upon entry into a RAC unit, several intake screening instruments are administered, including the Massachusetts Youth Screening Instrument (MAYSI), the Intake Suicide Prevention Assessment, and the Mental Status Exam Checklist. The MAYSI is administered to the youth by a non-QMHP staff, but scored by QMHP staff, whereas both the Intake Suicide Prevention Assessment and the Mental Status Exam Checklist are administered to the youth by QMHP staff. In addition, any time a youth is either observed and/or identified as being potentially suicidal, the youth is assessed by QMHP staff utilizing a Crisis Intervention Assessment (CIA) form. The CIA form contains the youth's name, "K" number, housing unit, date and time of assessment, QMHP staff performing the assessment, self-reported behavior, findings/observations, mental status exam, assessment, recommended suicide observation level, and plan. The Consultants Committee found that the CIA form is always administered well within 24 hours of the youth being initially identified and/or observed displaying potentially suicidal behavior.

Overall, the Consultants Committee found very good practices regarding the identification of suicidal youth through the suicide assessment process. Several recommendations to strengthen the process are offered below. A rating of partial compliance is given to this section because the newly revised policy was not approved and implemented as of the date of this compliance status report, as well as concerns expressed within Recommendation No. 1 below.

Recommendations: First, the most recent draft of the newly revised suicide prevention policy will require that QMHP staff conduct an assessment *if* a youth scores within the “Warning” range on the MAYSI. The assessment would include conducting a Suicide Probability Scale instrument, as well as the Intake Suicide Prevention Assessment (renamed the Initial Precautionary Status Risk Assessment). The Consultants Committee would not support this recommendation. The MAYSI is not a stand-alone form and should always be administered in conjunction with a suicide risk assessment. In addition, the SPS has not been validated in a juvenile correctional facility. The Consultants Committee believes that the current system of assessing suicide risk, including utilization of the MAYSI, Intake Suicide Prevention Assessment, Mental Status Exam Checklist, and Crisis Intervention Assessment form is preferred and should be retained.

Second, a Spanish-version of the MAYSI is now available and should be utilized when appropriate at the RAC units.

Third, current policy (4203.01) requires that the MAYSI is administered to all new youth (including parole violators) within an hour of arrival at a ADJC facility. In CMS, new youth committed to the ADJC from surrounding juvenile courts arrive at the facility on Tuesday and Thursday mornings awaiting transfer to the RAC units at either AMS or BCS. Although these youth are only in CMS for up to a few hours (and either kept in the lobby or the Separation Unit) and receive initial health screening by the medical staff, they are also subjected to the MAYSI screening. In addition, as a result of this screening, QMHP staff at CMS often receive computer-generated e-mail notifications regarding the youth’s MAYSI scoring several days later even though the youth has since been transferred out of the facility. This practice appears both counter-productive and time-consuming for QMHP staff at CMS, and it would appear more appropriate to conduct the MAYSI screening once the youth arrives at the designated RAC unit.

UFN 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: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. Notwithstanding the newly revised policy, the Consultants Committee found that existing practices indicate that QMHP staff do not consistently review either the clinical (health care) or master (field) files for documentation of any suicidal behavior. There are several reasons for this inconsistency.

First, medical and mental health records are still not integrated into a health care file (see 3.2.8 below for further discussion), resulting in psychological and/or community mental health records being filed in a youth’s field file and not reviewed by QMHP staff.

Second, several QMHP staff readily acknowledged that they rarely, if ever, review either a

youth's health care file or field files. In addition, these staff do not appear to routinely access the YouthBase management information system for documentation of any prior suicidal behavior by the youth in a ADJC facility.

Third, as discussed below in 3.2.8, not all pertinent records are contained within the health care file and some QMHP staff are not computer savvy and do not access their e-mail and other computer programs on a regular basis.

Fourth, as discussed below in 3.2.7, the ADJC still does not receive pertinent medical and/or mental health records from Superior Courts and county juvenile detention facilities in a timely fashion, therefore records that could be reviewed by QMHP staff are not.

The recent case of P.W. illustrates this continuing problem. P.W. arrived at the RAC in AMS on December 28, 2004. An Initial Suicide Prevention Assessment was conducted and the conclusion reached by the QMHP staff was that the youth had no mental health issues and was "emotionally stable." The RAC assessment was completed on January 10, 2005 and again the conclusion reached by the QMHP staff was that the youth had no mental health issues and "denies history of suicide ideation." Sometime during this RAC process, P.W.'s records from the community were received. They included a psychiatric evaluation from June 1995, a psychological evaluation from July 2002, and county juvenile detention records indicated that P.W. was found with a pair of pants wrapped around his neck in October 2004, whereupon he was placed on suicide precautions for several days, as well as again for three days ending December 5, 2005 (a few weeks prior to his arrival at AMS). The conclusion that can be drawn from this case is that either P.W.'s records did not arrive to AMS in a timely fashion and/or QMHP staff failed to review the records prior to completing the RAC assessment.

In conclusion, a rating of partial compliance is given because of the above troubling practices, as well as the fact that the newly revised policy was not approved and implemented as of the date of this compliance status report.

Recommendations: It is strongly recommended that the newly revised suicide prevention policy reflect a requirement that designated QMHP staff will routinely access the YouthBase management information system for documentation of any prior suicidal behavior by the youth in an ADJC facility.

UFN 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.

Status: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. Notwithstanding the newly revised policy, the Consultants Committee found that existing practices indicate that newly arrived youth remain under visual observation of direct care staff until they are assessed by QMHP within one hour of their arrival at the designated RAC unit. The newly revised policy will reflect this practice. A rating of partial compliance is given

because the newly revised policy was not approved and implemented as of the date of this compliance status report.

Recommendations: None at this time.

UFN 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: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. The newly revised policy states that "The QMHP shall review the juvenile's psychological and psychiatric records within seven days of the juvenile's arrival to an ADJC secure facility. However, for juveniles assessed as suicidal, the QMHP shall review the psychological and psychiatric records within 24 hours." The Consultants Committee has several concerns regarding this draft policy.

First, it is slightly different than the requirements of 3.2.7 which require that all pertinent records be *received* within seven days, whereas the draft policy requires that the records be *reviewed* within seven days.

Second, although the draft policy requires that pertinent records of a suicidal youth be required to be reviewed within 24 hours, there is no explanation as to how these records will be expedited from the Superior Courts and/or county juvenile detention facilities.

Third, the language in the draft policy is vague as to whether "pertinent records" refers to those documents from the Superior Courts and/or county juvenile detention facilities, or records currently in either ADJC's health care, field, or YouthBase files.

The Consultants Committee acknowledges that it is a difficult task to create a uniform practice of requiring the juvenile divisions of all Superior Courts in the state, as well as all county juvenile detention facilities and/or placement settings, to expedite pertinent records to ADJC. The Committee also acknowledges that there has been a slight improvement in records being transferred to the ADJC in a more timely manner. However, it would appear that little progress has been made in formalizing the process. The Committee also notes that this section of the compliance agreement (3.2.7) was perhaps inadvertently omitted from the "ADJC Memorandum of Agreement, Remedial Measure, Medical and Behavioral Health Division's Work Plan."

Recommendations: As this very serious issue was a central issue in at least one of the three AMS suicides, the Committee deems it to be critically important within the compliance agreement and would strongly recommend that 3.2.7 receive priority attention.

Further, on an interim basis, it is strongly recommended that a "Sending Agency/Transporting Officer Form" [that was previously recommended last year (see *Report on Suicide Prevention Practices within the Arizona Department of Juvenile Corrections*, July 23, 2003, Lindsay M. Hayes)] or similar form be created and distributed to the juvenile divisions of all Superior Courts in the state, as well as all county juvenile detention facilities and/or placement settings for implementation.

UFN 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.

Status: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. Although the newly revised policy will require that certain pertinent mental health records will be contained in the health care file, the policy does not address the issue of an integrated medical and mental health file.

At a minimum, the Consultants Committee believes that, for the purposes of suicide prevention, an integrated health care file for a suicidal youth should have the following documents in the mental health section: MAYSI, Intake Suicide Prevention Assessment, Mental Status Exam Checklist, Crisis Intervention Assessment forms, and psychiatric and psychological evaluations. While these records are frequently contained within the field file, they are not consistently found in the health care file. In addition, it is very inappropriate for psychiatric and psychological evaluations to be contained within the field file because these files are then accessible to non-medical/mental health personnel.

The Consultants Committee sampled youth files in AMS, BCS, and CMS, and only CMS currently had an integrated file system in place.

In the case reviewed at CMS, most of the integrated health care file contained the MAYSI, Intake Suicide Prevention Assessment, Mental Status Exam Checklist, Crisis Intervention Assessment forms, and psychiatric and psychological evaluations. The file, however, contained only 5 of the 9 CIA forms completed on the youth.

In the case reviewed at BCS, most of the pertinent documents were missing from the health care file, and only 12 of 36 completed CIA forms were in the file.

In the case reviewed at AMS, most of the pertinent documents were missing from the health care file, and only 4 of 12 completed CIA forms were in the file.

Finally, although the Consultant Committee commends the ADJC for requiring designating QMHP staff at each facility to e-mail completed CIA forms of youth on suicide precautions to other QMHP staff at each facility, the Committee found that not all QMHP staff are computer-savvy and do not access their e-mail and other computer programs on a regular basis.

Recommendations: None at this time.
UFN 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.
Status: Partial Compliance
<p>Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. Notwithstanding the newly revised policy, the Consultants Committee found that existing practices indicate clinical team meetings occur on a regular weekly basis at each facility, and these meetings consistently include psychology associates, psychologists, and psychiatrists. The management and treatment plan needs of each youth on suicide precautions are discussed during these weekly meetings. The Consultants Committee found this to be an excellent practice.</p> <p>It would appear that many medical staff are <u>not</u> aware on a daily basis which youth are on suicide precautions in the facility. Although the nursing supervisor at each facility receives a copy of the Daily Suicide Prevention Status List via e-mail, a hard copy of the list is not generated and distributed to nursing staff.</p>
Recommendations: It is strongly recommended that the nursing supervisors generate a hard copy of the Daily Suicide Prevention Status List and post and/or place the list in the nursing station on a daily basis.

3.3 Safe Housing of Suicidal Youth
UFN 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).
Status: Partial Compliance
<p>Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. To date, ADJC has expended significant resources to ensure that rooms housing suicidal youth are as “suicide-resistant” as possible. The Consultants Committee applauds the agency for its efforts in this area to date.</p>
Recommendations: <u>First</u> , it is strongly recommended that ADJC ensure that all interior door hinges of youth rooms bevel (slope) down to reduce the opportunity for their use as an anchoring device. <u>Second</u> , given the possibility of suicide attempts in the bathroom and shower rooms of

the housing units, it is strongly recommended that ADJC remove physical plant hazards (e.g., air vent covers, etc.) to these areas, as well as to ensure that these rooms are locked when not in use.

UFN 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 have immediate access to appropriate equipment to intervene in the event of an attempted suicide.

Status: Partial Compliance

Discussion: ADJC has created a policy regarding the Use of Rescue Kits (No. 4250.03) that adequately covers the requirements of 3.3.2, but the policy has not been approved and implemented as of the date of this compliance status report. The Consultants Committee observed that most, if not, all direct care staff in each facility carry a rescue kit pouch that contains a microshield, latex gloves, and a 911 extraction tool. A rating of partial compliance is given because the newly revised policy was not approved and implemented as of the date of this compliance status report.

Recommendations: None at this time.

3.4 Supervision

UFN 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: Not Reviewed

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. In addition, although the newly revised policy addresses the steps to be taken in reducing the suicide precaution level of suicidal youth, the Consultants Committee did not have adequate information to measure compliance at this time.

On a related matter, The Consultants Committee would note that the recently revised draft policy now defines “constant observation” as being “within arms-length or closer than 18 inches” from the youth. The Committee finds that this revised procedure is impractical because a staff member who literally remains within arms-length of a youth on a continuous basis during an 8-hour shift will likely create a situation in which the youth becomes agitated and engages into an altercation with staff.

Further, the Committee acknowledges that closed circuit television (CCTV) monitoring is utilized in the Separation Units at all three facilities. Although informed that CCTV is utilized as

a supplement to, not a replacement for, the physical checks conducted by staff, the Committee observed on several occasions that CCTV was being used as a replacement for personal observation of suicidal youth in the Separation Units. In addition, the Committee observed suicidal youth who were allowed to cover their heads with blankets in the Separation Units, thus obscuring complete visibility of the youth.

Recommendations: First, it is strongly recommended that the drafted definition of “constant observation” be revised to be “the continuous, uninterrupted supervision of youth by an assigned staff member.” Second, it is strongly recommended that the newly revised draft policy be further revised to re-enforce the policy that: 1) CCTV is utilized as a supplement to, not a replacement for, the physical checks conducted by staff, and 2) youth on suicide precautions are prohibited from covering their heads with blankets or other material that obstructs complete visibility of staff.

UFN 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: Not Reviewed

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. In addition, although the newly revised policy addresses the issue of follow-up treatment for youth discharged from suicide precautions, the procedures are vague and simply state that “If the juvenile is to be placed from Level 3 to Standard Supervision, the QMHP: i. shall consult with the YPO III to initiate notifications to Parent(s) or legal guardians(s); ii. Determine frequency of follow-up assessments of juvenile and the psychologist or designee shall co-sign that determination.”

Further, the Consultants Committee learned that each facility currently has a practice of continuing to list youth recently discharged from suicide precautions on the Daily Suicide Prevention Status List until their case can be discussed during the up-coming weekly clinical team meeting. A plan for follow-up assessment and treatment of the youth is then created. This appears to be an excellent practice.

In conclusion, the Consultants Committee did not have adequate information to measure compliance at this time.

Recommendations: First, the revised suicide prevention policy should be further revised to provide more clarity of follow-up treatment. Second, the practice of continuing to list youth recently discharged from suicide precautions on the Daily Suicide Prevention Status List until their case can be discussed during the up-coming weekly clinical team meeting should be incorporated in the newly revised policy.

3.5 Intervention

UFN 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.

Status: Partial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. Notwithstanding the newly revised policy, the Consultants Committee views the following training topics relevant to this section: Cardiopulmonary Resuscitation (CPR), extraction knife training, and mock demonstrations regarding the proper response to a suicide attempt.

According to ADJC Training Academy records, as of February 11, 2005, 89% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 4-hour CPR workshop, including 95% of direct care (including mental health) personnel, 34% of medical staff, and 81% of education staff. The compliance rate for CPR training of medical staff is very low and could be caused by the possibility that medical staff have retained CPR certification *outside* of their ADJC employment.

According to ADJC Training Academy records, as of February 11, 2005, 76% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 1-hour Extraction Knife Training workshop (see Section 3.1.1.8 which requires training on "the proper use of emergency equipment"), including 84% of direct care (including mental health) personnel, 20% of medical staff, and 48% of education staff. *ADJC Training Academy records also indicated that virtually no ADJC personnel have received any annual refresher Extraction Knife Training.*

As discussed in Section 3.1, the Compliance Agreement requires that all staff receive basic and annual training in "mock demonstrations regarding the proper response to a suicide attempt" (3.1.1.7). The Consultants Committee has reviewed the lessons plans for ADJC's suicide prevention, CPR, and extraction knife training workshops. These lesson plans do not appear to include presentation of mock drill demonstrations of suicide attempts.

Recommendations: First, it is strongly recommend that the ADJC Training Academy staff verify the actual CPR compliance rate of medical staff, including any certification received outside the agency. Second, it is also strongly recommended that compliance rates be increased for both medical and education personnel in the areas of CPR and Extraction Knife Training. Third, it is strongly recommended that the lesson plan for the Extraction Knife Training be revised to include mock drill demonstrations of suicide attempts, and emergency intervention responses for other types of suicide attempts (e.g., cutting, etc.). It might also be necessary to expand this training workshop to a 2-hour duration. In addition, because the current lesson plan contains instruction regarding the proper role of staff in responding to an emergency, it might be more appropriate to rename the Extraction Knife Training workshop to "Emergency Response to

a Suicide Attempt” or a similar name.

3.6 Mortality Review

UFN 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: Not Reviewed

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250), but the policy has not been approved and implemented as of the date of this compliance status report. The Consultants Committee did not have adequate information to measure compliance at this time.

Recommendations: Although the Consultants Committee did not have adequate information to measure compliance at this time, the section of the newly revised draft policy regarding “administrative review and follow-up” is in need of revision. The section is currently almost four pages long and can be considerably shortened. The theme of the revised section should simply reflect the following:

“Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment and/or hospitalization), will be examined through a mortality review process. The review, separate and apart from other formal investigations that may be required to determine the cause of death, will include a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. The review team will be multidisciplinary and include representatives from security, mental health, medical, and educational divisions, as well as from central office and the facility that sustained the incident.”

Simply procedures should then be written to provide proper guidance in accomplishing the above policy.

In addition, the section on “critical incident support” is currently almost three pages long and can also be considerably shortened. The theme of the revised section should simply reflect the following:

“A juvenile suicide is extremely stressful for both staff and other youth. Staff may also feel ostracized by fellow personnel and administration officials.

Following a suicide, misplaced guilt is sometimes displayed by a staff member who wonders: "What if I had made my room check earlier?" Youth are often traumatized by critical events occurring within a facility. Such trauma may lead to suicide contagion. When crises occur in which staff and youth are affected by the traumatic event, they should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, comprised of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, mental health personnel), provides affected staff and youth an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident."

Simply procedures should then be written to provide proper guidance in accomplishing the above policy.

4. JUVENILE JUSTICE

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:

Status: Partial Compliance

Discussion: ADJC has developed a grievance system. Policy & Procedures are in place (2304 ADJC operating manual). Its implementation is progressing and is in various stages at each of the facilities. (See Juvenile Grievances Summary of Paths Appendix C). Youth are to be informed of grievances through the orientation process, grievance forms are provided in each cottage, a box for collection and the Youth Rights Specialist has responsibility to collect the grievances and channel them to the appropriate authority. (I&I for abuse and staff misconduct) (Asst. Supt for violations of basic rights and facilities issues and all others handled by the YRS). Meetings were held with the Youth Rights Specialists in each of the facilities, youths and staff at each facility interviewed regarding their views of the process, its reliability in solving the grievances and problems that were identified. A meeting was held during the January site visit at AMS with all of the Youth Rights Specialists, Sheila Press, the new director of the Youth Rights Office and Lou Goodman, Assistant Director, Legal Division. During the course of this monitoring period there were at least four problems identified. First was the reluctance of some staff to accept the grievance process and the role of the Youth Rights Specialists. In some instances youth were denied grievance forms, and staff members tore up some forms. Youth Rights Specialists have not been invited to participate in management meetings in the facilities

and their input into issues surrounding youth care, consequently, not considered. Thirdly, the de-briefings or resolution of grievances were not taking place. Staff seemed overwhelmed with the management of the grievance (and Incident report requirements) and while grievances were being filed the resolution of those grievances were often times unknown to the staff. (Some were delayed for as long as 5 months pending resolution). Fourthly, when formal resolution meetings were held the youth was invited to a meeting with facility officials, usually the assistant Superintendent, and asked to agree to a resolution. The exclusion of the Youth Rights Specialist from this meeting was seen as extremely inappropriate since the individual youth would be placed in a position of having to not accept the offered resolution without the benefit of advocacy. This particular issue was brought to the attention of Director Branham in the leadership de-briefing meeting and was quickly remedied so that all meetings to resolve grievances now include the Youth Rights Specialist.

Recommendation: ADJC should insure during this next reporting report that past grievances are resolved so that staff and youth are not spending time on very old issues. Also, that Youth Rights Specialists are, in fact, attending all resolution meetings and that Youth Rights Specialists are participating in staff meetings. This information needs to be collected and available for verification during the next reporting period.

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.

Status: Partial-Compliance

Discussion: During each of the 4 site visits conducted during this first reporting period youth at each of the facilities were asked about their orientation. During the last site visit, in February, 20 youth were interviewed, at all three facilities and asked specifically about the orientation and the grievance process. While youth acknowledged that an orientation had taken place they seemed very unsure about their rights, the general knowledge of the facility and system that would have accompanied that orientation. All of the youth verified that a grievance process was in place but the majority indicated that it did not work. The handbook being used is very old (1999) and is to be updated for orientation use by March of this year.

Recommendation: Complete the updating of the handbook and begin its use during the next reporting period. Be able to document, in writing, that youth have attended the orientation. Create a tracking process as part of Youth Base so that orientation can be verified.

UFN 4.1.1.2 Ensure that, without any staff involvement, youths can easily obtain grievance forms and submit grievances directly.

Status: Partial Compliance

Discussion: In meetings with youth and staff it is clear that youth and staff understand the grievance process. Youth are aware of grievance boxes and forms, as is staff. There is some evidence, however, through youth interviews, that forms have been denied to youth, or torn up

by staff when submitted. In addition, the current process does not allow for verification that grievances are submitted, received and resolved. Many youth spoke of submitting grievances but not receiving notification of the receipt of the grievance by the receiving authority or a resolution of the grievance. Currently forms may be refused to youth, destroyed after being submitted, lost in the process, not resolved etc. The Consultants Committee acknowledges the progress being made in this arena. ADJC has acknowledged the deficiencies to the Committee and steps are being taken to respond to them.

Recommendation One consideration might be the numbering of grievances as they are assigned to each cottage. The YRS could then require, weekly, that each of the grievance forms be accounted for. This would also allow for the tracking of the forms through the process and a management report could be developed showing the status of the forms. Youth and staff would then know that each form had to be accounted for, and only upon official resolution would the form discontinue. Time of the process could also be tracked. In addition, resolutions need to be tracked. Are they implemented? This process would also allow for the process to be completed.

UFN 4.1.1.3 Ensure that there are no formal or informal preconditions to the completion and submission of a grievance.

Status: Partial Compliance

Discussion: Through meetings with the Youth Rights Specialists in each facility and newly appointed Director of this office, Sheila Press as well as Lou Goodman, Assistant Director, Legal Division, it is clear that there are no formal preconditions to the completion and submission of a grievance. The current process allows for any youth to submit a grievance. There are some informal preconditions that have been identified. The most mentioned is the lack of support of some staff both to youth and to the Youth Rights Specialists. The Consultants Committee recognizes the progress being made in this area and the immediate response to recommendations made in de-briefings with the leadership team after site visits.

Recommendation: It is strongly recommended that the newly formed Quality Assurance Office make this area a top priority and create documentation through the recommendation in 4.1.1.2

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.

Status: Partial Compliance

Discussion: The current process for submission, collection and resolution of grievances (see appendix C) does ensure that the grievances are assigned either to I&I or to the Superintendent. Direct care staff and supervisors are not assuming responsibility for grievances. In the meetings held with the Youth Rights Specialists and with Sheila Press and Lou Goodman this issue was discussed and the need for the grievance process to be removed from the direct care staff supervisors was understood and agreed upon.

Recommendation: The Consultants Committee would strongly recommend that the use of mediation be emphasized during this next reporting period. While mediation is a part of the current process it has not been entirely successful. Reasons for that are not yet clear. The Youth Rights Office should make this a priority as the grievance process is being revised.

UFN 4.1.1.5 Ensure that a youth who files a grievance is informed in writing of the results of the grievance process.

Status: Non-Compliance

Discussion: Youth at BCS, AMS and CMS were interviewed during the 4 site visits, over 30 youth, and in that sampling none of the youth who had filed grievances, had received notification, in writing, of the resolution of their grievance. The backlog of grievances, as identified in staff interviews indicates that youth are not always receiving timely notification. Future monitoring will better clarify this.

Recommendation: The Consultants Committee strongly recommends that youth be informed in writing of the resolution of the grievance and that in addition to the youth the Youth Rights Specialist also sign indicating a concurrence with the resolution. The form should provide space for a dissenting comment if the resolution is not satisfactory to the aggrieved parties.

4.2 Protection from Harm

UFN 4.2.1 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: The most significant event in responding to this portion of the settlement agreement was the development of the Inspections and Investigations Unit (I&I). This unit was formerly internal affairs. John Dempsey was hired as the Administrator of I&I. The evidence for the rating given was compiled through interviews with Mr. Dempsey and his staff, as well as a review of the changes in policy and procedure since Michael Branham was hired as the Director of ADJC and I&I was established. This time frame is approximately April, 2004 to the present. The Consultants Committee, in interviews with I&I staff identified some of the problem areas. Examples are provided here in order to demonstrate the change in culture in the agency. Prior to the establishment of I&I administrative and criminal cases were selectively assigned for

investigations without continuity and protocol. Administrative and criminal cases were jointly investigated-endangering successful criminal prosecution as it pertains to 'Garrity'. Case management was haphazard and tracking of information was difficult. There was an unwarranted staff influence in criminal investigations that hindered successful prosecution. A lack of cooperation between management and investigators in facilitating investigations. Weak working relationship with Maricopa County attorney's Office, poor evidence management and collection-endangering criminal cases. Feedback on cases investigated by I&I were little to non-existent, no communications between ADJC Juvenile Rights personnel and I&I investigators. With the development of the I&I, the Division expanded from five to 20 personnel with the following changes: A clear chain of command was established between the I&I Division and the Director to ensure timely notification of significant issues and events. An experienced and qualified Administrator was hired to oversee and facilitate improvements and processes for the I&I Division and ADJC's compliance to the CRIPA agreement. A clear delineation was made between criminal investigations and administrative investigation by the establishment of a criminal investigation unit and a professional standards unit. The I&I unit was divided into two units: The Investigations Unit which consists of Professional Standards Unit (three investigators) which investigates Administrative (staff misconduct) cases; Criminal Investigations Unit (five investigators) which investigates all criminal cases and the Inspections Unit (five inspectors/investigators) to conduct audits and inspections of ADJC. Clear supervisory oversight and quality checks on all cases and processes was begun. An employee Conduct Policy was written in order to promote consistent discipline and identify consequences for unacceptable behavior. An automated case management tracking system and electronic reporting and management system were developed. An improved working relationship with ADJC legal staff (Youth Rights/Ombudsman and AG liaison), improving the investigation of youth grievances that involve alleged staff misconduct. The establishment of improved working relationship with Maricopa and Pima County Attorney's Office where ADJC facilities exist. An early warning system (identification early on of employee behavior issues that could affect the safety and security of youths-that allows for early intervention and correction) is being developed. Since October of 2003, 77 agency personnel have been dismissed from ADJC. Approximately 28 additional employees resigned in lieu of termination, two employees were charged with felony crimes (a sex abuse, 1 child abuse) and one was charged with misdemeanor theft. 65 additional employees received discipline ranging from reprimands to 80 hours of suspension. The 2004 summary of I&I investigations as of October:

350 total cases

227 cases opened criminally (staff misconduct that could be criminal and youth crimes)

123 cases opened by Protective Services (A majority were staff misconduct allegations)

31 cases reissued to Protective Services from Criminal Investigations

3 cases issued simultaneously to Criminal and PSU investigations

It is important to point out that the level of intervention in staff misconduct reported by the Investigations and Inspections Unit (I&I) is very unusual in juvenile justice systems. A major part of the difficulty in preventing abuse within juvenile institutions is the continued inability of most systems to effectively discipline and terminate staff that perpetrates the abuse. The early warning system being proposed is also very noteworthy because it suggests an ability to intervene due to warning signals generated by staff misconduct and prevent abuse from occurring. The Consultants Committee acknowledges the substantial progress made in the investigation and inspections unit within ADJC. The hiring of former law enforcement

personnel appears to have brought a professionalism and efficiency that were quite lacking in the previous administration as evidenced by the actions cited above

Recommendation: The Consultants Committee strongly recommends that every effort be made to integrate the QA and the early warning system into this process as quickly as possible. The relationship of QA to I&I needs to be clarified immediately in the next reporting period for the monitoring to be effective.

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.

Status: Partial Compliance

Discussion: A site visit was conducted the week of February 7, 2005 to specifically interview youth to determine if youth knew how to report abuse and of their right to be protected from retaliation. Every youth interviewed indicated that they had attended an orientation but the content of that orientation was not very clear. Only one youth, out of 30 interviewed, could give any detail as to the process for reporting abuse and of their right to be protected. The Consultants Committee specifically asked each youth if they felt safe. Interviewed youth at BCS said they felt safe and were confident that they would be protected if protection were needed. The results were not as good at CMS and AMS. About 1/3 of the youth in those two facilities reported not feeling safe and skeptical of the staff's ability to protect them. Most youth indicated that their sense of protection was directly tied to the staff on duty. Some staff, they felt, would protect them while others were not capable of it. The sample at AMS was very small (only 5 youth) so this issue will be more carefully reviewed in the next reporting period. Sample size at BCS was 10 and at CMS 15.

Recommendation: The Consultants Committee strongly recommends that the handbook be completed and put into operation, as we understand it is scheduled, this March. In addition, any youth alleging abuse should be tracked for resolution of the grievance, or allegation of abuse, as well as any evidence of retaliation.

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: Not reviewed

Discussion: Time limitations within the first reporting period precluded sufficient time for meetings with the local child protective services officials. Interviews with staff of the Investigations and Inspections Unit indicate that the process is in place. As noted in UFN 4.2.1 157 cases have been referred to Child Protective Services by the I&I unit. The management of those cases by PSU is not known at this time.

Recommendation: In preparation for the next reporting period the Consultants Committee would recommend that I&I develop a list of all referred cases to PSU with current status. In addition, identify PSU caseworkers that can be interviewed regarding a random sampling of these cases.

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:

Status: Partial Compliance

Discussion: This provision is mostly in compliance but due to the limitations in the physical plant at CMS occasionally compliance is not possible. A ½ wall is all that separates youth being examined from those waiting at CMS. It is not clear why there is a half-wall in the waiting area of the CMS facility. While it is possible to conduct the interview without being heard, although difficult, youth waiting can easily view the interview and a portion of the exam Staff radios are left on purposely so that the conversation is as private as possible. At AMS separation is possible. The physical plant is also very limited but individual rooms do allow for separation of those needing medical attention due to injury from those waiting to see the staff for medications or illnesses. At BCS the physical plant is very good and examination rooms are well furnished and private. In each facility the nurses interviewed all gave similar responses to their assessment of abuse. If, during the course of an examination youth appear to have suffered an assault, they are questioned and in almost all cases, as reported by the staff, youth will indicate the source of the injury. If the youth does not disclose the source and abuse is still suspected the staff proceed with documenting the injury. Nursing staff was interviewed in all three facilities.

Recommendation: The Consultants Committee would recommend that ADJC review the possibility of creating private space through the building of full walls. Even a very small exam room would be preferable to that currently being utilized.

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);

Status: Substantial Compliance

Discussion: The procedure as described by nursing staff in all three facilities was essentially the same. The type of injury creates the response. If the injury suggests hitting, some form of assault, then the staff request that security come to the health unit to take pictures of the injuries. If the nurse suspects staff abuse an electronic mail is sent to the Captain of security to memorialize the incident. If staff feel that the youth may be in danger they will ask that the youth be moved. Only one of the nurses interviewed had made that request. She has made that request twice in nearly six years of work experience with the agency. At each facility the location of the evidence room, the containers of the evidence and access to the evidence were examined. The evidence in each facility is kept in drop boxes that are locked with only one key available to someone not working within the facility. Mailbox type boxes are used so that staff

can deposit but not extract material. Multiple boxes are available in each facility so that medical evidence is separated from miscellaneous evidence of other investigations. The Consultants Committee acknowledges the effort currently being made to safeguard evidence. What appears to be lacking is the oversight of the Captain of Security. How evidence is gathered, safeguarded and submitted to I&I is dependent upon each individual Captain on each shift.

Recommendation: The Committee recommends a careful review of this responsibility so that a more thorough check and balance of this process is in place. For example, when nurses were queried about the result of abuse allegations none of them seemed to be aware of the investigations, their status or findings. In most cases they were uncomfortable with not being included in the process more extensively.

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;

Status: Partial Compliance

Discussion: The procedures are slightly different in each facility. At CMS the health unit reports to the superintendent who reviews them with the captain of security. All assaults are sent to I&I. I&I determines the course of the investigation and who will conduct it. Those that are not kept by I&I are returned to CMS for administrative review and resolution. AT AMS the IR's are entered into the database by the midnight shift. I&I then reviews the IR's and determines where it belongs, who investigates it. Those that I&I does not investigate are sent back to AMS and the captain of security is responsible for following up to see that assignments are made and the incidents investigated and resolved. At BCS the process is different only in that decisions are made there regarding which IR's are sent to I&I. The IR writer checks a box on the form and that determines whether it is for I&I or retained at BCS for investigation. The narrative on the form must support the box checked. If the IR is kept at BCS the assistant superintendent reviews them and assigns to unit managers. The IR's are then placed in the youth's hard file. I&I is responsible for reporting incidents of child abuse to Child Protective Services. It is the opinion of I&I, at the present that CPS is not able to make referrals from ADJC a priority, due to their workload, so CPS investigations are not currently occurring within the facilities. The captains of security were interviewed in all three facilities and the Youth Base data reviewed with each captain for this information. Time did not allow for contact with CPS regarding their response to referrals from ADJC. That will occur in the next reporting period. During the course of this monitoring the question about the propriety of the CPS referral going from I&I to CPS was raised by several health care personnel. Health care personnel are acutely aware of their responsibility to report child abuse and the current procedure does not allow them to directly do that. IR's go to I&I and a decision is made at that point regarding referral to CPS. The question was even raised about licensing requirements of medical personnel and their responsibility to report abuse. Does the reporting through the agency, as it is currently constituted fulfill their ethical and legal responsibility?

Recommendation: The Consultants Committee recommends that the reporting of abuse as it is currently constituted needs more thorough examination. Specifically, health Care's role in this process. Also, the minor differences in processing the IR's within the 3 facilities should be

reviewed and a best practice identified and replicated in all 3 facilities.
UFN 4.2.4.3 document adequately the matter in the youth's medical record; and
Status: Partial Compliance
Discussion: This is rated as partial compliance because the adequacy of the documentation also requires that Dr. Kraus review these records. That will occur in the next reporting period. Two files were pulled at each facility and reviewed. Each one contained documentation of the incident. Injury and treatment.
Recommendation: A review of the need for notice of referral for abuse in the medical record needs to be conducted. One youth whose nose had been broken twice while in CMS provided a good example. The medical care could be documented but in order to understand the facility or system response it was necessary to access other files. Perhaps just a notation by the medical staff of the receipt of the IR, their decision about the probable cause of the injury, and the referral to the security captain for action would be adequate. This review was not in the file and it is incomplete without it. The medical staff is raising the question of responsibility and it seems it would go at least as far as noting the need for CPS intervention.
UFN 4.2.4.4 complete an incident report.
Status: Substantial Compliance
Discussion: Incident reports are integral to the operation of ADJC. The issue is not the development of the IR it is the resolution of each one that presents some problems for the agency at this time.
Recommendation: There is no recommendation specifically to the incident report. The form and the development of the report comply with the agreement.
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;
Status: Partial Compliance
Discussion: Procedure No. 1160.05, Ref. Policy No. 1160 in the manual of Policies & Procedures that Implicate and/or Allude to the CRIPA Agreement. This policy and procedure was issued on 05/04/04. It provides a purpose statement, definitions of abuse, child abuse, neglect or neglected, reportable offense, physical injury, serious physical injury. It also outlines the rules that govern the reporting and the completing of an incident report. The referral process to Child Protective Services has not yet been reviewed or monitored. The procedure used to be that if child abuse was suspected it was investigated and if sustained it was reported to CPS.

Now all child abuse reports, from all facilities are reported to CPS. If staff is suspected of abuse of ADJC youth outside of the facility I&I does a preliminary investigation, determines where it occurred and then refers it to local jurisdiction. Referrals have been made to CPS. An automated tracking system is being developed so that referrals and their resolution can be determined.

Recommendation: None at this time.

UFN 4.2.5.1 a health care provider, staff or youth reports suspected abuse; or

Status: Partial compliance

Discussion: IR's are being filled out, processed and referrals being made to CPS. Currently the system does not allow for tracking of those referrals. Hard copy IR's were reviewed, Youth Base was accessed and IR's read. Tracking of IR's also reviewed with Captains of security and with I&I Administrator.

Recommendation: The Consultants Committee strongly recommends that a tracking system be developed for all abuse referrals. It also recommended that health care providers, those at the facilities be involved in the development of this process and their concerns about their lack of participation in the abuse investigations be resolved.

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.

Status: Partial Compliance

Discussion: The IR's are written by whoever witnessed the incident. The processing of those IR's is being improved. At one time the night shift would summarize what happened in each incident on the IR to avoid the length of the report. Now the verbatim report is placed into the database. At Catalina the IR is amended to include the health or injury documentation. This does not occur at AMS or BCS. BCS does require that the person writing the IR gain the signature of the health unit showing that the youth was treated. Interviews were held with health personnel and IR's read.

Recommendation: This is another area where procedures differ slightly. The Consultants Committee strongly recommends that best practice be determined and then replicated in each facility.

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.

Status: Substantial Compliance

Discussion: Every Youth Correctional Officer I (YCO) must attend the Pre-Service Training Academy and that requirement has a 100% compliance rate. The job classification of YCO I is

the only job classification that is required to attend the Pre-Service training Academy. All written tests administered in the Pre-Service Training Academy require the cadet achieve a passing score of 80%. The “Academy Standards” form must be signed by all cadets stating that they must achieve 80% on all tests to graduate the Academy. A compilation of test scores for each cadet is maintained in the cadet’s academy file. (Correspondence from Donna Marcum) (Review of Youth Base document All Facilities TCI Compliance). The charts showing compliance with this training include all facility staff, not just YCO I’s and therefore do not reflect the 100% reported

Recommendation: The Consultants Committee recommends that QA include in its newly developed procedures content-based evaluations of the training. Competency scores are important but only reflect the learning of presented material. The relevance of that material must also be validated.

UFN 4.2.7 All staff shall continue to complete successfully competency based training in behavior management/crisis intervention before working directly with youths.

Status: Partial Compliance

Discussion: Two reports, “All Facilities Therapeutic Crisis Intervention compliance Report” and “All Facilities Suicide Prevention Compliance Report” break down training for all facilities by direct care staff, medical staff, education staff and then the percentage of compliance. The percentages are low when all staff is taken into the equation. When just reviewing compliance by direct care staff the compliance rates are 96% for Suicide prevention training 69% for TCI compliance.

Recommendation: The Consultants Committee would recommend that ADJC look at training requirements that insure that all direct care staff complete training before working in direct care positions. Suicide prevention training almost qualifies all of the staff but Therapeutic Crisis Intervention training is completed by less than 3 out of 4 staff. With the number of youth in facilities TCI training would seem to be mandatory prior to working. In addition, a policy that does not allow those who fail competency tests to work with youth should be implemented. Content evaluations should also be part of this policy to insure relevance to work environment.

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: Non-Compliance

Discussion: Information for this finding came from an interview with Donna Marcum, training

academy director. The quality assurance portion of this section, like the others, is in development. Ms. Marcum is developing Subject matter leaders whose job it will be to insure that any curriculum developed represents what leadership wants. Also, a nominations list has been developed to identify new instructors for the Academy. This list will be used to develop faculty for training the trainer's academy. Each faculty must complete the 16 hr. train the trainers course, 16 hours of methodology training and be certified as faculty for teaching either at in-service or in the Academy. A curriculum advisory committee is also in development. This committee will review the 7-week academy curricula to see if it meets needs of the system. This will be an on-going process.

Recommendation: None at this time.

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: Partial Compliance

Discussion: Procedure No. 4002.05; Safe School Employee to Juvenile Ratio Standards. ADJC commits to maintaining employees to juvenile ratios that ensure safety, security, and effective programming. Meetings were held with Jim Hilliard, Deputy Director for facilities and with the superintendent of each facility to review staffing ratios and accountability for staffing. An on-shift report from Black Canyon school, a position control matrix from Catalina Mountain School and a weekly staff accountability report from Adobe Mountain School. Currently the ADJC minimum safety standards matrix shows Housing unit populations from 20 to 36. Cottages from 20 to 32 require first shift of 2 staff that allow ratios from 1:10 to 1:16. Cottage populations of 33 to 36 will have 3 staff in the 1st shift for ratios of 1:11 to 1:12. On the 2nd shift cottages housing 20 to 27 youth will have at least 2 staff giving ratios of 1:10 to 1:13. Cottages housing 28 to 36 youth will have at least 3 staff giving ratios of 1:9 to 1:12. Totals would be an average of staff to youth ratio on the first shift of 1:12.4 and on the 2nd shift, an average ratio of 1:10.8 By contrast the current ADJC Employee to Juvenile Ratio Standards show Cottages that house populations of 20 to 27 must have at least two staff giving ratios of between 1:10 and 1:14 on the 1st shift. On the 2nd shift cottages housing 20 to 27 youth must have 3 staff for ratios between 1:7 and 1:9 and cottages housing between 28 and 36 youth must have 4 staff giving ratios that would vary from 1:7 to 1:9, with an average of 1:10.8 on the 1st shift and 1:8 on the 2nd shift. At the time of this report no units were reporting more than 28 youth in any one cottage. The night shift is to be maintained at 1:24. Best practice in juvenile justice systems indicates that cottages should not exceed 25 juveniles. Arizona does operate some cottages with 32 youth. With current staffing of two staff this increases the ratio from 1:12 to 1:16. Both of these ratios exceed the ACA recommended ratio of 1:8. The current midnight shift staffing of 1:24 also exceeds the recommended coverage of 1:16.

Recommendation: In order for ADJC to provide for ratios that meet best practice and to more adequately supervise youth ratios need to not exceed those recommended by the standard setting bodies nationally and by best practice. 1:8 staff-to-juvenile ratio during the day and a 1:16 ratio at night for all facility types. The Consultants Committee would also recommend that ADJC adopt the “on-shift” report currently being utilized at BCS as the best method of providing assurance that staffed ratios are actually met through notification of critical posts during staff changes. In addition, Security captains at each facility on each shift should verify presence of staff at critical posts through random checks that are documented.

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.

Status: Partial Compliance

Discussion: Partial Compliance is provided due to the need for further monitoring. Reasonable access to medical and mental health services, education and adequate time spent in out-of-room activities must still be monitored. A decision about what is adequate has not been held and will have to occur in the next reporting period. The Consultants Committee did review the access to the restroom by reviewing restroom breakdown reports from CMS during the January 10 through February 6 time period. The data includes total restroom calls by unit (15 to 29) by youth (23 to 93) the average calls per night (2.14 to 4.14) the least calls in one night (1 to 2) most calls in one night (4 to 8) average response time (1 min. to 1.83 min) the longest response time (3 to 4 minutes) and the number of calls that took longer than 5 minutes (0). The bathroom procedure was witnessed the night of Feb. 16 at the change of shift, approximately 10 p.m. at AMS. The roving night shift goes to each cottage and provides restroom calls for everyone who wants one. The cottage staff goes from room to room announcing restroom breaks and everyone who wants one takes one at that time. During this occasion only one youth declined the use of the restroom. The process was very orderly and efficient taking approximately 15 minutes from start to finish. After each of the cottages has been visited then staff responds to restroom calls and those calls are documented as described above. BCS was not visited since it does not have dry rooms. The Consultants Committee however did raise the access to restroom issue with youth during site visits and some youth indicated problems with access which does not necessarily confirm the official reporting. The sampling was small, however, and will require further monitoring.

Recommendations: The issue obviously is the use of cottages with dry rooms. AMS is currently contemplating discontinuing the use of one of its dry cottages. ADJC needs to continue its efforts to discontinue use of dry room cottages. Bathroom breaks are not a good use of very scarce staff resources and at times when circumstances do not permit timely access a significant problem for those youth involved.

4.4 ADJC's Investigations and Inspections Unit and Quality Assurance Team

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.

Status: Substantial Compliance

Discussion: John Dempsey is the Administrator of the Investigations & Inspections Unit (I&I). He reports directly to Director Michael Branham. The office is currently sufficiently staffed to perform the tasks of the agreement. A review of the work as outlined in a memorandum from Mr. Dempsey as well as several meetings with the I&I staff are evidence of this finding. The Consultants Committee acknowledges the effort that has been undertaken by this unit and the impact it has had on the safety of youth housed by ADJC. Currently the adequacy of the staff is verified only through interviews with I&I staff

Recommendation: During the next reporting period the Consultants Committee would recommend that I&I prepare a listing of investigations and inspections with man-hours needed for quality investigations and inspections. As this unit has become active actual reported incidents has gone up which is an artifact of reporting and investigating not an increase in activity. What is not known is how these trends will look in the near future and the ability of the agency to continue to adequately provide the staff necessary.

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.

Status: Partial Compliance

Discussion: The newly hired Director of Quality Assurance, Megan McGlynn does not report directly to Director Michael Branham but to Deputy Director Diane Gadow and is working cooperatively with the Investigations and Inspections Unit. That working relationship will be developed during the next reporting period. The Quality Assurance Teams will be multidisciplinary both at facility and agency levels. Members from facility teams are nominated by their team to represent their facility on the agency team. The agency team consists of members from facility teams and members from central office (such as policy and I&I). This agency team will then meet regularly with central office leadership from Deputy Director's office. Each facility team will have a UPS-Unit Manager, YPO I, YPO II, Community Corrections, Security, Medical Education, Assistant Super or Superintendent and Mental Health representative. At the agency level, the team will consist of YPS, YPO I, YPO II, Education, Community Corrections, Security, Medical, Policy (agency team only), I&I (agency team only) Superintendent, Assistant Superintendent, and Mental Health. Interview with QA administrator provided this information.

Recommendation: None at this time.
UFN 4.4.3 The Investigations and Inspections Unit and the Quality Assurance Team, in Coordination, shall be responsible for the following tasks:
Status: Not Reviewed
Discussion: The I&I has been developed, its policies and procedures mostly written and inspections and investigations have been on going for more than one year. The Quality Assurance Office is just being developed and will not become operational until March 15 of this year. The first audit is scheduled to be conducted on March 15 and so the functions of the QA will show non-compliance until the next reporting period. A review of the weekly investigation status log from 11/22/04 to 2/15/05 identifies all investigations and their current status.
Recommendation: None at this time.
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;
Status: Non-Compliance
Discussion: QA in the process of developing compliance protocols.
Recommendation: None at this time.
UFN 4.4.3.2 conducting audits and other quality assurance activities as described in 4 (d) below;
Status: Non-Compliance
Discussion: The first audit that will be conducted by the QA will be March 15. The first report is also due on that date so the progress of this unit will be reported in the second semi-annual report.
Recommendation: None at this time.
UFN 4.4.3.3 reviewing and, where appropriate, investigating allegations, of child abuse;
Status: Partial Compliance
Discussion: The I&I Unit is actively investigating allegations of child abuse and that has been detailed in earlier portions of this report. QA has not yet begun its activity.
Recommendation: None at this time.
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

Status: Non-Compliance
Discussion: See above
Recommendation: None at this time.
UFN 4.4.3.5 coordinating quality assurance activities performed by various Division offices to prevent unnecessary duplication of efforts.
Status: Non-Compliance
Discussion: See above
Recommendation: None at this time.
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:
Status: Partial Compliance
Discussion: The newly formed Quality Assurance team is currently writing the quality assurance program, in collaboration with the Investigations and Inspections Unit. This program is being developed consistent with the definitions section of this agreement.
Recommendation: None at this time.
UFN 4.4.4.1 The comprehensive audits as specified in the Definitions Section shall include:
Status: Non-Compliance
Discussion: Audits will begin on March 15 of this year
Recommendation: None at this time.
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.;
Status: Partial Compliance
Discussion: I&I is currently conducting inspections. QA will begin on March 15. The QA has not yet begun its inspections. When those inspections begin one of the protocols that will be used will be the Youth Base data system. Using that system incident reports can be identified by facility, seriousness, disposition and resolution. A check of Youth Base on 2/04/05 found that from 1/31/05 to 2/04/05 a total of 71 incident reports had been reported in all facilities in ADJC.

None of those IR's included a serious incident, although one did indicate suicidal behavior with injury.
Recommendation: Develop a monitoring protocol that includes a review of all SIR's and a random selection of others on at least a monthly basis. The incident itself should be reviewed for accuracy of reporting by staff, and then the process reviewed for thoroughness and appropriate resolution.
UFN 4.4.4.1.2 Interviews with staff, administrators, and youth at each facility;
Status: Non-Compliance
Discussion: The QA has not yet begun its interviews with staff, administrators and youth.
Recommendation: None at this time.
UFN 4.4.4.1.3 where appropriate, interviews with the parents or other care givers of youth confined in the facilities;
Status: Non-Compliance
Discussion: The QA will begin to conduct these interviews during the next reporting period.
Recommendation: None at this time.
UFN 4.4.4.1.4 inspection of the physical plant;
Status: Partial Compliance
Discussion: I&I is currently conducting inspections. QA will become part of that process on March 15. These inspections will be reviewed during the next reporting period
Recommendation: None at this time.
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
Status: Partial Compliance
Discussion: Policies are being re-written so they are measurable. Audits will be conducted, based on the policy revision, during the next reporting period as described in several interviews with the QA administrator.

Recommendation: None at this time.
UFN 4.4.4.1.6 A written report recording the findings of the audit.
Status: Non-Compliance
Discussion: No audits have yet been conducted.
Recommendation: None at this time.
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: Partial Compliance
Discussion: This is rated as partial compliance only due to the fact that the QA process has not begun. The I&I process is several years old now and has substantial documentation that demonstrates unannounced site visits. During the most recent site visit several reports were randomly identified and reviewed. Report # 2004-01 conducted on 8/19/04 at AMS with amendments through 9/23/04. The two amendments to this report were follow up visits. The report includes the inspection overview (reason for the visit) and policy and procedure number references this; Commendable observations; Inspectors actions during the inspection; inspector's recommendations for corrective action; observations made and follow-up results. During this inspection the inspectors researched all IR's for the last three months, talked to teachers, YCO's, Juveniles YSR's, Superintendents to see if concerns that had been identified were being addressed. The inspectors addressed inappropriate behaviors and dress to youth and staff and investigated a youth assault. Report #2004-20 was also reviewed at BCS on 12/20/04. This was a review of the health unit, kitchen & Maya Unit. The I&I process is thorough. The Consultants Committee will need to look at long-term follow-up during the next site visit.
Recommendation: None at this time.
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.
Status: Partial Compliance
Discussion: The IR's that are deemed important enough and all serious Incident reports (SIR's)

are brought to the Director's attention each morning. When investigations are initiated by I&I e-mails are sent to the appropriate Director. Youth base has a listing of all I&I investigations by youth, type of investigation, current status and summary. (This was reviewed in detail with Administrator Dempsey). Director Branham has access to all reports, reviews their status through youth Base. A weekly report on the status of investigations is prepared for the Director. In addition to the Director the Deputy Director, Superintendents, assistant superintendents, and Captains all receive this report. This system is still in development. Currently formal reports with findings and recommendations are not completed on each investigation. The technology development will include the capability to track the report from IR to assignment, to findings, resolution and recommendations. That capability is approximately six months away. This information gathered in interviews with the Director of the I&I unit and a review of Youth base. Investigation # DJC20050028C, an incident of 1/21/05, was reviewed to document the referral of an assault to the County Attorney's office.

Recommendation: None at this time.

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: Partial Compliance

Discussion: The I&I is reviewing all IR's and use of separation. The Unit is not yet to the point where it is able to capture all of the issues raised and respond to them completely. I&I cannot currently verify that all use of force reports are being sent to them. The criterion under which the incidents shall be independently investigated is currently being developed. A review of all incidents does occur and the threshold for review has been lowered so that all incidents are reviewed not just those resulting in serious injury or hospitalization. Youth base contains all IR's; SIR's and their processing can currently be tracked. A random sampling was pulled and followed for verification. In addition the Arizona Department of Juvenile Corrections Separation Data Review of January 2005 was reviewed with Administrator Dempsey. This report includes the following: Average daily population at each facility; total number of referrals by facility; the referral rate; the # of referrals not including self referrals; referral rate not including self referrals; number of individual youth referred; # of youth with 2 or more referrals. The report then breaks this information down by percentages. The second page of the report includes referrals/admission by category by facility: danger to self, danger to other, escape risk (attempt) disruption of facility, destruction of property, self-referral, other. Restraint use that includes # of youth arriving in restraints, percent of youth arriving in restraints, number of hearings held, number of approved extension hearings % of hearing with approved extensions, and then breaks down the extensions by superintendent, assistant director and director levels. Time spent in separation at each facility beginning with 4 hours or less, 4-8 hours, 8-24 hours, 1-2 days, 2-3 days, 3-5 days, 5-10 days, 10 days or more. Average time spent in Separation by the above categories. The final page of the report includes a listing of all youth with multiple admissions.

During January no one had been held in separation, in any of the facilities, more than 5 days. Only 1-2% had been held from 3-5 days. Approximately 95% of the youth were held 24 hours or less. The management report is thorough but the verification is not. The Consultants Committee looks forward to working with I&I and QA during the next reporting period to determine how verification can be determined

Recommendation: None at this time. .

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.

Status: Partial Compliance

Discussion: I&I is currently not able to review all grievances. The backlog of grievances amounted to over 100 just at BCS during my initial visit. The combination of clearance of old grievances, the development of the policy & procedure that would be followed has not allowed for all grievances, at the present time to be reviewed. This was determined by discussions with the I&I administrator and YRS's in each facility.

Recommendation: I&I and QA should take the necessary time to resolve the grievance backlog. A considerable of time was being spent on this, at least at BCS during initial visits, with little benefit. It appeared to be mostly a paper shuffle. The continuation of a backlog only assures that a backlog will continue. The need for timeliness on grievance responses has been emphasized and agreed upon by ADJC and the Consultants Committee.

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: Non-Compliance

Discussion: A plan of correction is part of the developmental process for both I&I and QA but primarily the QA office. Corrective action plans are included in the reports mentioned in 4.4.4.2 but the inclusion of QA in this process will begin during the next reporting period. The need for corrective action plans is included in the outline for the QA office but it is not fully developed nor as yet implemented. Discussion with QA and I&I administrators.

Recommendation: None at this time

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.

Status: Partial Compliance

Discussion: I&I has hired sufficient numbers of qualified investigators, including some senior

investigators that can mentor junior investigators. Some of these investigators come to the agency with long law enforcement experience and are in the process of adapting that experience to the needs of a juvenile justice agency. The training is in place and is on-going. Training includes forensic schools and police academies as needed. The I&I has developed a curriculum that has been adopted by a local college and new I&I staff will be able to access this resource. Discussion with I&I administrator.

Recommendation: The connection between this process and the QA office is not clear. The curriculum that has been developed by I&I needs to be reviewed regarding its relevance to the QA office and perhaps expanded to include the needs of that office.

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.

Status: Partial Compliance

Discussion: ADJC has developed the policies and procedures for the functions listed. The General Operating Policy Manual lists those as 1160 through 1165.04. The implementation of these policies is being undertaken and will be more thoroughly monitored during the next reporting period.

Recommendation: None at this time.

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.

Status: Substantial Compliance

Discussion: P&P 1160.05 discusses the rules and procedures that an ADJC employee, volunteer, intern, and/or service provider under contract with ADJC shall take if they reasonably believe that a minor is or has been the victim of abuse. In addition lockers have been installed in each of the 3 facilities for the protection of all evidence related to investigations of injury and abuse. Those lockers were inspected. They are drop boxes; some are old mailboxes, that all for the deposit of material but not the extraction. A key is held by I&I and not available on the campus of and of the facilities. In addition, I&I and staff interviewed indicated that youth have been and will be moved if abuse is suspected and by their best judgment is in need of protection.

Recommendation: None at this time.

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.

Status: Partial Compliance

Discussion: This manual is currently under development. It is entitled the "Multidisciplinary Protocol for the Investigation of Child Abuse". The Interagency Council, Maricopa County Children's Justice Project, is developing it. This manual was first created in July 1995, and revised in July 1999, September 2003, and June 2004. The I&I unit is using this manual as the basis for the development of its protocols.

Recommendation: None at this time.

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:

Status: Partial Compliance

Discussion: Manual under development and it will be reviewed during the next reporting period.

Recommendations: None at this time.

UFN 4.4.9.1 An interview with the alleged victim and perpetrator:

Status: Partial Compliance

Discussion: Pages 9, 10 & 11 of the above referenced manual contain the protocol. This protocol is currently being revised and tested.

Recommendation: None at this time.

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;

Status: Partial Compliance

Discussion: The protocol is in the manual but under review and revision. A review of incident reports and investigations does document witness interviews but the time frame during this reporting period has not allowed for more than a paper review.

Recommendation: None at this time.

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;

Status: Partial Compliance
Discussion: This procedure is included in the protocol (page 15). This is also under review and revision.
Recommendation: None at this time.
UFN 4.4.9.4 Examination of any potentially relevant medical records; and
Status: Partial Compliance
Discussion: Manual contains the P&P (page 15). The I&I may add to this as the agency has more time to develop and revise the manual.
Recommendation: None at this time.
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.
Status: Not Reviewed
Discussion: This area is not specifically identified in the current manual. This area will have to be thoroughly monitored in the next reporting period.
Recommendation: None at this time.
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.
Status: Partial Compliance
Discussion: Reports are produced on each allegation of abuse. Those reports are kept on Youth Base and the confidentiality is protected through passwords so that only authorized personnel can access those screens. Youth Base was accessed and reports verified. The level of the reporting was not reviewed during this period and will take place in the next reporting period. Steps taken during the investigation, information obtained, factual conclusions, results of the investigation etc.
Recommendation: None at this time.

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.

Status: Partial Compliance

Discussion: The Administrator of I&I in an interview indicated that this process has occurred. A complete review of it, including a discussion with Director Branham has not taken place due to time limitations in this reporting period. It is clear, from other information reviewed during this reporting however, that investigations have taken place and staff have been dismissed in response to those investigations.

Recommendation: None at this time.

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,

Status: Partial Compliance

Discussion: An interview with the I&I administrator indicates that this provision is being followed. Two specific examples were given. The compliance with this however, will need to wait for the development of the QA function. Corrective Action Plans are a main component of the QA function and those will not begin until audits are initiated beginning March 15, 2005.

Recommendation: None at this time.

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: Partial Compliance

Discussion: ADJC has developed policy and procedure for the use of exclusion and separation.

The Operating Procedures Manual contains Procedures beginning with Procedure No. 4060.02 (time out in secure schools) Procedure 4061 (Separation program) Procedure No. 4061.01 (Separation Program: Referrals to separation) Procedure 4061.02 (Separation Program: Admission and Relapse Avoidance Plans) Procedure No. 4061.03 (Separation Program: extended Confinement) Procedure No. 4061.04 (Separation Program: Releases) Procedure No. 4061.05 (Separation Program: Programs, services, and Quality Management) Procedure No. 4061.06 (Separation Program: Use of Mechanical Restraint) Procedure No. 4064 (Exclusion) Procedure No. 4064.01 (Exclusion). Some of these procedures date back to 1994 but most have been revised since 2000. Five of the procedures are scheduled for re-write and revision so that will become part of the monitoring process during the next reporting period. The next reporting period will be able to focus more on the extent to which exclusion is used in various cottages. During this period the use of "slow down" was observed in the Nova cottage at Adobe Mountain School. Slow Down was described as the placement of a youth on a chair outside his room. Staff could observe the youth as they supervised the larger group in the cottage day room but the youth was excluded from interacting with the larger group. This technique was used by the staff to manage youth who were not cooperative in large group interactions. The use of such techniques needs to be continually reviewed since the use of exclusion or separation has, in the past, created management problems for this agency. In discussing the use of slow down with the Unit manager he stated that it was a very necessary and useful corrections management technique and that to take it away as a group management tool would be harmful to other residents. This is, of course, the issue. The proper management of youth. Exclusion or separation may be used for staff convenience rather than group management. On 2/04/05 a review of the Youth Base data system revealed that from January 8 to February 4th, 2005 10 youth had been in Separation in all facilities in ADJC. Four of those youth were in the facility not included in this Settlement Agreement, leaving six youth, 3 at BCS and 3 at CMS. One youth had been in Separation for 8 days and one for 30 days at BCS. Please see UFN # 4.4.4.4 for further details on this issue.

Recommendation: It would be helpful to look at the pre-service training within the Academy and its emphasis on the use of effective group management techniques. There seems to be a wide range of opinions on the use of separation, exclusion, slow-down etc. It would appear that YCO's view it as a legitimate management tool but disagree on what constitutes good management from abusive practices. Best practice in this arena from other similar facilities would be a useful training exercise in order to determine legitimate use of separation from staff convenience.

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.

Status: Substantial Compliance

Discussion: The Youth Base system was reviewed. Youth were identified who had stayed more than 24 hours and confirmation of hearings held. Youth base has a separation report, which summarizes its use. For January AMS had 27 hearings, 18 were approved for extension. BCS had 9 hearings 9 approved for extensions. CMS 9 hearings, 4 approved for extension. Separation

logs were reviewed at each of the three facilities and separation staff interviewed to verify records of youth base to be accurate. The shift superintendent determines if a youth needs to be extended. This is based on the IR and the youth's behavior while in separation. A list of hearing officers is available on each campus and hearings are set for each day when it appears a youth may need an extension. If an extension is granted the reasons are stated and a corrective action plan developed so that the youth and staff are clear as to the reasons for the extension and the tasks to be completed for release. An extension hearing was attended at AMS. The hearing officer and the staff who wrote the IR attended along with the youth advocate from AMS (the YRS on duty at the time). The advocate pointed out that the staff member had not completed the paperwork and had not met with the youth prior to the hearing. The staff member wanted the youth to undergo conflict resolution. The advocate pointed out that the staff member could have met with the youth at any time during that day and offered the plan of correction, not needing to wait until the 24 hours extension was being held. The proper procedure was to resolve the issue as soon as possible and not wait for hearings. (This is a good example of staff being able to successfully accomplish a long period of separation within current P&P because there is no requirement for timeliness of staff to meet with the youth. Once separation is accomplished the youth has to await the IR producing staff to visit separation and resolve the issues) The youth was then told of the need to agree to conflict resolution, that will take place and if successful, he would return to the cottage.

Recommendation: The policies and procedures governing this area need to be revised to require that staff that initiate separation meet with the youth in a short time period. (Within the first hour. In most instances the separation is only necessary for a very short period of time). Separation reports indicate that most youth spend less than 24 hours in separation and nearly 50% spend less than 4 hours. It would seem that the report ought to look at youth who are returned within the first hour.

5. SPECIAL EDUCATION

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: Partial compliance

Discussion: The ADJC has made great strides to improve special education service delivery during this first 6 month period of monitoring. Discussion of various areas of compliance follows.

Recommendation: None at this time.

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: Partial Compliance
Discussion: ADJC, named Dr. Judith Lanphar as Superintendent of Education in 2004. Immediately prior to her appointment she was Associate Superintendent of Education in ADJC. Before coming to ADJC, she worked in the public schools as a superintendent, director of curriculum, principal, director of staff development, and teacher. The Consultants' Committee has not completed an assessment of the adequacy of resources.
Recommendation: None at this time.
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: A member of the Consultants' Committee met with the Superintendent of Education, Dr. Lanphar on three occasions during this monitoring period. The Consultants' Committee reviewed staff development plans and discussed the current curriculum and the adequacy of resources with Dr. Lanphar. ADJC has hired Dr. Gail Jacobs, the former Arizona Department of Education secure care specialist as special education director for the agency. Dr. Jacobs who began work on January 3, 2005, brings to ADJC experience in monitoring secure care and an understanding of Department of Education requirements. The school program has two intercessions or breaks during the year. Agency required and education related staff development activities have been scheduled for this year.
Recommendation: None at this time.
UFN 5.2.2 Monitoring whether special education staffing and resources are sufficient to provide adequate special education services to youth at both (?) facilities and to ensure compliance with this agreement;
Status: Partial compliance
Discussion: The Committee discussed this issue with Deputy Director Gadow and Education Superintendent Lanphar. During this monitoring period, ADJC has offered 5K \$ stipends to attract and retain additional special education teachers. Prior to the start of this monitoring period, ADJC began a process of providing a dual-certification program that enabled teachers on staff to obtain an additional certification in special education. During the monitoring period, internal documents reviewed by the Consultants' Committee indicated that from October 1, 2004 to the present, 31 job vacancies were posted for education positions within ADJC. Since October 1, two new special education teachers and three special education records clerks have been hired. A new school psychologist, two transition specialists, four general education teachers, and two guidance counselors have also been hired. In January, ADJC sent a request to the Department of Administration for five permanent substitute teachers

for the facilities.

Recommendation: The Committee is encouraged by the proactive steps ADJC has taken to hire staff for hard to fill positions. The Committee encourages Dr. Lanphar and her staff to continue to work with human resources and Department of Administration staff to ensure all education staff vacancies are filled.

UFN 5.2.3 Development and implementation of a quality assurance program for special education services.

Status: Not reviewed

Discussion: Consultants' Committee reviewed a draft copy of the Action Plan developed by Dr. Lanphar and met with Dr. Megan McGlynn, the coordinator of quality assurance efforts of ADJC. Dr. McGlynn, the special education director before assuming the role as quality assurance director for ADJC, has a good background in special education that will serve the agency well as the quality assurance program is implemented.

Recommendation: None at this time.

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: Partial compliance

Discussion: Discussion with ADJC education staff, review of the Arizona Department of Education (ADE) monitoring reports and the corrective action plan for BCS indicate that the identification or "child find" procedures need to be further developed. For example, at BCS staff training on procedures and dissemination of information about the identification process was deemed inadequate by the ADE. At AMS the "child identification" process was rated as "in compliance" by ADE.

Recommendation: Implement the Corrective Action Plans for BCS and AMS as submitted to the ADE. Insure that the site coordinators (see UFN 5.7.5) participate in the development of remedial measures in response to this and other issues.

UFN 5.3.1 Guidelines for interviewing youth to determine past receipt of special education services;

Status: Partial compliance

Discussion: The Consultants' Committee reviewed internal memorandum concerning the Reception Assessment and Classification (RAC) intake process at Adobe Mountain School. At RAC, youth are interviewed about their education history including prior receipt of special

<p>education services. This information is recorded on the RAC Education System – Education History Form. At the time of intake, previous education records are requested for all students. Internal memoranda indicate that within 10 days of admission youths’ files are reviewed by the RAC diagnostician for special education and 504 issues.</p>
<p>Recommendation: The intake questions asked of students should begin with broad questions concerning remedial assistance, counseling, and other academic and social supports. For example, some students will acknowledge receiving services for learning disabilities but will deny ever receiving special education services.</p>
<p>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;</p>
<p>Status: Non compliance</p>
<p>Discussion: ADJC education staff have participated in an interagency task force concerning Vocational Education and Workforce Development.</p>
<p>Recommendation: Work with the ADE and several school districts to create protocols for reporting and communicating information about students’ special education history.</p>
<p>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 to evaluation;</p>
<p>Status: Not reviewed</p>
<p>Discussion:</p>
<p>Recommendation: None at this time.</p>
<p>UFN 5.3.4 Policies describing the required activities of Student Support Team pre-referral and support team functions;</p>
<p>Status: Not reviewed</p>
<p>Discussion:</p>
<p>Recommendation: None at this time.</p>
<p>UFN 5.3.5 Policies describing the requirements for comprehensive evaluation procedures to determine eligibility for special education services; and</p>
<p>Status: Not reviewed</p>

Discussion:
Recommendation: None at this time.
UFN 5.3.6 Policies describing the criteria for multidisciplinary team decision-making regarding eligibility for special education.
Status: Not reviewed
Discussion:
Recommendation: None at this time.
UFN 5.4 The State shall continue to ensure that qualified professionals participate in the process for determining special education eligibility, and required by federal regulations.
Status: Substantial Compliance
Discussion: The Consultants' Committee reviewed 16 students' files to identify who participated in MET/IEP meetings.
Recommendation: Continue to involve professionals from mental health, health, and custody staff in the development of students' education plans.
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: Not reviewed
Discussion:
Recommendation: None at this time.
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: Not reviewed
Discussion:
Recommendation: None at this time.

5.7 Individual Education Plans

UFN 5.7.1 ADJC shall, in a reasonable time period, create and/or implement an IEP, as defined in 34 C.F.R. § 300.340, 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 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: Partial compliance

Discussion: The Consultants' Committee reviewed 16 IEPs for students at AMS and BCS and found IEPs that did an adequate job of identifying a range of services and supports for youth. In most all cases students participated in the MET/IEP meetings and in several cases parents participated. The Committee was not able to assess the adequacy of parent participation nor review the schedule of team meetings and topics covered.

Recommendation: None at this time.

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: Partial compliance

Discussion: Interviews with six boys at AMS and three girls at BCS indicated that with a couple of exceptions, students held favorable opinions about the education services they received and the adequacy of those services. Site visits and discussions with staff indicate that several new vocational education options have been developed at BCS and AMS. My interviews with students and review of IEPs indicate that for those students who have access to range of course offerings, there is a high level of satisfaction and engagement. This was confirmed through observations and discussion with the AMS principal. Education staff needs to ensure that all eligible youths at AMS have the option for vocational education coursework.

Recommendation: Ensure that as the curriculum is revised and new electives are added to the curriculum, students with IEPs have access to these new courses.

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: Partial compliance
Discussion: Of 16 IEPs reviewed, parents and/or surrogate participated in some of meetings where these documents were developed. Consultants' Committee found notices about students' right to special education services posted at Black Canyon School.
Recommendation: At each facility, the person responsible for coordination of special education services should explore ways of increasing family and student participation
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: Partial compliance
Discussion: The Consultants' Committee met with Dr. Lanphar and Deputy Director Gadow to review plans to attract and retain additional teachers. ADJC has requested and was given approval to hire additional staff. Key vacancies exist in the education program including vocational instructors at AMS and BCS and guidance counselors at CMS, BCS, and AMS.
Recommendation: None at this time.
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: Partial compliance
Discussion: Inadequate numbers of special education teachers will make it difficult to achieve compliance and maintain compliance.
Recommendation: None at this time.
UFN 5.7.4.2 Sufficient psychologist services to provide psychologist participation in the development of 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: Not reviewed
Discussion:

Recommendation: None at this time.
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: Not reviewed
Discussion: The Consultants' Committee discussed special education compliance issues at length with Dr. Lanphar and briefly with the principals at AMS, BCS, and CMS.
Recommendation: None at this time.

5.8 Section 504 Plans
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.
Status: Partial compliance
Discussion: Internal documents reviewed by the Consultants' Committee indicate that a Section 504 coordinator/guidance counselor has been hired for the Reception and Classification unit (RAC) at Adobe Mountain School. Candidates have been interviewed for the second position at AMS and for the vacancies at CMS, and BCS.
Recommendation: None at this time.

5.9 Training and Quality Assurance
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 days per year, to enhance their ability to implement their duties under the provisions of this agreement.
Status: Substantial Compliance
Discussion: The Education Superintendent and her staff have developed an inservice plan of more than four days per year. An upcoming staff development activity during the intercession focuses on integration of instruction across the curriculum.

Recommendation: None at this time.
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: Not reviewed
Discussion:
Recommendation: None at this time.

6. MEDICAL CARE

UFN 6.1 The State shall ensure that youth in the facilities receive adequate, appropriate and timely medical, dental, and nursing care to meet the individual needs of youth.
Status: Substantial compliance
<p>Discussion: I interviewed Dr. Raker, Brenda Vold, RN-C, and Mr. Lafond, CMS, PA. All three of these practitioners have a strong interest in childcare and are proficient in what they do. In the initial CRIPA investigation there was no immediate concern regarding the overall care of the youth within these facilities and they are still doing a consistent job. Charting appeared consistent. There were several areas which were discussed which had been on the initial CRIPA investigation. According to Dr. Raker, the procedure for creating an infectious disease committee was created in 2003, but was not available for review. However, there was ongoing discussion regarding infectious disease issues, immunizations, MRSA outbreaks, STD testing technology, etc. It appears that this is in place and the concept of the ID committee has been taken seriously. As time progresses it will be important to see the followup for this committee.</p> <p>I had some concern regarding whether Mr. Lafond was being supervised on a consistent weekly pattern regarding the youth which he was seeing at the Catalina School. According to Mr. Lafond, the primary supervision which he received when he saw Dr. Raker at the Black Canyon was related to youth which he evaluated while at Black Canyon School. Dr. Raker reported that they would also discuss youth who were evaluated at the Catalina School. He assured me that there would be more consistent documentation of weekly supervision regarding Mr. Lafond's work at the Catalina School. This will be consistent with the requirements of a physician's assistant and needed supervision. Dr. Raker reported reviewing specific patients with him, selected medical topics and updates in medical guidelines. In addition, he reported that direct patient interaction is observed and medical handouts are discussed. He reported that the</p>

documentation is in logs and a patient discussion notebook. At the time of my initial assessment I did not review these notebooks. I will assume that they exist and will make a point of looking at these notebooks upon the next site visit.

Although without any impropriety, I did have concern over a male doing the pap smears on the female patients. One of my concerns is the high level of trauma that many of these females have had and the potential risks and distortions of reality which could occur and this was simply an unnecessary risk. All agreed, according to Dr. Raker, Brenda Vold, RN-C will now be doing the pap smears. I have reviewed a variety of medical protocols which overall, appear to be applied.

Adequate quality assurance has not been clearly documented regarding its implementation. However, at the present time, all aspects of medical care appear to be under a magnifying glass and I am not immediately concerned about this. However, further clarification and implementation of quality assurance should be put into place.

I have reviewed protocols and summaries regarding dental services. I have also reviewed with Mr. Neitzke, deficits identified in the initial CRIPA evaluation. Deficits are primarily related to a consulting dentist not being obtained at Catalina Mountain School. At the present time they have a consulting dentist. They have reported that there are no specific dental concerns. The children are consistently being seen.

I did not have a chance to speak with any of the dentists. The only apparent issue which needed to be addressed had to do with obtaining the consulting dentist at Catalina School. This was obtained and as such I will assume at the present time dental services are being met.

Recommendation:

1. I would recommend a female completing pap smears and consider a female pediatrician or RN or physician assistant for physical evaluations at Black Canyon School.
2. Clear documentation of procedures and implementation regarding quality assurance.
3. Documentation of infectious disease committee and ongoing meetings.
4. Documentation, logs, and patient discussion notebook regarding supervision of Mr. Lafond.

Dr. Raker should go to Catalina School at least once every two weeks, if not weekly, for assessment of the medical facility and supervision of Mr. Lafond on site.

UFN 6.2 The State shall ensure there is a sufficient number of adequately trained nursing staff on all shifts to provide medical and nursing care to youth as needed. If, despite the State's good faith efforts to recruit and retain nursing staff, nursing shortages significantly impede substantial compliance with the paragraph, the State may utilize a sufficient number of adequately trained

paramedics, as necessary, to provide medical coverage during the overnight shifts at the facilities.

Status: Partial compliance

Discussion: I met with the nurse manager at Black Canyon School, Kevin Harper, BSN, RN and the nurse manager at the Adobe Mountain School. There is no current nurse manager at the Catalina School. There were concerns expressed by the nursing supervisors at both Black Canyon School and Adobe Mountain School.

One of the concerns reported had to do with an inability to keep a full staff of nurses. Both supervisors reported that reimbursement for staff nurses were below what their counterpart at the state hospitals received and as such, even though they had positions available which potentially could care for their shifts, these positions were not filled. In addition, strong concern was expressed as when they were able to get agency nurses to fill in, they could only fill in half of the needed spots due to the cost of agency nurses. During the initial time that I was at Adobe Mountain School they were down five nurses with only two agency nurses substituting. However at the time of my last evaluation, all but one of these positions had been filled. Additional bonuses and salary increases had brought the positions closer to the reimbursement of the state facilities and as such allowed for better likelihood of staff being hired.

There were no complaints or concerns expressed at the Catalina School. However, there was no nurse manager to discuss specific issues with. As such, specific needs at Catalina School were somewhat difficult to fully assess.

At the present time, none of the three facilities have an infirmary or 24-hour nursing.

There were additional safety issues regarding nursing which was of strong concern. Nurses were transporting patients and evaluating patients with no security oversight. I brought this issue up initially and again at my last meeting. During the interim, there were a number of aggressive incidences which had occurred at the Adobe Mountain School, which likely could have been avoided if security had been present.

While at the Adobe Mountain School and at Black Canyon School, I observed the nursing staff handing out medications. There should be some attempt to hand out medications on a one-to-one basis to help improve a level of confidentiality. In association with this, there was no documentation of medication education for the students. At no point, did any of the nurses ask about any side effects. In addition, there were no consistent procedures for when students refused medications, although typically they are eventually referred back to their treating physician.

There were concerns in the initial CRIPA investigation that the oxygen tanks were not filled with oxygen at the Adobe Mountain facility. At the time of my last assessment, the oxygen tanks were full. There were empty tanks that were yet to be given back to the company that they were no longer using.

Collateral information reviewed included a report completed by Victoria Lund, Ph.D., the Memorandum of Agreement between the US Department of Justice and the State of Arizona and a variety of medical charts.

Recommendation:

1. Effort should be made to fill any open nursing hours. If these cannot be filled, there should be further review of why this is the case and a significant attempt to ameliorate this problem.
2. I recommend an infirmary in each facility. In association with this, they are in need of 24-hour nursing. There are numerous justifications for 24-hour nursing and the need for an infirmary. This includes the care of children who are more sickly, the care of children with infectious diseases, the care of children who have just recently returned from the hospital who may have significant medical needs, external fixators or other medical issues which should be handled by nurses. In talking with numerous security professionals, they expressed significant anxiety and concern in having this responsibility fall onto them. In addition, there is always the possibility that a child will be placed in restraint on the night shift. A nurse should be present for that as well.

UFN 6.3 The State shall continue to implement a nursing quality assurance process, including audits of medical charts and medication administration records to monitor nursing assessments, care and documentation. Where problematic trends are identified, the State shall timely develop, implement, and monitor a corrective action plan.

Status: Partial compliance

Discussion: I met with upper administration, Meghan McGlynn, Dean Neitzke, the nurse manager at Black Canyon School, and Kevin Harper, BSN, RN, and the nurse manager at Adobe Mountain School. Catalina School did not have a nurse manager.

The impression given to me was that staff was beginning to work with the National Commission of Correctional Health Care in an attempt to revise and structure the quality assurance. However, at the time of my last interview, specific interventions regarding this had not yet been put into place. Again, as in many areas observed, much attention has been given to the concept of consistent care and quickly addressing any areas of potential concern. However, clear consistent protocols need to be in place. If new protocols are going to be implemented these should be established. If the protocols sent to me are going to be the ones to be established as the four-phase project being described to assist with medical services, it is my belief that this will continue to show progress and I am looking forward to evaluating this on future meetings.

I spoke with Dean Neitzke regarding quality assurance for nursing. He assured me that quality assurance was in place. Overall, it appears that there are a variety of placements regarding quality assurance. A variety of protocols were reviewed as well. The staff has also reported that they are beginning talks with the National Commission on Correctional Health Care. However, there was very little specific structuring of new quality assurance. In addition, when speaking to

the nurse manager at Adobe Mountain School, she did not have a clear understanding of the quality assurance requirements, what needed to be filled out and what was even being filled out within the facility.

Articles reviewed included a report completed by Victoria Lund, Ph.D., the Memorandum of Agreement between the US Department of Justice and the State of Arizona, a Memorandum: Pharmacy and Therapeutic Committee Members (P&T) meetings dated July 22, 2004 and ADJD monthly psychopharmacology report dated August 31, 2004. Dental report reviewed for consulting regarding Adobe Mountain School, Black Canyon School, Catalina School and Eagle Point.

Recommendation:

1. There needs to be well structured quality assurance. The impression given to me was that staff was beginning to work with the National Commission of Correctional Health Care in an attempt to revise and structure the quality assurance. However, at the time of my last interview, specific interventions regarding this had not yet been put into place. Again, as in many areas observed, much attention has been given to the concept of consistent care and quickly addressing any areas of potential concern. However, clear consistent protocols need to be in place. If new protocols are going to be implemented these should be established. If the protocols sent to me are going to be the ones to be established as the four-phase project being described to assist with medical services, it is my belief that this will continue to show progress and I am looking forward to evaluating this on future meetings.

UFN 6.4 The State shall develop and implement a formal system for the pharmacist to document alerts to the physicians regarding information about any youth's medication issues.

Status: Substantial Compliance

Discussion: Initial concerns regarding the pharmacist had to do with no active pharmacy and therapeutics (P&T) committee. In addition, there was prior concern that the medication box had not been evaluated and looked at in approximately 6 months. The list of medications within the box were undocumented and at least one medication had expired.

I met with the pharmacist, Dennis Haag. He reported that they have a significant formulary and when a nonformulary medication is needed, such as Wellbutrin XR that a request for the medication can be made. He informed me that in 100 percent of the occasions where the request had been made for a nonformulary medication, it had been granted. Mr. Haag reported that medications are sent to Tucson on a weekly basis. In addition, on occasion when Dr. Raker travels to Tucson, or others, they may take medications with them as well. In the interim, if medications are needed they can be delivered by a local pharmacy. P&T meetings are now scheduled on a monthly basis. This appears to be sufficient. In addition, Mr. Haag reported that if there is a request from a physician for additional side effect information, this can be provided. Overall, in my opinion, Mr. Haag is doing a great job. The facilities are lucky to have a pharmacist on premise. This is not typical and in and of itself minimizes any likelihood of

medication lapses and improves the ability for physicians to be informed of any new potential side effects or concerns with medications or combination of medications.

Mr. Haag also reported that when youth are discharged from the facility they are given a 10-day supply of medication. Although this appears sufficient, there is some concern as to whether or not appropriate followup care for the youth can be set up within that amount of time.

Collateral information reviewed included a report completed by Victoria Lund, Ph.D., the Memorandum of Agreement between the US Department of Justice and the State of Arizona, a Memorandum: Pharmacy and Therapeutic Committee Members (P&T) meetings dated July 22, 2004 and ADJD monthly psychopharmacology report dated August 31, 2004. the ADJC Drug Formulary for 2004. Dental report reviewed for consulting regarding Adobe Mountain School, Black Canyon School, Catalina School and Eagle Point.

Recommendation:

1. I would question whether or not the 10-day supply of medication is sufficient. Although this is not necessarily a pharmacy issue, I will overlap this in several different areas. Based on my experience, it is unlikely for a youth to followup with either a pediatrician/family practitioner or a psychiatrist within 10-days of release. Although this is possible, I doubt that it occurs most of the time. I would recommend attempting to followup regarding how soon a youth actually follows up with a psychiatrist. My concern is that a 10-day supply of medication may not be sufficient supply for them.

7. MENTAL HEALTH CARE

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

Status: Partial Compliance

Discussion: I have reviewed a variety of documents. Documents listed here cover all sections in (7). In addition, I have reviewed a multitude of youth's charts in all three facilities. I will not review the specific chart information, but do have this available.

To meet the requirements the state shall ensure adequate mental healthcare and treatment services, is all encompassing and complex. The subcategories may overlap but will help to clarify the more specific rating. There are several areas which will be addressed including: Policy and procedures, implementations of policy and procedures, documentation, psychiatric services, supervision and the application of exactly what is meant by mental health care.

Training Issues

Overall, it has appeared that appropriate training has been implemented. If anything, specific staff have begun to complain about all of the training they have needed to do. There were still some areas of training which needed to be completed, but are underway. There are numerous specific training, including intake training, proper use of emergency equipment and other specific medical and mental health training.

I had specific concerns regarding non-mental health professionals being responsible for mental health care. There is a clear role for non-mental health professionals with experience and specific training. This can include being a co-group leader with a mental health professional, assisting with behavior plans and milieu groups. More complicated treatment involving dynamic therapy, affect, cognitive therapy, or has been described, dialectical behavior therapy should be implemented by a mental health professional. A 40-hour training for a non-mental health professional, in my opinion, is not sufficient. For these staff to potentially co-lead a group with a mental health professional at either a social work or psychology level potentially is appropriate, but not running these groups, such as what occurs in the Maya Dorm at Catalina School or at the Adobe Mountain School. Again, there are staffing issues at all three facilities. All three facilities are interviewing for psych-associate positions and have openings for psych-associates positions. No interim plan such as using agency psychologists or social workers to assist has been developed

The substance abuse dorm at Catalina School, although having a substance abuse trained person as their dorm supervisor (YPS), does not have anybody with substance training actually running the groups or doing the therapeutic components in the dorm. This area is also problematic at Black Canyon School and Adobe Mountain School. At each facility, reference was made to a federal grant supporting the substance abuse program which will be up in June. I had asked for a copy of the grant, but did not receive it. I would like to review what the expectations of the grant were. On the positive side, a structured substance abuse program was implemented. Again, there is a pervasive issue in that there were non-mental health professionals who were the primary implementers of this plan.

Bi-Lingual Issues

Mr. Veloz reported concern over the large percentage of Mexican American and Mexican National children, some of whom the primary language is Spanish and many of whose parents' primary language is Spanish, with little or no ability to speak English. Yet, even though they make up approximately one-half of the youth within the institutions, there are a paucity of bilingual therapists, psychologists and physicians. There was additional concern regarding youth who are from Native American reservations and the relative high level of recidivism after the youth are released. This extends to a larger global issue of a paucity of family interventions. There are numerous reasons why this is the case. For many families it is very difficult, if not impossible, for them to come to the facility and not possible for the facility to facilitate this. For others, there simply have not been scheduled family sessions.

Staff Availability for Therapy Sessions

It was not possible to assess exactly how many individual and family sessions therapists had at Adobe Mountain School and Black Canyon School. This is because there has not been clear documentation regarding this. Dr. Otto has done an exceptional job documenting therapeutic

sessions for each of her psychology associates. When reviewing the total number of psych associates at Catalina School and assuming they have a 40-hour workweek, they only spend approximately 15 percent of their time in either individual or family therapy. In the entire facility that would only average 3 to 4 family sessions per week, in total. All of the treaters, in my opinion, are very motivated and can likely improve upon this. Their rationale in part, is related to having to do a variety of other activities, including assessing children in crisis, assessing children who have recently arrived to the facility and other administrative meetings, including training. When reviewing all of this additional time, it would still be possible to justify additional time for treatment

Use of Separation

There are several different reasons that youth go to separation. These can include aggressive or destructive behavior, a request by the youth to want to go to separation, or suicidal ideations/intent. Children who go to separation for any reason must be evaluated by a mental health professional. This can be a superficial note, as was reviewed on at least one youth at Catalina School, who was on separation. The head of separation (MHTC), in my opinion, should report to the head of psychology since this is primarily a mental health position. Obviously, part of their position is administrative and requires interactions with dorm supervisors (YPS) and others. The different titles at times become somewhat confusing. I am unclear why that position couldn't simply be a psych-associate in charge of separation.

Mental Health Supervision

At the present time, the psych-associates report to both the YPS and to psychology. The psychologists have had some difficulty attempting to organize their staff's activities. For example, a psych-associate spoke to the dorm supervisor regarding their Christmas vacation and the psychologist had planned for that psych-associate to be there for part of the time regarding coverage. Mental health professionals need to be supervised by mental health professionals. Mental health professionals should not be supervised by non-mental health professionals regarding mental health. However, it is extremely important that part of their job description include communication and interaction with the YPS and others within the dorm. When speaking with Dr. Warren, she has already recognized this issue. In a document which I reviewed, she plans to have the psych-associates report to and be supervised by the psychologist and to have the head of separation be at least at a level of a psych-associate and hopes to have this position report to the psychologist as well.

When reviewing this organizational chart, reporting lines appear clear. Dr. Warren's hope will be that the psych associates and head of separation would report to psychology. In my opinion, each of the specialty treatment units (Triumph and Maya) should have a psychologist overseeing the unit. Triumph currently has a psychologist. Much of the current published research describes increased psychopathology and trauma with female delinquents compared to their male counterparts. One would assume as such, that there would be more mental health interventions, not less, at the Black Canyon School secondary to this. I would recommend consistency, minimally, regarding this. The heads of each of these specialty units should then report to the head psychologist for the facility.

The head psychologist for the facility should then report to the position held by Dr. Petta, who would then report to Dr. Warren, who would report to Ms. Gadow, who would report to Mr.

Brenham. Obviously, within a secure school there is always a level of dual reporting to the superintendent and assistant superintendents, as deemed appropriate. For the purpose of this evaluation, I am not focusing on that component, but rather on the mental health needs and lines of communication. In my opinion, this is how the structure is in the process of being implemented. However, staff still are not clear about this and there still appears to be some areas of gray zone regarding reporting lines of communication

Use of Restraints

Although it is quite rare that therapeutic restraints are used, they are. I am assuming that the nursing will be 24-hours per day. As such, nursing should be assessing vitals and assessing the youth once they have been placed in restraints for any morbidity. Ideally, it is best when the psychiatrist can be contacted prior to the child being placed in restraint. When they are placed in restraint it would be my recommendation that they are contacted within one hour and are able to assess the child within two hours. Specific national protocols continue to be variable. Many hospital settings in 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 oncall psychiatrists, many hospitals would use their emergency room physicians or other physicians who may be oncall for that initial assessment. Any MD for this service can initially assess the child, ideally it should be the psychiatrist. In my opinion, there will be an additional cost.

Documentation

Documents reviewed beyond what has already been reported included numerous chart reviews, a progress report dated March 2004, a variety of Flow sheets, a list of cottages and prior population numbers, list of clinical and mental health services for the Department of Juvenile Corrections, the agency annual report, a number of additional sheets including: financial considerations, housing units, staffing, proposed teacher ratio, suicide prevention and facility renovations, booklets for the substance abuse program entitled: "The Seven Challenges", written by Robert Scwebel, Ph.D., packet of information from the Office of Policy, Strategic Diversity and Equity, dated April 21, 2004, put together by Esteban Veloz, Director, the Level System Manual for ADJC, Secure Schools, dated August 2004, the CV of Maryann Picardo, DO (psychiatrist at Adobe Mountain School), a draft manuscript entitled: "Required programming for housing units; How to Build Daily Successes Hour by Hour" dated 7-1-99, several legal correspondences, outline of the youth information computer program, the ADJC Drug Formulary for 2004, draft letter of agreement between the Arizona State Hospital and the Arizona Department of Juvenile Corrections, Memo from Kevin Harper to Kelly Warren, several referrals to Dr. Picardo from William Macklin, both dated 11-4-04, a suicide prevention example from Wednesday, November 3rd clinical meeting, a variety of demographic informational sheets, additional correspondences from Kevin Harper, a list of 19 residents at Black Canyon School who have IEP's, a BCS Psychopharmacology report dated 11-4-04, Task Analysis from Kevin Harper, a list from the last year on monthly schedules regarding the Adobe Mountain School noting such things as assault and other incidences, a memo from Judy Dyess to Kevin Harper regarding health unit transport/security, other single page memos, correspondences and worksheets regarding staff issues at Black Canyon School, a list of housing units at the Adobe Mountain School with their classifications, two juvenile fact sheets on residents at Adobe Mountain School, Alpha daily program schedule for Adobe Mountain School, a Cachina weekly

program schedule at the Adobe Mountain School, Challenge weekly program from Adobe Mountain School, Enterprise weekly program, Challenge weekly groups, Crossroads youth program, a variety of other program schedules including the 3-phase program and the Unit Recovery Group Schedule, Operating Process and Procedures, chapter on Communications regarding Cultural Competence, Gender Responsivity and Equal Access Effective 3-15-04, Memo from Stanley Raker to Kevin Harper and Sandy Domzella dated 11-16-04 regarding pap smears, Memo from Dean Neitske to Dr. Raker dated 1-20-05 regarding infectious disease procedure, followup memo from Dr. Raker dated 1-20-05 to Michael Braham, Director, Consultants meeting agenda dated 1-19-05 for Adobe Mountain School, copy of screening and assessing mental health and substance use disorders among youth in the juvenile justice system report by Thomas Grisso and Lee Underwood, Psy. D., dated 12, 2004, biographical sketch and curriculum vitae of Lee Underwood, Psy. D., Operating Procedures Manual, Secure Facilities Procedure No. 406.1.06 dated 4-28-03, a large folder entitled CRIPPA Action Plan dated 2005, additional information that was sent to me which covers a variety of different areas including areas of quality assurance, multidisciplinary team processes draft, variety of different procedures and protocols, Power Point presentation on Cultural Competency, a variety of procurement requests for data sets.

I reviewed the procedural guidelines for administering mental health and substance use screening and assessment instruments dated December 17, 2004 prepared by Lee Underwood, Psy. D.

I reviewed Procedure No. 4210.01, individual mental health counseling, Procedure No. 3100.17, psychiatric health services, Procedure No. 3100.21 referrals from psychiatric services at secure care facilities.

I also interviewed many of the psych-associates at each of the facilities, supervising psychologists, a number of the WYPO-3's and reviewed many of their resume summaries with a specific emphasis on education and their licensing. I met with and interviewed numerous administrative and clinical staff. Everyone was very cooperative and upfront. Their hard work and dedication to improving their program was made quite clear. Their director, Michael Branham, Deputy Director Dianne Gadow, Jim Hilliard, Kellie Warren, medical/behavioral health program administrator, Dr. Meghan McGlynn, previously head of education, now head of QA, Debra Peterson and Lou Goodman, Legal Systems Assistant Director, Lorraine Petta, Psy. D., behavioral services administrator, Tracy Wherry, MD, psychiatric service administrator, Stan Raker, MD, Medical Service Administrator, Dr. William Gillespie was not interviewed, but several specific questions which I had were addressed. I also met the superintendent at the facilities, including spending several hours in a meeting with Manny Lopez, Superintendent of Catalina School. I met with Esteban Veloz, Director of the Office of Policy, Strategic Diversity and Equity, and Edwin Grady.

I interviewed all but one of the treating psychiatrists. At Catalina School I interviewed Dr. Helmann. At Black Canyon School I interviewed Dr. Wherry and Dr. Link and at Adobe Mountain School, I interviewed Dr. Picardo

Recommendation:

1. The state needs to continue to work in appropriately stratifying their mental health program. They need to determine those mental health professionals who have training and those staff who are performing mental health services who have no training or have

a relatively minimal amount of training without a specific degree.

2. The Triumph Program at Adobe has a psychologist who assists with their programming. In a similar vein, there should be a psychologist (Ph.D. or Psy. D.), spending at least half of their time at the other specialty units as well, in particular Maya Unit at Black Canyon School.
3. There continue to be deficits in staffing for mental health professionals, particularly psych-associates. If it is not possible to hire psych-associates, one must review the interview process, salary, and job description, to at least attempt to determine why these positions remain open.
4. Alcohol and substance treatment programs are clearly important. All of the programs are doing a great job in structuring these programs and using structured material for these programs. It is imperative that each of these programs have at least one staff member who participates in groups and in individual work who has specific training and certification in substance abuse. In addition, if the federal grant is to continue for this, I would like a copy to review to better understand the goals and responsibilities of the program.
5. The Department of Juvenile Justice has begun to address cultural competency issues. As is known, there is a tremendous minority over representation of Mexican Nationals and Mexican Americans within corrections (approximately 50%). There needs to be more staff and mental health treaters who are bilingual and there needs to be more extensive family interventions with these youth. These youth are less represented in the special education program and there is a paucity of usage of mental health services. This will be an ongoing process which needs to be better understood. Hopefully, the improved intake process will help to assist with this.

A smaller, but even more concerning component has to do with the Native American population. There are a variety of difficulties working with families, including transitioning back to the community, extensive alcohol and substance abuse issues and again a paucity of special education and mental health services for these children.

6. I would recommend, as Dr. Otto has done at Catalina School, that there be clear documentation of what exactly the mental health professionals are doing. A similar type of documentation style should be implemented at Adobe Mountain School and at Black Canyon School to assess this so that future determination of needs can be made. I would expect that there be a comprehensive assessment of this prior to the next evaluation.
7. Lines of reporting and supervision for mental health professionals have begun to be addressed by Dr. Warren. This appears to be going in a very positive direction and I look forward to seeing how this has been implemented as policy in the near future.
8. There is a paucity of family therapy. It will be important to address this as much as is

possible. This may require additional funding to allow parents to come in and case managers to assist with this process. My understanding is that a family community based program has been started. I will look forward to the process of this program s time continues.

9. I would not recommend using the therapeutic restraint chair. If restraints are necessary, I would recommend 4-point leather restraints in a supine position. I would also recommend a psychiatrist being contacted within one hour of a child being placed in restraints. A physician needs to assess the child within 2 hours.
10. I would recommend that mental health oncall coverage be within the institution. There will be a higher likelihood that the therapist, whether psych-associate or psychologist, will have a better understanding of the institution than someone form outside the institution. There can always be oversight and quality assurance regarding this issue. I would think that many of the psych-associates would be quite qualified to do this. Consistency regarding interventions needs to be established prior to that occurring. In my opinion, Dr. Warren has already begun this process.

UFN 7.2 The State shall secure a Deputy Director, who shall meet minimum standards as specified by the State, to oversee the mental health care and rehabilitative treatment of youth at the facilities. The State shall provide the Deputy Director with sufficient staff and resources to perform the tasks required by this Agreement, including:

Status: Substantial compliance

Discussion: I met with Michael Branham, Director of the Arizona Department of Juvenile Corrections and with Dianne Gadow, Deputy Director of the Arizona Department of Juvenile Corrections. Ms. Gadow is working full time in this position and oversees mental health care and rehabilitative treatment of youth at the facilities. An extensive amount of staff have been hired, many of whom were interviewed. ADJC is still in the process of obtaining some of the additional resources through the state government that they are in need of, but have consistently been working to meet the requirements of the CRIPA agreement.

Recommendation:

1. It will be important in order to meet the goals of the CRIPA agreement, that there be the needed resources and funding available for the Arizona Juvenile Department of Corrections.

UFN 7.2.1 Oversight of mental health care in the facilities, including monitoring the performance of psychologists, counselors and private psychiatric contractors, and the development and implementation of policies and training program; and

UFN 7.2.2 Monitoring whether staffing and resources are sufficient to provide adequate mental health care and rehabilitative treatment services to the facilities' youth and to ensure compliance with this Agreement;

Status: Partial compliance

Discussion:

1. Interviews with mental health staff, as previously described.
2. Reviewing the supervisory structure of each facility and current attempts at monitoring psychologists, counselors and psychiatric contractors.

At the present time, there have been great strides in attempting to complete this task. However, it is still in process. Lines of reporting and a clear organizational chart are in the process of development. Lines of supervision between mental health professionals and non mental health professionals are still being discussed and have not yet been formalized.

Dr. Wherry, in my opinion, has a very clear understanding of the psychiatrists whom she supervises. She has an understanding of areas of strength and deficit and areas of need. Specific documentation regarding how the psychiatrists are supervised and are assessed still needs to be developed.

At the present time, clear documentation regarding how many patients are being seen, how much time the psychologists and psych-associates are spending in direct mental health interventions cannot be determined.

There were tremendous strides to show the attempts of overseeing these areas and in my opinion, the Arizona Department of Juvenile Corrections are very close to getting this in place. Once protocols have been implemented and reporting lines and supervisory lines are clear, in association with clear documentation of what is and what is not being done, so that specific needs can be better determined, I am sure this is an area that will shortly be in substantial compliance.

Recommendation:

1. As stated in 7.0
 - a. Developing better lines of supervisory communication
 - b. Identifying the amount of treatment that is actually occurring
 - c. Better solidifying a QA process.

UFN 7.2.3 Development and implementation of a quality assurance program for mental health care in coordination with the Quality Assurance Team.

Status: Partial compliance

Discussion:

Recommendation:

1. Clear procedure and then policy needs to be developed for mental health QA. These

are not yet fully developed. However, even without the development of these procedures, it is evident that supervisory staff has made significant effort and gains in currently providing a level of quality assurance and oversight supervision. Once this can be better standardized and developed into policy, I am sure that this area will be significantly compliant.

7.3 Intake Screening and Assessment

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 onsite 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 psychologist or psychiatrist shall review and sign the mental health needs assessment.

Status: Substantial compliance

Discussion:

Recommendation:

1. To further staff development within the RAC at Adobe Mountain School.
2. Confidentiality is potentially compromised at the RAC, secondary to the open area where this occurs. Better care for confidentiality needs to be undertaken
3. Consideration of further discussion of ways to potentially unify the intake so that it all occurs at the RAC. I am in understanding that this may not be possible and that there are other children who may come into Catalina including parole violators who may only be there for a very brief period of time. However, ways to attempt to streamline this would be worthwhile.

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 psychiatrist when necessary and referral to the facility's psychiatrist for evaluation.

Status: Substantial compliance

Discussion: Discussion with intake staff and discussion with psychiatry and multiple chart reviews. There was not a single example of a child that had been on a psychotropic medication where there was a delay in them seeing the psychiatrist or in any way that psychotropic medication was not given. However, I did not see examples of attempting to contact the

prescribing psychiatrist. In fact, in the charts I reviewed, this did not occur. However, overall I felt that there has been a strong success.

Recommendation:

1. Develop appropriate steps for contacting the prescribing psychiatrist.
2. While in the detention facility all attempts should be made to obtain available collateral information dealing with psychiatric and mental health care, so that appropriate interventions can be put into place once the children arrive for evaluation at the RAC at Adobe Mountain School.

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 facilities. 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 or the youth has been diagnosed as mentally ill;

Status: Substantial Compliance

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: Partial compliance

7.3.3.3 The youth is determined to be taking psychotropic medications, or has taken them in the past; or

Status: Partial compliance

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

Status: Substantial compliance

Discussion for 7.3.3.1; 7.3.3.2; 7.3.3.3; 7.3.3.4: Interviews with mental health staff and administrators as previously defined. Review of referral for psychiatric services at secure care facilities (psychiatric medication management, Procedure No. 3100.11), individual mental health counseling, Procedure No. 4210.01

At the present time, it still appeared somewhat difficult to identify youth who had already been placed at the facility who were not using mental health services, but at a particular point was in

need of mental health services. For example, at Catalina Mountain School there are numerous youth who have been in separation on three or four occasions, through self-referral or otherwise. These youth may or may not be evaluated by a psych-associate, are not evaluated by psychiatry, are not evaluated by psychology. I evaluated one child on the separation unit at Catalina Mountain School, three and a half hours after he had been placed on the unit, he had not been seen by a nurse, not been seen by a psych-associate from his dorm, and had not yet been seen by the separation unit manger (MHTC). In this particular case, the psych-associate from the Geronimo dorm was offsite and had no coverage.

Dr. Otto and Dr. Warren explained to me that youth who are placed on separation due to a fight for example or danger to others, may not necessarily be evaluated by a psych-associate at all.

When reviewing the number of youth at the Catalina facility who had three or more admissions to separation between June 1st and December 14th of 2004, it totaled 21 children. No additional interventions were put into place. No psychiatric services were specifically put into place.

An additional issue has to do when youth are hospitalized. At present youth who are hospitalized are not typically seen by a psychiatrist prior to hospitalization.

Recommendation:

1. It is my strong recommendation that a psychiatrist should assess youth prior to hospitalization and make those specific recommendations. One should realize that hospitalization is a restriction of one's rights. I would strongly recommend using an MD in assisting with that decision process. In my opinion, having this initial assessment will help with followup and discharge planning.
2. The issue of patient privilege, confidentiality and HIPPA compliancy needs to be addressed. This has been discussed and personnel have been hired in legal to assist with this.
3. Referrals to psychiatry need to be made not simply because a patient is, or has been, on medication but to assist with treatment planning, diagnostic opinions and for treatment recommendations.

UFN 7.3.4 The Deputy Director shall, if a need for mental health treatment is indicated, ensure the youth receives the treatment indicated.

Status: Substantial compliancy

Discussion: The Deputy Director has hired a supervisor of mental health in clinical services, Kelli Warren, Psy. D., who has continued to have consistent restructuring and monitoring of youth needing mental health treatment and attempting to ensure that this occurs. Her clinical oversight proposal describes this further.

Recommendation:

1. Structured protocols for children going to separation should be reviewed.

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: Partial compliance

Discussion: I reviewed a multitude of patient charts; many of the youth were quite complex and these were no treatment plans. I met with the psychologists within the given facilities who reported that although there are team meetings, that comprehensive treatment plans have not yet been implemented in any type of consistent fashion. Psychiatrists have not been involved in treatment plans and the school system has not been involved in treatment plans.

There were a number of books which were reportedly reviewed by Dr. Warren regarding treatment plans.

In addition, Dr. Warren has written up a draft multidisciplinary team process. Within this, she attempted to define initial multidisciplinary staffings, weekly multidisciplinary staffings, monthly multidisciplinary staffings, 90-day multidisciplinary team meetings and special circumstance staffings. This six and a half page document is quite comprehensive. However, the facilities have not yet implemented this and this is not yet policy.

The awareness of mental health and administration to the need of multidisciplinary treatment planning is great. It will likely be complex in implementing regarding potential time restraints, the potential need for additional psychiatric hours, secretarial service, mental health and educational support.

Part of multidisciplinary planning is to involve families and to begin addressing the concept of transition and the need for these youth when they are released from the facility. Without doing this, there will be an increased risk for recidivism.

Recommendation:

1. I would recommend that clear procedures and policies be developed for multidisciplinary staffings. I will assume the draft multidisciplinary team process will be the basic structure for this and look forward to review of a final version.
2. I would recommend defining a specific multidisciplinary procedure to allow them to become policy so that one can begin to implement these.
3. I recommend speaking with all potentially involved staff to better understand their perspectives so that if additional time is needed, this can be defined.
4. Family interventions and cultural competency with a concept of transition to the community must be part of the multidisciplinary meeting.

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 An identification of the mental and/or behavioral health issues to be addressed;

7.3.6.3. A description of any medication or medical course of action to be pursued, including the initiation of psychotropic medication;

7.3.6.4 A description of planned activities to monitor the efficacy of any medication or the possibility of any side effects;

7.3.6.5 A description of any behavioral management plan or strategies to be undertaken;

7.3.6.6 A description of any counseling or psychotherapy to be provided;

7.3.6.7 A determination of whether the type or level of treatment needed can be provided in the youth's current placement;

7.3.6.8 A plan for monitoring the course of treatment; and

7.3.6.9 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. 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: Partial compliance

Discussion: See discussion in 7.3.5

Recommendation:

1. Earlier attempts at developing transition planning needs to be implemented.
2. Better case management in setting up appointments should be implemented. I would recommend a 30-day supply and not a 10-day supply of medication, as it is unlikely than many youth can get an appointment within two weeks of discharge. If it does appear that youth can get appointments within 10 days of discharge then a 10-day supply would be sufficient.
3. The transition plan should involve the multidisciplinary treatment team. If certain people cannot attend a discharge planning meeting, such as the psychiatrist, recommendations

from the psychiatrist should be made, preferably in writing. The school program should be involved with this as well.

UFN 7.3.7 The Deputy Director shall issue and implement policies and procedures for the administration of appropriate tests (including, for example, blood tests, EKGs and Abnormal Involuntary Movement Scale test) to monitor the efficacy and any side effects of psychotropic medications in accordance with professional standards.

Status: Partial compliance

Discussion: Chart reviews and interviewing with psychiatrists at the three facilities.

Although many of the baseline lab work and followup lab work which is indicated is being completed, there is a level of inconsistency with this. There are few protocols and no written consistency. Informed consent is not clearly documented consistently.

Recommendation:

1. I would recommend protocols for lab work be developed.
2. Protocols need to be identified which will, for example, include obtaining EKG's both before and once a maintenance dose of a medication which can cause electro-conduction changes, cardiac electro-conduction changes, particularly QTc widening. When medications which can widen QTc's are used, remember that if more than one is used, there will be a higher risk for QTc widening. Examples of these medications can include Geodon, Clonidine, Tenex and others. When using Depakote liver function tests, CBC and Depakote levels need to be obtained. Baseline labs need to be obtained prior to starting the medication. Followup lab work should be obtained every four months, with the initial followup lab work being obtained in one month. When Tegretol is used a baseline CBC needs to be obtained and obtained on followup lab work. When Lithium is used, a baseline BUN and Creatinine and thyroid panel and TSH need to be obtained. Again, followup lab work in one month and in 4-month increments after that should be obtained. A thyroid stimulating hormone (TSH) should be all that is necessary following this. There are few definitive protocols at present. These are reasonable safe protocols which I have recommended which are often typically used by child psychiatrists within the community. When starting a child on a psychotropic, particularly if their symptomatology is significant, I would recommend followup within 1-week and some level of communication with his psych-associate during that time.
3. 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, I would recommend documenting what handout was given and how it was explained.

APPENDIX A

Site Visits by Consultants

Lindsay Hayes

Dates	Locations
October 20-21, 2004	BCS, AMS
October 22, 2004	CMS
January 31, 2005	AMS
February 1, 2005	AMS
February 2, 2005	BCS
February 3, 2005	CMS
February 4, 2005	Central Office

Louis Kraus

Dates	Locations
November 1-5, 2004	AMS, BCS
January 19-20, 2005	CMS

Peter Leone

Dates	Locations
October 20-21, 2004	AMS
December 20-22, 2004	AMS, BCS, CMS
January 18-19, 2005	AMS, BCS

Russ Van Vleet

Dates	Locations/Event
September 15, 2004	Governor's announcement of settlement agreement
September 21, 2004	Governor's Task Force on Juvenile Justice
October 14, 2004	Community Advisory Board, Yuma
October 20-22, 2004	AMS, BCS, CMS
Nov 2, 2004	Governor's Task Force
Dec. 20-23, 2004	AMS, BCS, CMS
Jan 18-20, 2005	AMS, BCS, CMS
February 8-10, 2005	AMS, BCS, CMS

APPENDIX B

Unique File Numbering (UFN) Ratings

3. SUICIDE PREVENTION

3.1.1 Training

UFN	Rating
3.1.1.1	Partial Compliance
3.1.1.2	Partial Compliance
3.1.1.3	Partial Compliance
3.1.1.4	Partial Compliance
3.1.1.5	Partial Compliance
3.1.1.6	Partial Compliance
3.1.1.7	Partial Compliance
3.1.1.8	Partial Compliance
3.1.2	Partial Compliance

3.2 Identification/Screening

UFN	Rating
3.2.1	Partial Compliance
3.2.2	Partial Compliance
3.2.3	Partial Compliance
3.2.4	Partial Compliance
3.2.5	Partial Compliance
3.2.6	Partial Compliance
3.2.7	Partial Compliance
3.2.8	Partial Compliance
3.2.9	Partial Compliance

3.3 Safe Housing of Suicidal Youth

UFN	Rating
3.3.1	Partial Compliance
3.3.2	Partial Compliance

3.4. Supervision

UFN	Rating
3.4.1	Not Reviewed
3.4.2	Not Reviewed

3.5. Intervention

UFN	Rating
3.5.1	Partial Compliance

3.6 Mortality Review

UFN	Rating
3.6.1	Not Reviewed

4. JUVENILE JUSTICE

4.1 Grievance System

UFN	Rating
4.1.1	Partial Compliance
4.1.1.1	Partial Compliance
4.1.1.2	Partial Compliance
4.1.1.3	Partial Compliance
4.1.1.4	Partial Compliance
4.1.1.5	Non-Compliance

4.2 Protection from Harm

UFN	Rating
4.2.1	Substantial Compliance
4.2.2	Partial Compliance
4.2.3	Non-Compliance
4.2.4	Partial Compliance
4.2.4.1	Substantial Compliance
4.2.4.2	Partial Compliance
4.2.4.3	Partial Compliance
4.2.4.4	Substantial Compliance
4.2.5	Partial Compliance
4.2.5.1	Partial Compliance
4.2.5.2	Partial Compliance
4.2.6	Substantial Compliance
4.2.7	Partial Compliance
4.2.8	Non-Compliance

4.3 Staffing

UFN	Rating
4.3.1	Partial Compliance
4.3.2	Partial Compliance

4.4 ADJC's Investigations and Inspections
Unit and Quality Assurance Team

UFN	Rating
4.4.1	Substantial Compliance
4.4.2	Partial Compliance
4.4.3	Not Reviewed
4.4.3.1	Non-Compliance
4.4.3.2	Non-Compliance
4.4.3.3	Partial Compliance
4.4.3.4	Non-Compliance
4.4.3.5	Non-Compliance
4.4.4	Partial Compliance
4.4.4.1	Non-Compliance
4.4.4.1.1	Partial Compliance
4.4.4.1.2	Non-Compliance
4.4.4.1.3	Non-Compliance
4.4.4.1.4	Partial Compliance
4.4.4.1.5	Partial Compliance
4.4.4.1.6	Non-Compliance
4.4.4.2	Partial Compliance
4.4.4.3	Partial Compliance
4.4.4.4	Partial Compliance
4.4.4.5	Partial Compliance
4.4.4.6	Non-Compliance
4.4.5	Partial Compliance
4.4.6	Partial Compliance
4.4.7	Substantial Compliance
4.4.8	Partial Compliance
4.4.9	Partial Compliance
4.4.9.1	Partial Compliance
4.4.9.2	Partial Compliance
4.4.9.3	Partial Compliance
4.4.9.4	Partial Compliance
4.4.9.5	Not Reviewed
4.4.10	Partial Compliance
4.4.11	Partial Compliance
4.4.12	Partial Compliance

4.5 Disciplinary Confinement/Due Process

UFN	Rating
4.5.1	Partial Compliance
4.5.2	Substantial Compliance

5. SPECIAL EDUCATION

UFN	Rating
5.1	Partial Compliance
5.2	Partial Compliance
5.2.1	Substantial Compliance
5.2.2	Partial Compliance
5.2.3	Not Reviewed
5.3	Partial Compliance
5.3.1	Partial Compliance
5.3.2	Non-Compliance
5.3.3	Not Reviewed
5.3.4	Not Reviewed
5.3.5	Not Reviewed
5.3.6	Not Reviewed
5.4	Substantial Compliance
5.5	Not Reviewed
5.6	Not Reviewed

5.7 Individual Education Plans

UFN	Rating
5.7.1	Partial Compliance
5.7.2	Partial Compliance
5.7.3	Partial Compliance
5.7.4	Partial Compliance
5.7.4.1	Partial Compliance
5.7.4.2	Not Reviewed
5.7.5	Not Reviewed

5.8 Section 504 Plans

UFN	Rating
5.8.1	Partial Compliance

5.9 Training and Quality Assurance

UFN	Rating
5.9.1	Substantial Compliance
5.9.2	Not Reviewed

6. MEDICAL CARE

UFN	Rating
6.1	Substantial Compliance
6.2	Partial Compliance
6.3	Partial Compliance
6.4	Substantial Compliance

7. MENTAL HEALTH CARE

UFN	Rating
7.1	Partial Compliance
7.2	Substantial Compliance
7.2.1	Partial Compliance
7.2.2	Partial Compliance
7.2.3	Partial Compliance

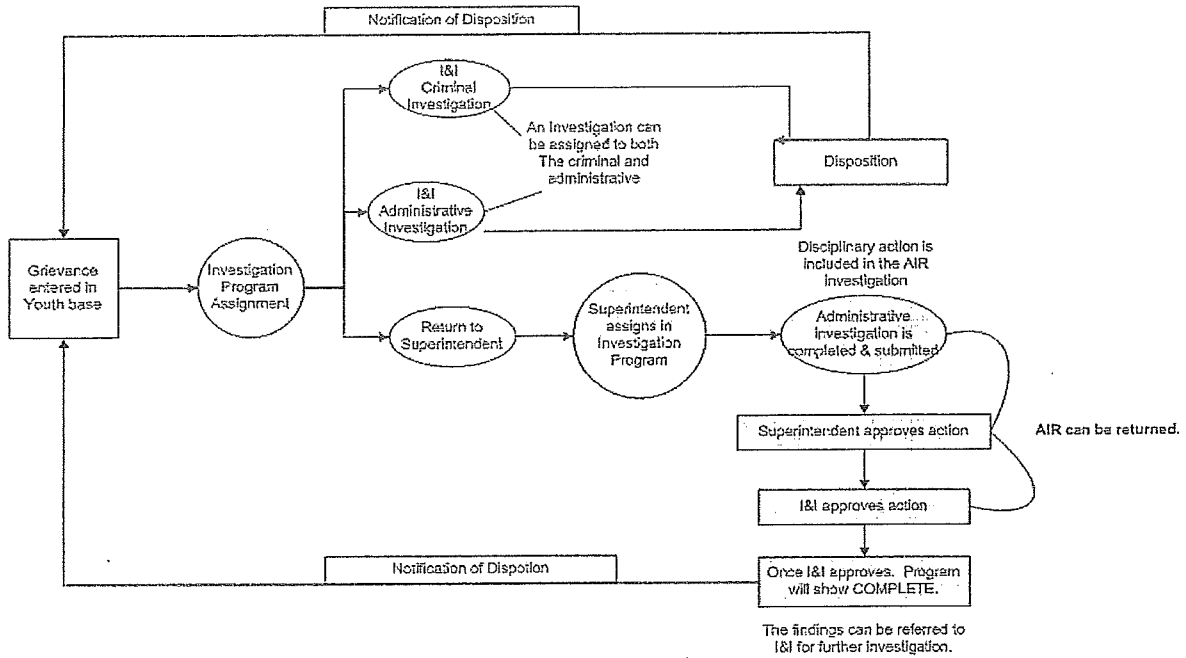
7.3 Intake Screening and Assessment

UFN	Rating
7.3.1	Substantial Compliance
7.3.2	Substantial Compliance
7.3.3	Not Reviewed
7.3.3.1	Substantial Compliance
7.3.3.2	Substantial Compliance
7.3.3.3	Substantial Compliance
7.3.3.4	Substantial Compliance
7.3.4	Substantial Compliance
7.3.5	Partial Compliance
7.3.6	Not Reviewed
7.3.6.1	Partial Compliance
7.3.6.2	Partial Compliance
7.3.6.3	Partial Compliance
7.3.6.4	Partial Compliance
7.3.6.5	Partial Compliance
7.3.6.6	Partial Compliance
7.3.6.7	Partial Compliance
7.3.6.8	Partial Compliance
7.3.6.9	Partial Compliance
7.3.7	Partial Compliance

APPENDIX C

ADJC Youth Grievance Flow Chart

ADJC YOUTH GRIEVANCE FLOW CHART



*The disposition of this information will be used in the Employee Information Sharing System (EISS).

1. This program is in development as of this writing. The key stakeholders involved are the Youth Ombudsman Administrator, The Inspections and Investigations Administrator, and the M.I.S. Administrator.
2. The tracking and timeliness of the Youth Grievance Investigations is critical in order to validate the usefulness of the process. Besides improved tracking of each youth grievance-a ten calendar day turnaround (per Director Branham) will be implemented.
3. Linkage of data bases and time-bound email notifications will further manage timeliness and information sharing of investigations and status.